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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Date of inspection visit: 04-06 July 2016
Date of publication: 15/11/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RTV06	Warrington	Sheridan Ward	WA2 8WA
RTV03	Halton	Weaver Ward	WA7 2DA
RTV04	Wigan	Lakeside Unit Cavendish Unit	WN7 1SD
RTV02	St Helens	Taylor Ward	WA9 3DE

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.

Summary of findings

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

Where applicable, we have reported on each core service provided by 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?	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 acute wards for adults of working age and psychiatric intensive care units as good because:

- Following the inspection in July 2015, we rated the core service as good for the key questions of effective, caring, responsive and well-led. We did not inspect these key questions during the most recent inspection in July 2016 and we have not changed these ratings.
- Following the inspection in July 2015, we rated safe as requires improvement. As a result of the most recent inspection, we have revised this rating to good.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The trust had robust procedures in place for monitoring and managing patient risk across all five wards.
- Where wards required additional staffing, there were good protocols in place for inducting new agency and bank workers that included an explanation of ligature risks relevant to the ward area.
- Staff knew what incidents required reporting and reported incidents promptly and thoroughly using the trust's electronic incident reporting system.
- Staff risk assessed patients individually and only used blanket restrictions where a clinical need had been identified.
- Patients were consistently accessing authorised leave where detained under the Mental Health Act.

However:

- The seclusion room on Sheridan ward was old and did not meet current guidance outlined in the Mental Health Act code of practice.
- Communal toilets on Cavendish unit were covered with ash from patients' smoking. Sanitary towel dispensers were overflowing with paper towels and used cigarettes.
- On Taylor ward, staff had not completed all the required physical health checks for one patient that was prescribed a high-risk anti-psychotic medication.

Summary of findings

Information about the service

The trust had ten acute wards for people of working age across five hospitals for adults who required hospital admission due to their mental health needs. Some patients were detained under the Mental Health Act.

The wards were:

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

5 Boroughs Partnership NHS Foundation Trust also had a unit which provided intensive care services for people who presented more risks and required increased levels of observation and support:

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

We conducted our first comprehensive inspection of acute wards for adults of working age and psychiatric intensive care units under the Health and Social Care Act in July 2015. We issued one requirement notice against regulation 12 Safe care and treatment.

Our inspection team

Our inspection team was led by:

Team Leader: Sarah Dunnett, Inspection Manager, Care Quality Commission.

The team inspecting acute wards and psychiatric intensive care units comprised three Care Quality Commission inspectors.

Why we carried out this inspection

We undertook this inspection to find out whether 5 Boroughs Partnership NHS Foundation Trust had made improvements to their acute wards for adults of working age since our last comprehensive inspection of the trust in July 2015.

When we last inspected the trust in July 2015 we rated acute wards for adults of working age and psychiatric intensive care units as good overall. We rated the core service as requires improvement for Safe, good for Effective, good for Caring, good for Responsive and good for Well-led.

Following this inspection we told the trust that it must take the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

Summary of findings

- 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 degrees. It must also ensure that staff attend 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.

We also told the trust that it should take the following actions 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 trust's 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 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.
- 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 on Austen, Sheridan, Cavendish and Grasmere whereby staff were locking the toilets. The restrictions should be individually risk assessed.
- The trust should review the furnishing on Coniston ward, this was in need of updating and the arm chairs would benefit from recovering.

Following our inspection in July 2015, we issued the trust with one requirement notice that affected acute wards for adults of working age and psychiatric intensive care units. This related to:

- Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment

How we carried out this inspection

On this inspection, we assessed whether the trust had made improvements to the specific concerns we identified during our last inspection.

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent to us by the trust. A notification is information about important events which the trust is required to send to us.

During the inspection visit the inspection team:

- visited five acute wards for adults of working age and psychiatric intensive care units based at Hollins Park, Peasley Cross, the Brooker Centre and Leigh Infirmary and looked at the quality of the ward environments

Summary of findings

- spoke with all five ward managers
- spoke with 21 other staff, including consultant psychiatrists, nurses, support workers, pharmacists and occupational therapists
- reviewed 18 patient care records
- looked at team meeting minutes
- looked at staff rotas
- looked at local and mandatory training records
- looked at safeguarding referrals
- reviewed three seclusion suites
- reviewed two incidents of restraint, including those in the face down position
- reviewed staff and patient debriefs
- reviewed seclusion logs at four locations and one episode of seclusion in detail
- reviewed eight 'my safety' plans
- reviewed 21 medication charts
- reviewed medication errors recorded on the electronic recording system.

What people who use the provider's services say

Patients using the service were positive about the care they received. Patients told us that they felt safe on the wards and that staff had a good understanding of their individual needs. Patients felt valued by staff and said that most of the time there were enough to staff to meet their care needs. This included consistent access to authorised leave where the patient was detained under the Mental Health Act.

Good practice

All wards had well embedded systems and procedures to monitor and address patient risk. All wards had a summary and task board that staff used to chart current information about patients. This was a dry wipe board on all wards except Sheridan which was electronic. The summary and tasks board documented key areas relating to patients' risk, such as when their risk assessment had last been updated and their current leave status. For each ward, a multidisciplinary team made up of nurses, medical staff, a psychologist and modern matron would review the summary and tasks board every morning. This meant that all patient risks were continually being reviewed by the multidisciplinary team involved in their care which meant that patient risks were being addressed and minimised promptly.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should review all seclusion facilities against the Mental Health Act code of practice.
- The trust should ensure that post-seclusion debriefs are routinely completed with patients and captured in their care records.
- The trust should ensure that patients receive the appropriate physical health checks when being administered high risk medications.
- The trust should ensure the environment on Cavendish ward is regularly cleaned and smoke- free.

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
Sheridan Ward	Warrington
Weaver Ward	Halton
Lakeside Unit	Wigan
Cavendish Unit	Wigan
Taylor Ward	St Helens

Mental Health Act responsibilities

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

We reviewed three seclusion rooms against the requirements of the Mental Health Act code of practice. The seclusion rooms on Iris ward and the Rivington unit met the requirements of the code of practice. The seclusion room on Sheridan ward was old and had been built before the code of practice had been introduced in 2015. This meant that some of the seclusion room's facilities did not meet the requirements of the code of practice; the seclusion room lacked a two way communication system, had limited access to natural light and externally controlled lighting.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not look at Mental Capacity Act and Deprivation of Liberty safeguards during this inspection.

Good

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

On all wards, appropriate measures had been put in place to reduce blind spots, including concave ceiling mirrors and extra staff support for patients with an increased level of risk.

All five wards had a comprehensive ligature risk assessment in place. The assessments included details of any amendments that were required to the ward environments and any further updates such as when amendments had been made and by whom. On Weaver ward the manager had taken photographs of a number of the risks to ensure staff were fully aware of what the risks were.

Ligature risk assessments were located in a red folder in each of the wards' main offices. The front laminated page had bullet points detailing each of the risk areas within the ward. There was a signing sheet beside this that staff, including bank and agency workers, would sign to indicate they had reviewed and understood the risks. Security nurses had a corresponding chart detailing the risk areas. The security nurse checked the designated risk areas hourly or more frequently if a clinical need had been identified. Their checks were in addition to patient observations that were allocated to other members of staff. We found that the security nurses had a good knowledge of the risk areas and understood why certain things were detailed on the security checklist.

All five wards were single sex. This meant the service was meeting the guidance on same sex-accommodation.

During our last inspection we found medicines were not stored safely on Weaver ward because the ambient room temperature in the clinic room was regularly in excess of 25 degrees. Twenty five degrees is the maximum room temperature recommended for storage of medicines. We reviewed the last three months recordings of the clinic room temperature for Weaver ward provided by the trust's medicines management team (1 April – 30 June 2016). We found that between 22 April and 6 May no data had been collected. Data that had been collected for the remaining 11 weeks identified the clinic room temperature was regularly in excess of 25 degrees for three weeks. The audit further identified that the clinic room temperature on Weaver ward was too high because staff were not activating the air conditioning facility until the temperature had exceeded 25 degrees. The medicines management team identified this specific issue on Weaver ward in May 2016 and we found that the staff had promptly addressed this. In June 2016 the clinic room temperature was recorded as within an acceptable range for four consecutive weeks.

Although all clinic rooms had either a fan or an air conditioning unit to help maintain an adequate room temperature, the trust had put a contingency plan in place should the temperature exceed 25 degrees. The plan was based on guidance from the north west quality control medicine management committee. The guidance identified that if the clinic room temperature exceeded 25 degrees for more than three days all medication stored in that environment should have the expiry date brought forward by six weeks. The trust decided to bring the expiry date forward by 12 weeks as an additional safety measure.

Clinic rooms on all five wards were clean and well maintained. Emergency bags were available which included resuscitation equipment and emergency drugs. Staff checked these daily to ensure that all equipment was in date and fit for purpose.

The trust was in the process of building a new seclusion room on Taylor ward. This was to ensure the seclusion room met the requirements of the Mental Health code of practice. It was due to be completed by September 2016. In the interim, patients who required seclusion on Taylor ward used the seclusion room on Iris ward. This was located on the first floor of the building which meant that patients had to be escorted up a flight of stairs to reach the facility. Staff had received additional training from the trust's management of violence and aggression team so they could safely escort patients who may be distressed or resistive during transfer via the stairs. The senior management team on Taylor ward told us that they had no difficulty in accessing the seclusion room on Iris ward when a patient required it. We reviewed seclusion records for Taylor ward and found that since the seclusion room had been decommissioned in February 2016, they had only used Iris ward's seclusion room three times, the most

Good

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recent being in April 2016. Taylor ward staff were able to support patients that became distressed and agitated through appropriate use of medication and de-escalation strategies.

The seclusion room on Iris ward was clean, had access to natural light and a clock was visible. A safe care area was also available for patients who required a low stimulus environment. Separate toilet and shower facilities were accessed via the safe care area.

The seclusion room on Sheridan ward was old and had been built before updated guidance for the provision of seclusion facilities in the Mental Health Act Code of Practice 2015. The seclusion room had subdued lighting but the only window was positioned very high so that patients had a limited view of the outside.

Lakeside unit and Cavendish unit, based at Leigh Infirmary, had access to one seclusion room. This was located on and shared with Rivington unit, the psychiatric intensive care ward. We were not able to fully review this room because a patient was secluded at the time of our inspection. During our last inspection in July 2015, we raised concerns because patients had to be escorted off the ward and, in Lakeside unit's case, upstairs to the seclusion facility. This could compromise patients' privacy and dignity, and increased risk to others as they were escorted off the ward. During this inspection, we found that staff had received additional training from the trust's management of violence and aggression team to ensure patients who were distressed or aggressive could safely be transferred via the stairs. The trust's risk register identified that one seclusion room to service three wards posed a risk because if the seclusion room was in use then another patient who required it would have to be transferred to another borough within the trust. However, we did not find that this had happened by the time of our inspection. The trust was also undertaking work to build a new hospital site to replace the existing unit at Leigh Infirmary which included new seclusion rooms. This work was due to be completed by 1 October 2016.

We reviewed all five wards cleaning rosters and all were up to date. The ward areas were clean and well maintained. However on Cavendish unit there was evidence that women had smoked in one communal toilet. This was shown by cigarette burns on the floor. There was ash on the floor indicating this was still occurring. The sanitary bin had been stuffed to overflowing with wet paper towels and used cigarettes. The ward manager confirmed this was an ongoing problem and a daily occurrence. This presented a potential fire risk. Wards based at Leigh were moving to a new build by 1 October 2016. We saw evidence that staff continued to promptly address any maintenance issues. This included changing a number of door locks during the time of our visit. Furnishings across all five wards were of a good standard. Lakeside and Cavendish units had dormitories but en-suite bedrooms would be available in the new build.

We reviewed all five wards' cleaning rosters and all were up to date. An infection prevention and control audit completed by the trust's modern matrons and quality leads in May 2016 identified that all five wards were scoring 100 percent for practicing bare below the elbow. All wards scored 100% for hand hygiene, except Sheridan which scored 60%. Compliance rates were red, amber and green rated; green compliant, amber moderate risk and red high risk (indicating scores below 85%). Areas scoring 85% or below were addressed immediately by senior ward management to improve compliance and minimise the associated risks.

We reviewed the environmental risk assessments for all five wards. All were up to date and had been reviewed within the last 12 months. These were stored both centrally within the trust and in individual wards offices so all staff had immediate access to them if required.

Safe staffing

Establishment levels qualified nurses (whole time equivalent)

Cavendish unit - 17

Lakeside unit - 16

Sheridan ward -14

Taylor ward - 14

Weaver ward - 15

Establishment levels nursing assistants (whole time equivalent)

Cavendish unit - 17

Lakeside unit - 16

Sheridan ward - 12

Taylor ward - 12

Good

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Weaver ward - 11

Number of whole time equivalent vacancies for all professions

Cavendish unit - 7

Lakeside unit - 4

Sheridan ward - 0

Taylor ward - 7

Weaver ward - 3

Number of shifts filled by bank or agency from 1 March 2016 to 31 May 2016

Cavendish unit - 631

Lakeside unit - 258

Sheridan ward - 302

Taylor ward - 317

Weaver ward - 388

Staff turnover from 1 June 2015 to 31 May 2016

Cavendish unit - 25%

Lakeside unit - 5%,

Sheridan ward - 10%

Taylor ward - 14%,

Weaver ward - 12%

Staff sickness rates from 1 June 2015 to 31 May 2016

Cavendish unit - 11%

Lakeside unit - 5%

Sheridan ward - 6%

Taylor ward - 5%,

Weaver ward - 7%

Taylor ward had the highest number of whole time equivalent vacancies. Cavendish unit had the highest staff turnover rate, shifts filled by bank or agency staff and staff sickness rate. We found that the trust had advertised all vacant posts at the time of our inspection. Since our last inspection of the trust in July 2015, the trust had improved their system for recruiting staff. The recruitment process was more effective which meant that the time from vacancy advertisement through to an established start date was much quicker.

We found staffing levels across all wards were reviewed in a weekly staffing meeting chaired by the locations operational manager. Additional staff could then be sourced from other wards within the unit to cover staffing shortfalls in advance where possible.

In the majority of cases, staffing shortfalls on all wards could be covered by bank and agency staff. Staff and patients told us most bank workers were familiar with the ward which provided continuity of care and familiarity for patients. We found that there were good induction plans in place for new workers to the wards and we observed one of these taking place effectively during our inspection. This included substantive staff explaining the observation protocol, emergency procedures and ligature risks.

All wards operated on a three shift model; early, late and night. Staff told us that although the wards were always busy, patient leave was rarely cancelled and staff were able to attend mandatory training as planned. This was reflected in high staff attendance at the majority of mandatory courses, averaging above 90% on all wards. Wards also employed a full time occupational therapist and activity worker who focused on providing therapeutic and recreational activities for patients, including planned leave.

We spoke with two consultant psychiatrists, one based at the Hollins Park site and another based at Leigh Infirmary. Both consultants were satisfied with the amount of medical cover. Consultant psychiatrists were employed on a full time basis and posts were fully recruited at the time of our inspection. All wards had sufficient medical cover. Sheridan ward did not have a specialist registrar in psychiatric medicine. Sheridan ward doctors in training were able to draw on support from the mid-grade doctor based on Austen ward. A 24 hour on-call medical rota was in place that worked efficiently; all medical grades covered this.

All ward based staff had completed control and restraint training. The trust's prevention and management of violence and aggression trainers delivered training. This comprised of an initial four-day training course with a day refresher course annually. Staff and patients told us they felt safe on the wards.

Good

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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 one (three yearly), basic life support (annual), immediate life support (annual) and the Mental Health Act (annually). Wards were achieving the trust target of 85% for staff completion of mandatory training. The only exception to this was fire safety on Sheridan ward; only 73% of staff had completed this. However, eligible staff were either on maternity leave, long-term sickness or had otherwise been booked on the relevant training course to attend at a future date.

Assessing and managing risk to patients and staff

Number of incidents of seclusion in the last six months from 01 January 2016 to 30 June 2016

Cavendish unit had ten incidents of seclusion and 61 incidents of restraint, of which 13 were in the face down position. Rapid tranquilisation was used on 65 occasions.

Lakeside unit had 19 incidents of seclusion and 23 incidents or restraint, of which three were in the face down position. Rapid tranquilisation was used on six occasions.

Sheridan ward had 18 incidents of seclusion and 56 incidents of restraint, of which two were in the face down position. Rapid tranquilisation was used on six occasions.

Taylor ward had 14 incidents of seclusion and 18 incidents of restraint, none of which were in the face down position. Rapid tranquilisation was used on three occasions.

Weaver ward had five incidents of seclusion and 14 incidents of restraint, none of which were in the face down position. Rapid tranquilisation was used on one occasion.

Incidents of restraint were highest on Cavendish unit and Sheridan ward. We reviewed the trust risk register which identified that since February 2016 the level of need for care of patients admitted to Sheridan ward was particularly high and this accounted for the increase in use of restraint. The risk register also identified that five of the 14 nurses on Sheridan were newly qualified and therefore leadership and staffing skill mix on the ward was compromised. This included the management of more complex situations that could lead to the use of restraint. A Mental Health Act review visit took place on Cavendish ward in February 2016. During this patients raised concerns because they felt unsafe due to the high number of incidents. Two patients, both detained under the Mental Health Act, had died in January 2016 and February 2016. Following a thorough investigation by the trust, extra support in the form of staffing was put into the ward. This had since had the positive effect of gradually reducing incidents of restraint and rapid tranquilisation on Cavendish ward over a six month period. For example, in January 2016 staff had used restraint 17 times and rapid tranquilisation 20 times. In June 2016, this had considerably reduced; staff had used restraint eight times and rapid tranquilisation eight times.

Where restraint in the face down position had been used, staff had explained why and under what circumstances this may be appropriate within the patient's care plan. Staff only used restraint in the face down position as a last resort once other attempts to minimise the patient's distress had failed.

Between 01 January 2016 and 30 June 2016, Lakeside unit had the highest number of incidents of use of seclusion. However, we checked and found that patients were generally only in seclusion for a few hours and this was for a proportionate reason, for example, due to an acute episode of distress and aggression towards others.

We reviewed18 patient risk assessments across all five wards. Staff used the trust's electronic records system to record these. Staff then printed risk assessments and filed these chronologically in the patients' paper care records. Risk assessments were comprehensive and were regularly updated following any incidents that had occurred. Risk assessments included a risk screening tool and a summary where new events/incidents that impacted on the patient's level of risk were documented. Staff also considered and documented what risk meant from the patient's perspective.

All wards also had a summary and task board that staff used to chart key current key information about patients. This was a dry wipe board on all wards except Sheridan which was electronic. The summary and tasks boards documented key areas relating to patient risk, such as when their risk assessment had last been updated, their current leave status and whether they had received all the appropriate physical health checks. For each ward, a multidisciplinary team made up of nurses, medical staff, a psychologist and modern matron would review the summary and tasks board every morning. This meant that the multidisciplinary team involved in their care was continually reviewing all patient risks.

Good

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Staff assessed patient risk and care planned this on an individual basis. We only found one exception to this on Taylor ward, however this was appropriate due to an identified area of risk. In the past two years there had been three serious incidents relating to the use of contraband items on the ward; one related to a patient death due to an overdose of non-prescribed medicines and two serious incidents of arson, one of which resulted in the death of a patient. To minimise this risk, ward management had firmly embedded the procedure of searching all patients on return from leave off the ward. The aim was to keep patients safe through preventing contraband items entering the ward. This procedure was detailed in the ward's admission pack and was reflected in individual patient care plans, including the level of search that was required. The ward manager explained that if patients refused and staff had followed the trust's search policy then police assistance would be sought. We asked how this related to patients who had not been assessed as at risk of deliberate self-harm when returning from leave off the ward. The ward manager explained that there had been incidents where patients who were not at risk of deliberate self-harm had brought contraband items back onto the ward for other patients. This meant that the procedure of searching patients on return from leave had to be extended to all. We found that there were no other blanket restrictions in place on Taylor ward.

Weaver and Sheridan wards were based on the first floor. Patients on these wards had their own key fob to leave the ward if a risk assessment had identified this was safe, or sought access to outdoor space with staff supervision. Wards with no direct garden access also had allocated smoke breaks that were facilitated by staff. However, this was due to stop as the trust were to introduce a no smoking policy two weeks following our inspection. Patients from all five wards had unrestricted access to their own bedrooms and mobile phones unless this had been risk assessed as not being appropriate on an individual basis. Each ward had a desktop for patient use with WIFI access. Again, WIFI access would be restricted individually if this had been identified as necessary during risk assessment.

Staff observed patients on a minimum of hourly observations. Some patients required enhanced observations, which in some cases included continuous one to one support from a member of staff. We checked and found that staff across all five wards were completing the relevant checks and these were documented promptly on the relevant observation chart. Staff completed an observation prescription document when reviewing observations. The document included the level of observation, the change and the rationale for this, and was signed off by staff involved in the review. The review always included a member of qualified nursing staff as per trust policy.

Staff we spoke with identified that seclusion and restraint were only used as a last resort to support patients who were distressed or agitated. The 18 patient care records we reviewed confirmed that staff used de-escalation techniques, such as encouraging the patient to move to a low stimulus area of the ward, verbal support and distraction techniques, before using restraint, seclusion and/or rapid tranquilisation. These de-escalation techniques are all supported as a first line form of intervention by the National Institute for Health Care and Excellence guidelines; Violence and aggression: short term management in mental health, health and community settings (March 2015). This included wards where the use of restraint, rapid tranquilisation and seclusion were highest. Weaver ward was part of the trust's 'REsTRAIN' initiative which aimed to reduce the use of restraint through training staff in advanced de-escalation techniques.

We found that where staff had administered rapid tranquilisation they had continued to monitor patients' physical health as per trust policy. Nursing staff we spoke with were able to identify what the frequency of these checks was and why it was important to complete them.

The trust had a policy in place for guidance around placing patients in seclusion. The trust had last updated this in October 2014 and it was due for review in October 2017. We reviewed the seclusion logs for four wards. Records showed that the appropriate staff were carrying out the necessary checks of patients in seclusion as recommended in the Mental Health Act code of practice. This included documentation by a nurse or nursing assistant every 15 minutes regarding the patients presentation, a nursing review every 30 minutes and independent nurse review (for example, a nurse who was not regularly involved in the care of the patient from another ward) every two hours. A doctor also reviewed and documented the patient's progress every four hours.

Staff offered patients in seclusion food and drink at regular intervals and physical observations were taken and

Good

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recorded where possible. If patients required further medications to help reduce their distress staff documented a clear rationale for this and it was administered with support from the psychiatric emergency team where necessary.

Staff we spoke with knew what would constitute a safeguarding concern and gave examples of where they had raised concerns in practice. Staff also displayed a good knowledge of trust safeguarding procedures for escalating any concerns. Nursing assistants explained how they would report concerns to a senior nurse who would then make a referral to the trust's safeguarding team. This was done by completing a form located within the trust's incident reporting system. We reviewed safeguarding records and referrals for all five wards. We found that safeguarding concerns on the female only wards, Sheridan and Cavendish, were particularly high. Concerns related to issues of domestic violence. However, we found that staff had taken the necessary measures to safeguard the individuals involved and this was clearly documented within patient care records. All wards had achieved above the trust target of 85% in staff training in safeguarding children and vulnerable adults.

We reviewed medication prescription charts for 21 patients. On Taylor ward we reviewed 17 medication charts and found that in eight of these there were gaps where staff had not signed to confirm whether a medication had been administered. There were between one and three missing signatures per administration chart. However, we found that ward management and pharmacy were currently addressing this issue. This included addressing staff performance within management supervision and supporting individual staff under a medicines management supervision programme where appropriate to improve performance. In all cases we found that medicines that were not signed for were not deemed critical medicines. Critical medicines are identified as a medicine that otherwise not administered promptly as prescribed can cause serious health complications, including, but not limited to, antibiotics, anticoagulants and antiepileptic medication. Omissions regarding signatures generally related to topical medicines and milder forms of pain relief. On Taylor ward we reviewed monitoring for one patient that was prescribed an anti-psychotic drug called clozaril. Trust policy identified that patients' blood pressure should be monitored and recorded post administration. This is because clozaril is associated with potentially serious side effects such as increased heart rate, low blood pressure and seizures. We found that staff had not recorded the patient's blood pressure for seven consecutive days for one of the two doses administered.

All wards received good support from a pharmacy team who compiled an up to date list of patients' medications admission. We also found that patients were able to access pharmacy support to discuss their medication. This support included one to one discussions with a pharmacist and provision of leaflets to explain different types of medication.

Patient care records included screening of risk related to patients' physical health. This included a falls and water-low risk assessment to identify patients who may be at risk of developing pressure sores. Staff made prompt referrals to specialist services, such as physiotherapy and tissue viability where a risk had been identified.

Track record on safety

Between 01 July 2015 and 30 June 2016, there had been three serious incidents across five wards. The incidents were two unexpected deaths and one suicide. In response to these incidents, the trust had completed the initial 72 hour-review and completed investigations in full. A coroner had also imposed a regulation 28 which related to the suicide of one patient. A regulation 28 is a prevention of future deaths report which sets out what a service must do to improve and prevent the reoccurrence of another serious incident. Actions identified from the report included addressing the locking mechanisms on some of the disabled toilet doors. At the time of this inspection, we found that the trust had addressed this issue.

A coroner had also imposed a regulation 28 which related to a death on Lakeside ward in December 2014. Actions identified for immediate improvement included effective information sharing regarding patient care with acute hospital services. We found the trust had reviewed their service level agreement with the acute trust and now all information regarding patient care was to be shared within a maximum 24 hours. We also found that medical staff employed by 5 Boroughs NHS Foundation Trust had direct access to the acute trust's medical reporting system. This meant that they could review x-ray and blood results promptly so that patients' physical health needs were monitored and managed appropriately.

Good

Are services safe?

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

From 01 April to 30 June 2016 there were 532 reported incidents across the five wards; 71 abscontions, 134 incidents of self-harm, 72 medication incidents (including pharmacy dispensing, medication record monitoring, controlled drug issues and patient medication reaction) and 126 classified as violence and aggression.

We reviewed the trust risk register which identified 11 items relating to acute wards for adults of working age and psychiatric intensive care unit. Five of these items related to the five wards we inspected, and highlighted chronic staffing issues on Sheridan, Lakeside, Cavendish and Weaver wards. We found that senior management were managing staffing shortfalls by booking bank and agency staff and reallocating staff around the hospitals where needed. Bank and agency were familiar with the wards and received a thorough induction to the service. The trust had advertised vacant posts and had improved their recruitment systems and processes.

Reporting incidents and learning from when things go wrong

Staff of all professions knew how to report incidents and all had access to the trusts electronic incident report system to do this.

Staff we spoke with was aware of their responsibilities under the Duty of Candour. This included explaining to patients where the service had made an error in their care and providing them with a formal apology where appropriate. Staff conducted debriefs with patients following episodes of seclusion. However, this was a new initiative as the trust's seclusion debrief template had only recently been ratified. We only found one debrief pack across all five wards that staff had completed. This meant that seclusion debriefs were not routinely documented, although patients' daily records identified that staff were mindful to consider the patients perspective when using seclusion and how they said it could prevented in the future.

Ward managers received information regarding lessons from serious incidents at local quality and risk management meetings. The trust regularly issued patient safety alerts to all staff via email. These highlighted areas staff needed to be more vigilant of, or changes in practice because of a serious incident investigation. One recent patient safety alert included the thermostats in rooms posing a ligature risk following a patient suicide. Following this, changes had been made to each ward; extractor fans had been removed, anti-ligature handles had been fitted and the thermostats had been changed. Staff we spoke with were aware of these risks and were knowledgeable of mitigation plans in place to manage the risk on their respective ward. Posters displaying patient safety alerts were displayed within all ward offices.

Ward staff told us that they felt well supported by senior management and received a formal and informal debrief following an incident. Psychology staff also provided additional support and guidance where required.