Manchester Mental Health and Social Care 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)
TAE03	Park House	Elm, Juniper, Laurel, Mulberry and Redwood wards	M8 5RB
TAE02	Laureate House	Blake and Bronte	M23 9LT

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for acute wards for working age adults and the psychiatric intensive care unit (PICU) of **requires improvement** because:

- Elm, Laurel, Mulberry and Redwood wards all had shared single sex bed bays. Due to this environmental limitation patient privacy and dignity was not always respected.
- Elm ward has 4 rooms; an activity room, multi functions room, quiet room and nativity room. If any of these are in use for de-escalation or for any other reason, another room is used as a quiet room or for activities.
- The records relating to the seclusion of patients on Juniper PICU ward did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the Code of Practice: Mental Health Act 1983 (CoP). There were concerns about the seclusion room admission process.
- Ligature points (places to which patient might tie something to strangle themselves) were identified in the risk register and the plan to reduce these fixtures was set out in the Capital programme. Further measures to address ligature risk on a daily basis were identified via individual risk assessments.
- On some of the wards, staff did not have clear lines of sight to all patient areas.
- There were blanket restrictions in place across the acute and PICU wards that were not based on individual risk. For example, patients were not allowed to use rooms where there were ligature risks unsupervised, energy drinks were banned and drug detection dogs were routinely used to search all patient rooms.
- Staff and patients reported that escorted leave was often cancelled or reduced due to staff shortages. This was confirmed by the advocacy service.
- Many care plans were not holistic, personalised or recovery-focused. Patients confirmed their lack of involvement in their care and support planning.
- The wards did not provide psychological interventions or family therapies.
- Staff demonstrated a confused understanding of the Mental Capacity Act. We found that staff had assessed the mental capacity of a patient to consent to care yet they had not always acted in the patient's best interest.
- Staff supervision did not take place on a regular basis.
- Activities were cancelled whenever there was a shortage of staff or a ward round took place. There were even fewer activities during the weekend.
- Overall, the activities offered were not meaningful, nor did they take into account the individual needs of the patient. Some patients said they were bored.
- The local governance processes did not always enable identification of where the services needed to improve; where they did, no effective action plan was formulated. A system that ensured care plans and risk assessments were up to date relied on supervision to address quality issues.

With a few exceptions, patients spoke positively about the support they received from permanent staff. They said staff were respectful, helpful and caring. However, some patients commented that agency staff need to be more professional in their attitude, as some did not appear interested in the patients.

Staff morale was varied across the wards we visited. Some staff had a positive view of the organisation. Some staff were unaware of the vision and values of the organisation and felt disconnected from the trust. The staff conduct during the inspection varied, in that some staff were reluctant to enable interviews with service users, their carer and staff. Several acting/deputy ward managers had in been in post less than six months.

Monitoring of incidents, complaints and safeguarding incidents were used to make improvements to the service. Staff received debrief and feedback by means of team meetings and emails.

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:

- Elm, Laurel, Mulberry and Redwood wards all had shared single sex bed bays. Due to this environmental limitation patient privacy and dignity was not always respected.
- Elm ward has 4 rooms; an activity room, multi functions room, quiet room and nativity room. If any of these are in use for de-escalation or for any other reason, another room was used as a quiet room or for activities.
- The records relating to the seclusion of patients on Juniper PICU ward did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the Code of Practice: Mental Health Act 1983 (CoP).
- Ligature points (places to which patient might tie something to strangle themselves) were identified in the risk register and the plan to reduce these fixtures was set out in the Capital programme. Further measures to address ligature risk on a daily basis were identified via individual risk assessments.
- Some of the wards, staff did not have clear lines of sight to all patients areas.
- There were blanket restrictions in place across the acute and PICU wards that were not based on individual risk. For example, e.g. patients were not allowed to use rooms where there were ligature risks unsupervised, energy drinks were banned and drug detection dogs were routinely used to search all patient rooms.
- Staff and patients reported that escorted leave was often cancelled or reduced in length due to staff shortages. This was confirmed by the advocacy service.
- Information about how detained patients could leave the ward was not provided at the ward door.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Care plans were not holistic, personalised or patient-focused. Patients confirmed their lack of involvement in their care and support planning.
- The wards did not provide psychological interventions or family therapies.

Summary of findings

- Staff demonstrated limited understanding of the Mental Capacity Act. We found that staff had assessed the mental capacity of a patient to consent to care yet they had not always acted in the patient's best interest.
- Staff supervision did not take place on a regular basis.

However

- Patients had a comprehensive assessment of their needs upon admission including physical health needs.

Are services caring?

Good

We rated caring as **good** because:.

- With a few exceptions, patients spoke positively about the support they received from permanent staff. They said staff were respectful, helpful and caring. Some patients commented that agency staff needed to be more professional in their attitude, as some did not appear interested in the patients.
- Community meetings were held regularly on the wards to obtain the views of patients.
- Patients had regular access to advocacy and translators if they needed them.

However

- W observed there was limited interaction between staff and patients.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Patient compliments, complaints and concerns were listened to and responded to.
- Verbal complaints were responded to immediately. Written complaints were escalated by the ward manager.
- Staff received feedback on the outcome of investigations of complaints either individually from the ward manager or through team meetings and emails.

However

- Activities were cancelled whenever there was a shortage of staff or a ward round took place.
- Overall, the activities offered were not meaningful, nor did they take into account the individual needs of the patient. Some patients said they were bored.

Summary of findings

- There were delayed discharges for non-clinical reasons, for example, awaiting grants and community placements. Links with community mental health teams required improvement.

Are services well-led?

Good

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

- A system in place that ensured care plans and risk assessments were up to date relied on supervision to address quality issues. However supervision did not take place on a regular basis.
- Monitoring of incidents, complaints and safeguarding incidents were used to make improvements to the service. Staff received debrief and feedback by means of team meetings and emails.
- Staff morale was varied across the wards we visited: some staff had a positive view of the organisation. Some staff were unaware of the vision and values of the organisation and felt disconnected from the trust. The staff conduct during the inspection varied, in that some staff were reluctant to enable interviews with service users, their carer and staff.

Summary of findings

Background to the service

Manchester Mental Health and Social Care Trust provide inpatient services for working age men and women who have mental health conditions. The acute inpatient wards and psychiatric intensive care units (PICU) are provided for people who are admitted informally or compulsorily detained under The Mental Health Act.

The trust has five acute inpatient wards and two PICUs over two hospital locations.

Park House in North Manchester General Hospital:

Elm ward is a 24 bed female acute inpatient ward

Laurel ward is a 23 bed male acute inpatient ward

Mulberry and Redwood are both 20 bed male acute inpatient wards

Juniper is a 10 bed male PICU.

Summary of findings

Laureate House in Wythenshawe Hospital:
Bronte ward is a 31 bed mixed gender acute inpatient ward.

Blake ward is an 8 bed female PICU.

We have inspected the services provided by Manchester Mental Health and Social Care Trust on a number of occasions since registration. At their last inspection, Laureate House was not meeting the essential standards relating to Regulated Activities Regulations 2010 Care and welfare (Regulation 9). These compliance actions were inspected as part of this comprehensive review and the requirements had been met.

We have also carried out regular Mental Health Act (MHA) monitoring visits to all the acute wards and PICUs within the last 18 months.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubb, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included CQC inspectors and a variety of specialists and included:

- Experts by experience
- Mental health act reviewer
- Mental health and learning disability nurses
- Psychiatrists
- Psychologists

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

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We attended the trust's annual members meeting and invited patients and members of the public to meet with us. We also arranged a focus group prior to the inspection, facilitated by a voluntary organisation. We carried out announced visits to the service on 24, 25 and 26 March 2015

During the visit we met and interviewed 33 members of staff who worked within the service, including care workers, consultants, qualified nurses, matrons, ward managers and acting ward managers.

We met with 28 patients who were using the services who shared their views and experiences of the services we visited.

We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of 50 patients. We looked at a range of records including clinical and management records.

Summary of findings

During the inspection of the core services we spoke with two carers.

We completed a Mental Health Act monitoring visit

What people who use the provider's services say

The patients we spoke with told us that the staff treated them with respect. However, they also said that the staff were often busy which meant that they sometimes needed to ask several times before the staff were able to respond. One patient told us that in contrast to her experience on another ward she felt that the staff on Bronte Ward did not dismiss her requests but were very genuine and responded as soon as they were able.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The service must ensure that where environmental risks have been identified action is taken to ensure the safety and well-being of patients'.
- The service must ensure privacy and dignity is promoted.
- The service must ensure that there is an effective system in place to monitor and analyse incidents.
- The service must ensure there is sufficient staff with appropriate skills and competence to meet the needs of patients' at all times.
- The service must ensure patients' have access to activities to meet their needs effectively
- The service must ensure that care plans are holistic, personalised and patient focused.
- The service must ensure staff are suitably qualified, competent and skilled.
- the service must ensure that patents' have access to psychological intervention and therapies in accordance with published research and guidance.
- The service must ensure they work effectively with other professionals.
- The service must have an effective governance system to ensure improvements are made

Manchester Mental Health and Social Care 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
Elm ward Juniper ward PICU Laurel ward Mulberry ward Redwood ward	Park House
Blake ward PICU Bronte ward	Laureate House

Mental Health Act responsibilities

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

Mental Capacity Act and Deprivation of Liberty Safeguards

In each case record we reviewed on Bronte ward we saw that the Responsible Clinician had recorded the outcome of their assessment of whether the patient had the capacity to consent to their treatment; however, they had not recorded the steps they had taken in reaching this outcome.

Detailed findings

Staff on Laurel and Elm wards had a confused understanding of the MCA. For example, a patient who was nutritionally compromised was assessed as lacking capacity to make decisions about their care. Staff struggled to motivate this patient, who routinely declined breakfast and lunch so was given a supplement shake instead. No meeting had been arranged to determine what care should be given in the patient's best interests despite evidence that the patient continued to lose weight. A meeting had been arranged to discuss the best interests of another patient but there was no evidence that the Responsible Clinician had assessed whether the patient had capacity to make decisions about their own care.

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

Summary of findings

Our findings

Safe and clean ward environment

At Park House, all wards with the exception of Juniper PICU had bed bays. Each bay accommodating between four and two patients; each bed space was partitioned with thin curtains. There were some individual bedrooms on each ward for patients with more complex needs. At Laureate House the wards had individual bedrooms. Bronte ward was the only mixed ward and complied the requirements of same sex accommodation guidance. The bedrooms were segregated and located on three corridors; 11 bedrooms for male patients were located on one corridor and 10 bedrooms for female patients were on each of the other two. All of the bedrooms contained a hand basin and a safe for personal belongings. Six toilet / shower rooms were also located on each corridor and the other toilets on the ward were clearly segregated

All the services we visited were clean. On Laurel ward some furnishings were worn and sofas and chairs in the lounges were torn. On Blake ward the environment was in need of refurbishment. It was well worn, lacked colour and pictures and there was damage to fixtures and fittings.

We noted on both Elm and Laurel wards that the cleaner's trolley and equipment, which included cleaning products, had been left unattended in the corridor. Patients on both these wards had been assessed at risk from hurting themselves. Ingestion of cleaning products could cause serious potential harm to patients.

The garden spaces were secure but poorly maintained and unkempt. In particular Mulberry ward garden space was littered with cigarette butts and debris. We were told the garden was cleaned weekly but it was neither a therapeutic or clean environment for patients to spend time.

The wards conducted monthly infection control audits; we reviewed a ward's most recent audit and found that any actions needed to be implemented had been followed up.

On several wards staff had no clear line of view to patients in those sections of the ward furthest away from the nurses' office due to the layout of the corridors. On Blake PICU, closed circuit television (CCTV) had been installed to cover these blind areas. There were areas on other wards where there was no CCTV or mirrors installed. The risks were being mitigated by appointing a 'safety nurse' each shift to patrol these areas at regular hourly intervals. Activity rooms were kept locked due to ligature risks. During our visit two patients entered an unlocked activity room without the knowledge of staff and remained in there for 15 minutes unobserved by nursing staff. We brought this to the attention of ward staff who said they had been told that inspectors were in the room at the time.

Both sites had undertaken ligature risk assessments (identifying places to which patients might tie something to strangle themselves) and identified window locks, bed posts and door hinges as potential ligature risks. There was an approved action plan within the Capital Plan which addresses replacing these fixtures with ligature risk free alternatives.On the Blake ward the furniture was not fixed in line with PICU standards; however, all furniture on Juniper was fixed, except sofas and heavy weight chairs, in line with PICU standards.

On Elm ward, ligature cutters were kept in a specifically marked tray in the nurses' office. However the cutters were hidden underneath correspondence/paperwork and not visible. We brought this to the immediate attention of staff, who removed the paperwork.

Individual patient rooms were left unlocked unless the patient specifically asked for their room to be locked. Patient privacy and dignity was not always respected on those wards with shared bed bays; during our visit we observed patients entering bed spaces that were not theirs.

On Elm ward there was a direct line of view from the corridor into a patient's individual room. The window to the room was partially covered by a bed sheet. However, we could see the patient lying in bed. The patient was a vulnerable adult and staff responsible on the day of our inspection did not ensure the patient's privacy and dignity was protected.

Requires improvement

Are services safe?

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

Staff working on the wards were provided with portable alarms. There was a response team that attends from other wards to support following the activation of alarms. This was heard across the acute and PICU wards at Park House and resulted in a minimum of four staff attending. These were the bleep holder and the identified response nurse from each ward. On Blake PICU it was not possible to hear alarms being activated in the clinical room or in the garden area. There was a wall alarm installed in the garden area.

Each ward was allocated 15 minutes every hour to use the garden, which had to be supervised due to ligature risks from the trees and to prevent illicit substances being passed over the fence. There were a number of actions that were taken to minimise potential risks of drugs being supplied to individuals which included Garden patrols by staff, patrols of the garden by sniffer dogs and strict supervision of patients using the garden.

At Park House the seclusion room was located on Juniper ward. The seclusion room had a mirror installed, to ensure there was an unrestricted view in to tall areas of the room. The seclusion room needed cleaning at the time of our visit and this was remedied before we left.

We checked the equipment in the clinic rooms, which was accessible and checked in line with the trust policy. The emergency medication was in place and in date. Some of the clinic rooms did not have a couch. When needed, patients' beds were used.

Safe staffing

The trust had recently reviewed staffing levels at both sites and an active recruitment process was in place. The trust was recruiting over establishment to try to reduce the high levels of agency staff used. Ward managers told us they had the authority to increase staffing levels when patients needed higher levels of observation. Patients with substance misuse issues were frequently placed on 1:1 observations to ensure that illicit drugs were not taken supplied, passed to other patients. During our inspection we observed each ward had numerous staff on duty. This was due to the high levels of 1:1 observations.

Several wards had high levels of nursing (qualified and unqualified) vacancies. Staffing levels were maintained using a significant number of bank and agency staff to ensure there were enough staff on duty for each shift. Wherever possible, staff who were familiar with the ward were used. Each ward had an induction checklist that was completed by all new agency staff before their shift. On occasions shifts were not filled. Staff and patients told us when agency staff were used it impacted negatively on the care delivered as the therapeutic relationship between patient and staff had not been established.

Escorted leave, an essential part of patient recovery, was frequently either cancelled or the length of leave significantly reduced whenever staffing levels were too low to provide an escort. Staff told us there was not a credible audit tool for monitoring how often this happened so were unable to inform us how many times patient leave had been cancelled in the months leading to our inspection.

The seclusion log on both wards did not provide a clear record of medical and nursing reviews, to ensure that these were carried out in accordance with the Code of Practice: Mental Health Act 1983 (CoP) and demonstrate patients were appropriately reviewed. On Juniper ward a patient who had been in seclusion for 10 days was not seen by an independent reviewer during this period.

Staff told us there was a greater emphasis on verbal de-escalation techniques and reducing physical restraints. All managers said their wards were following the safer wards protocol.

Staff told us and recruitment records confirmed staff had received training in physical intervention. On Blake PICU there had been a recent incident where the police had to be called to assist staff with a patient who required seclusion because staff were unable to carry out physical interventions safely.

Training was a mixture of e learning and face to face training and designed to ensure staff were able to deliver care to people safely and to an appropriate standard. However, the ward managers' records showed that compliance with mandatory training was 69% across the wards.

Assessing and managing risks to patients and staff

We looked at 50 patients' records, which all had up to date risk assessments reviewed and updated by nurses on a weekly basis using a risk assessment matrix, which combined likelihood with consequence to give a score. Patients told us they felt safe and well cared for.

Staff received mandatory training in safeguarding vulnerable adults and children. The level of compliance with this mandatory training was over 80%. Staff we spoke

Requires improvement

Are services safe?

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

with knew how to recognise a safeguarding concern, make a referral, who their safeguarding lead was and who their local safeguarding authority was. Managers said that they would discuss potential safeguarding issues with the local authority safeguarding team when necessary.

There were some blanket restrictions in place that did not reflect patients' individual needs:

- Energy drinks were banned at Park House Hospital due to their high sugar and caffeine content.
- A detection dog was routinely taken into each patient bedroom to search for drugs. The staff told us that these actions were imposed routinely every two – three weeks without regard to any individually assessed risks. While we saw that a notice on the ward door informed patients of the routine searching by the detection dog, the permission of the patient was not sought and no patient was allowed either to refuse to show staff the contents of their post or to object to the dog searching their room. The use of the detection dog was in response to a serious drug related incident that had taken place on one of the wards. The searches had been unproductive on all the wards except Bronte, where cocaine was found on one occasion.
- Patients were only allowed access to outdoor spaces for 15 minutes every hour.
- The kitchens and activity rooms were locked and patients could only access these rooms with staff supervision.

Staff on all wards told us that informal patients were free to leave at will and were required to let staff know so they could be signed out. There were no signs in place on the locked ward doors telling informal patients they could leave the ward.

The wards were risk averse and would routinely increase the use of observations for complex health needs, substance misuse and patient preference. A patient had been on 1:1 observations for 3 months as a preventative measure with no clear plan for reducing the level of observation. At the time of our visit a patient with complex physical health needs was on 2:1 observations even when sleeping.

We checked how physical health was monitored following the use of rapid tranquilisation. Staff documented when physical monitoring checks had been refused, stating that the patient's respiration rate was observed instead. The respiration rate was not noted in the patient records or the National Early Warning Score (NEWS) observation sheet.

Track record on safety

In the last year/18 months there had been seven serious untoward incidents (SUIs). Two incidents related to physical health problems: a patient whose physical health deteriorated quickly and a patient who was admitted to intensive care after developing diabetic ketoacidosis patient.

There was evidence of learning from these SUIs. All wards had improved their monitoring of patients' physical health observations, using the NEWS observation tool. Elm ward had a dedicated physical health day once a week to reassess all patients. Following a patient death from overdose all acute inpatient wards and PICU introduced blanket restrictions to prevent a repeat incident by routinely searching patient rooms for drugs using a detection dog.

Reporting incidents and learning from when things go wrong

All staff we spoke with knew what incidents to report and how to report them using the trust's electronic incident recording system. Staff stated debriefing had taken place following incidents.

Staff told us they were offered support from management and peers following incidents and were made aware of incidents that had occurred on other wards at team meetings. We saw evidence that there was learning from incidents, e.g. male staff were not allowed to enter female patient rooms on Bronte ward following investigation of an allegation made by a patient.

Are services effective?

Requires improvement

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

Summary of findings

Our findings

Assessment of needs and planning of care

All patients had a comprehensive assessment in place, including a physical health assessment.

The majority of care plans were generic and personalised only by changing the patient's name as appropriate. They were not holistic or recovery focused. We saw that the clinical records chiefly contained objective accounts of the patients' behaviours and very few records of either the patients' own views or of their participation in their treatment. The patients we spoke with had a general view of what the purpose of their admission was but they could not say specifically what their care plan contained or what was needed to be achieved in order for them to be either discharged or transferred to another ward. One patient told us that she had been offered a copy of her care plan. On Elm ward a patient's care plan did not include essential information about dietary requirements. Ward managers carried out a weekly audit to ensure care plans and risk assessments had been updated. However, this audit did not review the quality of the care plan. We were told that quality was managed through supervision, which took place infrequently on some wards.

Patients' physical health needs were monitored using NEWS observation sheets.

Best practice in treatment and care

There was no psychologist on any of the acute or PICU wards. Consequently there were no psychological interventions or family therapies available to the patients unless they had been receiving input from community teams prior to hospital admission

Patients' health care needs were discussed and actioned appropriately.

All the patients were assessed using the Health of Nation Outcome Scales (HoNOS).

A range of audits were carried out to monitor the effectiveness of the service On all wards we visited we saw weekly audits to ensure care plans and risk assessments were up to date, regular medication audits and monthly infection control audits.

Skilled staff to deliver care

Supervision was variable and was not in line with trust policy. On Blake ward it was recognised that supervision needed reintroducing as it was not taking place. On Bronte ward all staff had had appraisals but only seven staff had supervision in the last three months. However, newly qualified nurses undergoing preceptorship on this ward had timely supervision.

Team meetings took place monthly across the wards. On some wards the minutes were not always documented although there was evidence that team meetings had taken place in the three months leading up to our inspection.

Multi-disciplinary and inter-agency team work

There were pre-scheduled, allotted, unrealistic time scales for handover across the wards. On Bronte ward the time allowed for handover was 15 minutes although there were 31 patients. This meant the sharing of essential information was rushed unless staff remained on duty in their own time to ensure effective handover of patients. We observed a handover on Redwood; staff were familiar with patients' needs. Feedback from ward rounds was either recorded in the patients' notes or sent via email.

Patients received multi-disciplinary team (MDT) input from medical staff, nursing staff and a pharmacist. MDT meetings occurred at least weekly. We observed a MDT meeting at Park House and found it had a strong medical focus with limited discussion of activities, formulation and barriers to recovery. Ward review days were carried out three times a week. The care-coordinator attended ward reviews at assessment and discharge only. Medical representation on the ward review we observed comprised of pharmacist and consultant.

Adherence to the MHA and MHA Code of Practice

Mental Health Act documents were in good order and the Approved Mental Health Professional's full report was stored in each patient's electronic record

We saw in the patients' electronic records that while the staff had informed each patient of their rights every month

Are services effective?

Requires improvement

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

they had not done so on the specific occasions required by the Code of Practice. Across the wards there was variable evidence that people had their rights explained to them on admission to hospital. A patient who had been detained four days prior to our inspection had not been informed of their rights under section 132 of the MHA. In some cases it was documented that patients had been given their rights but there was no record of the level of patient understanding. On Bronte ward staff had routinely recorded whether the patient had understood the information. In one case we saw that the staff had assessed the patient was unable to understand the information and that they had made a referral to the Independent Mental Health Advocacy (IMHA) service on the patient's behalf.

We found that patients across the wards had access to IMHA services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately. The patients we spoke with had a good understanding of their rights.

The patients we spoke with were all aware of their right to have their detention reviewed by the first-tier tribunal and none of the cases we reviewed had been detained beyond the period that would require the hospital to refer their detention for review.

The staff told us that although the Mental Health Act administration was not located on the hospital site they did not experience any administrative difficulties in the arrangement of a patient's tribunal.

While we saw that the details of the patient's leave had been clearly specified and that each form had been signed by the patient's responsible clinician, there was no record that the patient had been given a copy of the form. A box to record this was provided at the foot of each form but none had been checked. None of the patients we spoke with could say that they had been offered a copy of their leave form. Some patients were not able to take escorted leave or had their leave significantly reduced as staff escorts were not always available.

Five detention records were reviewed on Mulberry ward; two did not have copies of patients' current detention papers and these had to be obtained from MHA office.

There was also a missing capacity assessment for a patient treated under a T2 (this form states the patient has understood the nature, purpose and likely effects of treatment and has consented to it).

On Laurel ward four out of ten medication cards seen showed medication not authorised was prescribed. On Bronte ward we found two cases where the patients had been prescribed a medication that had not been authorised by an appropriate certificate. Copies of consent to treatment forms were attached to medication charts where applicable.

Where a patient was being treated under the authority of a T3 certificate (this form is used when a patient lacks capacity to consent to treatment or refuses to consent to the treatment and the treatment plan is reviewed by an independent doctor). on Bronte ward, we could not find any records made by the statutory consultees of their consultation with the Second Opinion Appointed Doctor (SOAD) or records by the responsible clinician of the feedback they had provided to the patient following the visit by the SOAD

Staff received training on the MHA during induction. However, only 57% of staff had completed the training.

Good practice in applying the MCA

In each case record we reviewed on Bronte ward we saw that the responsible clinician had recorded the outcome of their assessment of whether the patient had the capacity to consent to their treatment; however, they had not recorded the steps they had taken in reaching this outcome.

Staff on Laurel and Elm wards had a confused understanding of the MCA. A patient who was nutritionally compromised was assessed as lacking capacity. Staff struggled to motivate this patient who routinely declined breakfast and lunch so was given a supplement shake instead. No best interest meeting had been arranged despite evidence that the patient continued to lose weight. Another patient had a best interest meeting arranged but there was no evidence that a capacity assessment had been undertaken by the responsible clinician.

There was one DoLS application in place. This is the procedure necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

With a few exceptions the patients spoke positively about the care and treatment provided by staff. They said staff were helpful, had a good attitude and a good understanding of their individual needs. We observed staff interacted with patients in a caring and kind way. When patients became anxious or aggressive the staff responded promptly and de-escalated situations by speaking calmly giving assurance.

The patients we spoke with told us that the staff treated them with respect, but they also said that the staff were often busy which meant that they sometimes needed to ask several times before the staff were able to respond. One patient told us that in contrast to her experience on another ward she felt that the staff on Bronte Ward did not dismiss her requests but were very genuine and responded as soon as they were able.

Some patients were not clear or happy about why they were not able to take leave away from the ward. This was confirmed by the advocate, who felt this needed to be improved.

The involvement of patients in the care they receive

Independent Mental Health Advocacy (IMHA) services were provided to the ward by Manchester Rethink. Patients were aware of the days and times that advocates visited the ward and were complimentary about the support they received from the IMHA. The advocate told us that staff promotion of the IMHA service had improved in recent months

The wards held community meetings with patients to gather their views about the ward and we saw minutes of the latest meetings posted on the wards' notice boards. The minutes showed staff responses to issues or specific requests raised by patients and changes that were made as a result although the initials of the patients who had attended had not been recorded.

Care plans were not person centred and where people had complex needs or limited reading abilities and learning needs they had not been adapted in any way to make them accessible.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access, discharge and bed management

At Park House when a patient required the use of seclusion they were transferred to Juniper or Blake PICU. these ward were constantly full. This meant that existing patients had to be re-assessed and arrangements made to transfer a patient to another ward during their admission to accommodate the patient who needed the use of the seclusion room

The sites had an on-site bed manager; despite this there were delayed discharges mainly due to the challenges of finding accommodation and community placements. On Bronte ward there were six patients who did not need inpatient care but could not be discharged because there were insufficient resources in the community.

Patients who went on longer term leave or left by choice without arranging leave did not have a bed on their return as it was given to someone else. We were told by staff people would be accommodated on wards where there was a bed. We saw an example for one patient during the inspection who had to be accommodated on an alternative ward because their bed had been given to another patient.

The ward optimises recovery, comfort and dignity

Bronte ward had communal areas and quiet rooms, which could be used for de-escalation purposes and as private interview rooms. The wards all had access to activity rooms, although at Park House there was a shortage of quiet rooms. On Elm ward the activity room had to be used as a de-escalation room and as a family room. Consequently, activities were cancelled when this happened.

Staff and patients reported that toilets and showers were often blocked at Park House and the washing machine was broken on Redwood ward. This meant patients were transferring dirty washing between wards until it was replaced.

A weekly activities programme was advertised on all wards. Staff and patients told us that activities were cancelled when the wards were short staffed or when a ward round was taking place. We observed some patients participating in the breakfast club during our visit. Other activities included smoothie making, zumba exercise, art and crafts and movie club. At the weekend there was a pamper session. However, the activities did not reflect the individual needs of the patient, and staff reported this was particularly so at the weekend, when patients became frustrated by the lack of service user involvement. Several patients commented they were bored. The activities rooms were kept locked due to ligature risks.

Both sites offered access to garden areas although these were not well maintained or therapeutic.

Patients were able to make phone calls in private if they asked staff.

Patients were mainly complimentary about the meals provided for them.

While patients could access the beverage bay to make their own hot drinks they had to ask staff if they required anything as the kitchens were kept locked. Risk was not managed on an individual basis.

Patients did not have keys to their rooms. There was lockable personal storage space.

Meeting the needs of all people who use the service

All patients admitted to the acute and PICU wards were provided with a trust 'Welcome Pack'. This included a variety of information leaflets for service users, their carers and relatives. There was information on treatments, local services, how to complain and 'talkback' comment cards. On Bronte ward there was an area dedicated to information about different types of medication.

Wards had good access to interpreters, who could usually be booked within 24 hours.

Where requested food was available to reflect patients' religious and cultural choices.

There were multi-faith rooms located on both PICUs.

Local health services were used when needed for physical conditions.

Listening to and learning from concerns and complaints

Most of the patients we spoke with said they knew how to raise a complaint, or would discuss any concerns with the

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ward manager. Information on how to make a complaint was displayed on the wards' notice boards, as well as information on the patient advice and liaison service (PALS) and independent advocacy services.

Staff knew how to handle complaints appropriately. Staff said that they generally tried to respond to verbal complaints immediately to sort them out. Written complaints were escalated by the ward manager.

Staff received feedback on the outcome of investigations of complaints either individually from the ward manager or through team meetings and emails.

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.

Summary of findings

Our findings

Vision and values

There was a disconnection between ward staff and trust values. When we asked staff about the trust values and visions staff told us about the '6 C's', which are Care, Compassion, Competence, Communication, Courage and Commitment. This was the NHS vision and strategies for nurses, midwives and carers rather than trust values and visions. The 6 C's were displayed on the notice boards alongside information about the trust.

Staff knew who the most senior managers in the organisation were and these managers have visited the ward. Pictures of board members had recently been put on display on the wards. Senior staff said that a board member was sometimes present at ward manager meetings but the majority of staff would not recognise them without be introduced.

Good governance

Local governance processes were in place. Each month the ward managers submitted information electronically to centralised teams. This was in relation to safeguarding figures, medicine incidents and staffing returns, such as training that staff undertaken, sickness and absences. Information about the staffing of wards was provided, along with the ward occupancy levels. We were also shown the monitoring for physical health. However there was no clear process to address quality of care and analyse incidents so the service could identify the needs of patients effectively.

The ward managers all felt they had the autonomy to run their wards including the ability to manage their own budget.

Wards had key performance indicators around admission, physical health and care planning, and these were audited weekly. This ensured that care plans were up-to-date. However the audits did not assess the quality of care plans.

The trust monitored infection control across all services. The ward managers showed us the cleanliness audits that were undertaken on the ward each month.

Leadership, morale and staff engagement

Ward managers and modern matrons were visible on the wards during the day and were accessible to patients and provided support and guidance to staff.

The ward staff we spoke with were committed to their work and ensuring the patients were appropriately cared for. Some staff spoke of how the high use of agency staff made it difficult to ensure that the service still operated effectively, as it placed extra pressures upon them. Staff told us that management were not open to new ideas or innovations. We did not observe any signs advertising opportunities for staff and patients to give feedback within the trust.

Staff were aware of whistle-blowing processes and they felt able to report concerns and improvements needed.

The trust used emails to keep staff informed of developments and points arising from ward managers' meetings.

At the time of our inspection we were not made aware of any grievance procedures being pursued within the wards, and there were no allegations of bullying or harassment. However trust information supplied stated that in the last 12 months there have been two cases raised under the trust's bullying and harassment policy.

Staff morale was varied. Some staff felt well managed and said there was a good team ethic. However, staff at Park House told us that several colleagues had left the trust in recent months due to frustration with the job, training and lack of progression opportunities. It was difficult to interview managers, carers and patients in private without being interrupted, which made people we interviewed feel uncomfortable.

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 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** Care plans were not always person-centred and did not reflect personal preferences. Patients had not been provided with relevant information and support when they need it to make sure they understand the choices available to them. Assessments were not always being reviewed regularly and whenever needed throughout the person's care and treatment. Where the trust shares responsibility for providing care and treatment with other services through partnership working. A clear care and/or treatment plan, which includes agreed goals, must be developed and made available to all staff and others involved in providing the care. There were not nutritional and hydration assessment completed to support the wellbeing and quality of life.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The use of shared bays did not ensure that when people receive care and treatment they were treated with dignity and respect at all times.

Regulated activity	Regulation

Requirement notices

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:** In some of the areas visited there were not systems or processes to assess, monitor and improve the quality and safety of the service. Some wards did not have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Where risks had been identified, the service had not always introduced measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
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:** In some areas there were insufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Not all of the staff had received appropriate support, training, professional development, supervision and appraisals to enable them to carry out the duties they are employed to perform.