Cheshire and Wirral Partnership NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement 

We carried out this unannounced focused inspection because we had concerns about the safety and quality of the service, and wanted to see if the trust had made improvements following our last inspection.

The trust has 6 acute mental health wards for adults of working age and 2 psychiatric intensive care units (PICU) across 3 locations.

- Bowmere Hospital – Beech ward (22 beds), Juniper ward (24 beds), Willow ward (PICU, 7 beds)
- Clatterbridge Hospital Psychiatric Services – Brackendale ward (20 beds), Brooklands ward (PICU, 10 beds), Lakefield ward (20 beds), Riverwood ward (13 beds)
- Jocelyn Solly (Millbrook/Macclesfield DGH) – Mulberry ward (25 beds).

All 3 locations were visited by either inspectors or Mental Health Act reviewers. We visited 5 wards: Beech, Juniper and Willow wards at Bowmere Hospital, Brooklands ward at Clatterbridge Hospital, and Mulberry ward in Macclesfield. We reviewed information and documents about all 8 wards.

Our rating of services improved. We rated them as requires improvement because:

- The service did not always have enough nursing and medical staff, and not all staff were up to date with their mandatory training.
- Although staff had access to the information they needed to provide safe and effective care, records were not always fully completed, and the information was not always consistently recorded in the same place, which could make it difficult to monitor that it had been completed correctly.
- Patients were not always secluded in a suitable environment.
- Governance processes were in place, but they were not always effective.

However:

- Staff assessed and managed risks to patients and themselves and used restraint and seclusion only after attempts at de-escalation had failed. However, records of interventions were not always completed fully.
- Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. Patients had a physical health assessment on admission, but this was not always fully completed.
- The wards were generally safe, clean, equipped, furnished, maintained and fit for purpose.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Our findings

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Most staff felt respected, supported and valued, particularly by their teams and local managers, and were able to raise their concerns.
- Staff engaged actively in local and national quality improvement activities.

At our last inspection on 8, 9, 14 and 15 November 2022 we issued the trust with warning notices and rated this core service as inadequate overall, and inadequate for safe and well-led. At this inspection we found that the trust had taken actions to address the concerns outlined in the warning notices. However, although we found that the trust had made progress against the warning notices we issued in November 2022, they had still not fully met the regulations.

How we carried out the inspection

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit we:

- visited 3 of the 6 acute wards for working age adults and both PICUs, and looked at the ward environments and observed how staff were caring for patients
- spoke with 11 patients or their relatives
- spoke with staff on all the wards we visited
- spoke with senior managers covering all parts of the service
- reviewed 17 care records of patients, and other care related documents including observation and seclusion records
- looked in detail at the use of seclusion and enhanced observation
- attended 2 meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

The patients we spoke with had mixed views about the service, but their feedback was broadly positive.

Patients were generally positive about staff, with most finding them available, approachable and respectful. Some patients said there were not enough staff and that one-to-one sessions did not always happen, but most said there was someone to talk with if they needed support. There were mixed views about access to activities – for patients on the acute wards these tended to take place off the ward, so they were more accessible for patients who did not need to be escorted off the ward.

Patients who needed physical healthcare generally had their needs met.

Our findings

Patients had mixed views about how involved they were in their care, and how much information they had about medicines. Some patients felt very involved and informed, others less so.

Patients told us that the wards were usually clean.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

The wards were generally safe, clean, equipped, well furnished, maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

The trust had detailed environmental risk and ligature audits of all its acute wards and psychiatric intensive care units (PICUs). These identified the level of risk, actions required to remove the risks, and any mitigation. Staff were aware of these and had access to 'heat maps' that identified higher and lower risk areas of the ward. The audits were extensive, but there were some inconsistencies as to how they were applied on the wards.

There were low incidences of patients using ligatures from fixed points. The bedrooms and ensuite bathrooms had mostly anti-ligature furniture and fittings, which the trust kept under review. However, only a small number of bedrooms on each of the acute wards had a fitted bed. Staff told us this was due to the wards admitting working age and older patients, and needing to be able to move in beds and equipment to support their physical healthcare needs. The ligature assessment identified the potential risk, and was consistent with the staff view that this was mitigated by individual risk assessment, and that patients deemed at risk would have a bedroom with a fixed bed.

Staff could observe patients in all parts of the wards. Beech and Juniper wards were large, and the ends of the wards were relatively isolated from the main activity of the ward. This was identified in the risk assessment, and was mitigated by parabolic mirrors, individual risk assessment, and general observation of patients.

The ward complied with national guidance on mixed sex accommodation. All the acute wards and PICUs admitted both men and women, and all rooms were single with an ensuite toilet and shower. The acute wards had designated male and female bedroom areas, with some crossover beds that were usually closer to the main area of the ward. Staff told us that sometimes men were admitted to a female corridor, or vice versa, but they would change this as quickly as possible, and put in additional support. This was not classed as a breach of the national guidance, as all patients had their own bedroom and bathroom. The trust had reported no breaches of the national guidance since July 2019.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Our findings

Maintenance, cleanliness and infection control

Ward areas were generally clean, maintained, well furnished and fit for purpose. There was damage on some of the wards, such as broken internal doors, that were waiting to be repaired. Staff told us that maintenance and repairs were usually carried out quickly, but there could be delays if there were staffing difficulties or parts had to be ordered.

Staff followed infection control policies, including handwashing. An annual audit was carried out by the trust's infection control lead. This had last been carried out on the acute and PICU wards in May and June 2023. Where minor issues had been identified these had been addressed.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They were fitted out in accordance with the Mental Health Act Code of Practice and had a toilet and a clock. The seclusion rooms/suites were located on the 2 psychiatric intensive care units (PICUs). At the last inspection, we identified a longstanding issue where stains/dirt on the ceiling in the Brooklands ward seclusion room had not been removed. Staff told us this was because cleaning staff could not reach the high ceiling. The ceiling had now been cleaned, and staff had an agreed process for deep cleaning of the room, which included the ceiling.

The acute wards did not have seclusion rooms. However, at the last inspection we identified that staff on Mulberry ward were using an interview room to seclude patients, which was not fit for this purpose. At the time of this inspection, the trust were in the process of building a seclusion suite on Mulberry ward. This work was still in progress, and was due to be completed by December 2023. The trust had created a dedicated extra care suite on the ward. The trust was clear that this was not a seclusion room, but in the event that seclusion was required this room would be used temporarily. It did not meet the standards of a seclusion room, but it was a safer room to use whilst the dedicated seclusion suite was being built. The trust had made progress against the warning notice we issued in November 2022, but they had still not fully met the regulations.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked regularly. Emergency equipment was available on all of the wards and was routinely checked by staff. Staff maintained equipment and kept it clean.

Safe staffing

The service did not always have enough nursing and medical staff. Not all staff had received all their basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff. Managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. This had been reviewed and permanent increases made to the number of posts on some of the wards. The ward manager could adjust staffing levels according to the needs of the patients. However, the average fill rates for the 4 weeks prior to inspection showed that the planned staffing levels were not always achieved. For qualified nurses in the day time this ranged from 78.1% (Beech), 84.5% (Mulberry) and 92.8%(Juniper) to over 100% on Willow, Brooklands and Brackendale. For qualified nurses at night this ranged from 85% (Willow), 91.4% (Mulberry) and 92.7% (Juniper) to over 99% on Lakefield, Riverwood and Brooklands. For healthcare assistants in the daytime this ranged from 77% (Willow), 80.3% (Mulberry) and 86% (Juniper) to over 99% on Riverwood, Lakefield and Brackendale. For healthcare assistants at night this ranged from 67.9% (Willow), 91.6% (Brooklands) and 93.7% (Lakefield) to over 100% on Beech and Juniper.

Our findings

Managers told us that in addition to these fill rates, staff were moved between wards on the same unit in order to fill gaps and to balance experienced, new and temporary staff. The service regularly used bank and agency staff. However, many agency staff had worked regularly in the trust, and had access to the trust's mandatory training. In the 4 weeks prior to the inspection, the average proportion of bank and agency staff who worked across all the acute wards and PICUs was 32%. This ranged from 5% on Lakeland ward, to 50% on Brooklands ward.

Vacancy rates were variable across the wards, but actual staffing levels were impacted by absence (such as sickness and maternity leave) and the acuity of the wards, which meant more staff were needed. Recruiting staff and maintaining safe staffing levels was at the top of the trust's risk register. The wards had enacted their business continuity policy, which broadly meant focusing on key activities and limiting or stopping some non-essential activities. This may include training or meetings. Managers and staff were taking a number of actions to recruit staff in the short and medium term.

Managers had daily meetings to review staffing levels across the wards. They looked at staffing levels for the next 24 hours, and also at predicted staffing levels over the next week or two. From this they took action to fill empty shifts, but could also reduce bed numbers on the wards, and made decisions about whether new admissions could be accepted depending on the forecasted staffing levels. This led to bed occupancy being reduced on some of the wards.

Agency staff were block-booked for a ward or unit, initially for 3 to 6 months. This provided patients and staff with regular staff, who knew the ward they were working on. These staff received trust training, and had access to the electronic patient records.

Staffing skill mix was reviewed across the service. There was an ongoing recruitment campaign for registered nurses and healthcare assistants. Managers had over-recruited to healthcare assistant posts in some areas to help support the nursing shortages. The trust had introduced practice nurses, who supported new and existing staff with learning and clinical practice. This included providing support to international nurses, new/preceptor nurses and student nurses. The trust was actively recruiting student nurses for when they qualified in the Autumn and Spring.

The trust had plans to ensure that mandatory training for new staff was now completed as part of an improved induction process, so that staff completed all their training before they started working on the wards.

Patients had planned one-to-one sessions with their named nurse. Patients sometimes had their escorted leave or activities cancelled when the service was short staffed. The service usually had enough staff on each shift to carry out any physical interventions safely. However, there had been some occasions when staff had not been able to respond to other wards on the site.

The average staff sickness rate for the year up to the inspection was 9.85%. This ranged from 5.53% on Mulberry ward to 16.7% on Brooklands ward. This compares with the overall NHS sickness absence rate of 4.5% for the month of June 2023.

Medical staff

The service usually had enough daytime and night time medical cover and a doctor available to go to the wards quickly in an emergency. The trust risk register had identified consultant psychiatrist shortages as a significant risk across the trust, not just in this core service. This was due to a number of factors including vacancies and other absence such as sickness and maternity leave. There were ongoing actions to address this, including the use of locums and some changes to roles. At the time of inspection, temporary consultant cover was provided on two of the wards.

Our findings

Doctors from across the trust were rota-ed to provide out-of-hours medical cover. There was a consultant and junior doctor on-call for East Cheshire, West Cheshire and Wirral, and a Higher Trainee (middle grade doctor) on call across the whole trust.

Mandatory training

The content of the mandatory training programme was comprehensive and met the needs of patients and staff. Training was provided face to face and online, and depended on the role of each member of staff. The training programme included conflict resolution, moving and handling, fire safety, infection prevention and control, emergency life support, medicines management, proactive approach training (PAT) (for management of violence and aggression), safeguarding and suicide prevention.

Not all staff were up to date with their mandatory training. The overall compliance rates were lowest on Willow ward (66%), Brackendale ward (72%) and Brooklands ward (74%). Compliance rates varied between individual courses on each of the wards. This included in some key areas, such as refresher proactive approach training (PAT), which was below 75% on all the wards. Staff had completed the full PAT course (5 days), but not the annual refresher training (3 days). Managers told us the PAT training now included all the mandatory face to face training, such as moving and handling, fire safety, and basic and immediate life support.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff told us it was helpful to complete all the training at once, but it could be difficult for staff to attend training for several days at a time due to the staffing pressures on the service. However, there had been periods when training had been prioritised. The trust had plans to ensure that new staff completed their mandatory training before they started working on a ward.

The trust provided training to temporary staff if they were likely to be working regularly for the trust for an extended period.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves, and worked to anticipate, de-escalate and manage challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme, but records of interventions were not always completed fully.**

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. The service used the "5 Ps" model to formulate risk, and from this developed a safety plan in the electronic care record. The 5 Ps were: presenting risks, predisposing factors, precipitating (or triggering) events, perpetuating factors, and protective factors. Staff routinely discussed risks to or from patients in the multidisciplinary team meetings. This included following incidents, and reviewing whether restrictions, such as enhanced observations or seclusion, were still required.

The trust had a detailed process for the assessment, prevention and management of venous thromboembolism (VTE) which followed The National Institute for Health and Care Excellence (NICE) guidance. VTE is a blood clot in a vein, which if left untreated can cause serious harm to the body or death. NICE guidance says that all patients admitted to hospital should have a VTE assessment. This is due to people who are admitted to hospital being at significantly higher risk of VTE than the general population. The completion of VTE assessments across all the inpatient wards (not just those admitted to the acute wards and PICUs) varied between wards and from month to month. In December 2022, 29.9% of

patients admitted to all wards had had a VTE assessment completed. This had increased to 40.3% for patients admitted in May 2023 – the increase was not consistent, but the trend was upwards. The trust had identified this as a problem and implemented a physical health oversight group to oversee improvements in this, and taken actions to promote its use. For example, it was included in bitesize training and as part of the junior doctors' induction, and a VTE assessment tool was part of the physical health assessment in the electronic care record.

Management of patient risk

Staff knew about any potential risks to each patient and acted to prevent or reduce them. Staff identified and responded to any changes in risks to, or posed by, patients. Staff shared key information to keep patients safe when handing over their care to others. Staff attended a handover meeting at the beginning of each shift which shared information about each patient. This included information about specific patients, and about more general risks such as the environment or maintenance. The electronic care record contained risk assessments and care plans for each patient, which were reviewed routinely by the multidisciplinary team.

Staff could observe patients in all parts of the wards. Beech and Juniper wards were large, and the ends of the wards were relatively isolated from the main activity of the ward. This was identified in the risk assessment, and was mitigated by parabolic mirrors, individual risk assessment, and general observation of patients. Some patients were on enhanced observations and had at least one member of staff with them at all times.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

The trust recorded and monitored the use of restrictive interventions, including the use of rapid tranquilisation and physical restraint, and whether this was supine (face up) or prone (face down). Over the previous year, the number of restrictive interventions varied from ward to ward, and from month to month. Brooklands PICU had the highest number of restrictive interventions – varying from 8 to 39 each month (an average of just over 19 a month). Willow PICU, a smaller ward to Brooklands, ranged from 2 to 24 restrictive interventions each month (an average of 8.5 per month). The acute wards varied from 1 to 3, to 11 to 21 restrictive interventions per month. National guidance says the use of prone restraint should be avoided where possible, due to the increased risks to the patient. There were low levels of prone restraint during the previous year. This ranged from no use of prone restraint on Brackendale ward, to 10 incidences across the year on Willow ward. There were only 2 recorded instances of prone restraint lasting more than 5 minutes.

Staff followed NICE guidance when using rapid tranquilisation. Over the previous year its use varied across the wards, and from month to month. Over the previous 12 months all wards had at least 1 month when they had not used rapid tranquilisation at all, and this ranged from a maximum of 6 uses of rapid tranquilisation on Juniper ward to 18 uses on Willow ward in one month.

When a patient was placed in seclusion or long-term segregation, staff did not always keep clear records and follow best practice guidelines. At the last inspection we identified concerns about seclusion practices and documentation in the

trust. The trust has now implemented a new seclusion template in the electronic care record, which prompted staff with regards to checks and reviews and makes this easier to monitor. However, although this had improved documentation since the last inspection, it had not been embedded across the service. Many of the safeguards were met, but there were still records where it was not easy to see if all the necessary reviews had been carried out.

Most episodes of seclusion occurred on the 2 PICU wards which had seclusion suites. At the last inspection we found that non-designated seclusion rooms had been used to seclude patients. At this inspection we found that although there were still instances of this happening, this had improved and the necessary processes were followed to ensure that patients were safe and reviewed correctly. In the 3 months before the inspection, there had been 10 episodes of patients being secluded in a non-designated seclusion room. 3 of these were on Mulberry ward, and each patient was there for a short period (less than 24 hours) whilst they were assessed for or transferred to a PICU. There were 6 episodes of patients being secluded in their bedrooms on Willow ward. This was an unusual occurrence, which staff told us was due to high acuity of patients meaning no seclusion room was available. Consideration was given to availability and suitability of transferring the patients elsewhere. All but 1 of these seclusion episodes lasted for less than 24 hours before the patient was transferred elsewhere or the seclusion was ended. Patient bedrooms are not ideal for seclusion but were safe and the necessary safeguards were in place. All instances were appropriately recorded and escalated within the trust.

The trust had policies which reflected guidance in the Mental Health Act Code of Practice if a patient was placed in long-term segregation. There had been 1 episode of long-term segregation in the three months prior to the inspection.

Staff followed trust policies when patients required enhanced observations. However, the records were not always recorded consistently. We reviewed a sample of enhanced observation records for 17 patients across all 8 wards. There were inconsistencies in how times, comments and signatures were recorded. 9 patients had their sample of observation charts fully completed, but although entries had been made there was an occasional missing time, signature or comment. 8 patients had observation records where some hourly time slots had no entry at all. These charts covered between 7 to 20 days of observations for each patient, and there were between 1 to 10 gaps for each patient across these periods. The highest proportion was a patient on intermittent observations who had 10 gaps over 9.5 days. Over 106 days of observations (approximately 2,544 hours, though not all patients were on observations for the full 24 hour period), there were 42 hourly gaps. 10 of these were for patients on 1-1 observations. Managers and staff told us that they believed the observations had been carried out but had not been recorded. The gaps were a low proportion of the overall entries, and from the entries either side of the gaps there was no apparent harm or change of care to the patients during the period where nothing was recorded.

The trust's observation policy includes guidance on carrying out enhanced observations. The policy regarding intermittent observations implies that they should be carried out at fixed times such as every 15 minutes. The forms used to record observations had printed or set times (for example 1.00, 1.15, 1.30, 1.45) which may not necessarily be the actual time the observations were carried out. The Mental Health Act Code of Practice says that intermittent observations should be carried out at irregular and unpredictable intervals. With the current system there is a risk that patients may predict when they will next be checked, potentially mitigating the purpose of the observation, and also that staff are not accurately recording when they have checked patients. Managers told us that a mobile app is being developed for staff to enter observation information directly into the electronic care record, and this will prompt staff to record all the necessary information. This was due to be implemented later in the year.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role. All staff had received safeguarding training. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information about safeguarding was available on the trust's intranet. Staff were able to describe potential safeguarding concerns, and how they reported these. They knew who to contact for advice within the trust. All concerns were initially logged in the trust's incident reporting system, and reported to the trust's safeguarding team, who determined if a referral to the local authority safeguarding team was required. The trust had established links with the local authority, and worked with them to investigate safeguarding concerns.

Staff followed clear procedures to keep children visiting the ward safe. There were visiting areas for families including children at each of the sites.

Staff access to essential information

Staff had easy access to clinical information, and maintained clinical records both paper-based and electronic. However, records were not always completed consistently. Temporary staff who were likely to work in the trust regularly, or over a period of time, were given access to the electronic care record system. The patient care records system was comprehensive and all staff could access it easily. Staff feedback was mostly positive about the care record system, though some staff said the computers could be slow at busy times. The trust had developed cover pages and templates to make it easier for staff to find and record key information. This included for seclusion records and physical healthcare. However, we found gaps in observation and seclusion records, which were not always completed consistently.

When patients transferred to a new team, there were no delays in staff accessing their records. All teams within the trust recorded information in the same electronic record.

Records were stored securely. Staff had secure access to the electronic care records system. Paper records were stored in staff-only offices and lockable storage. Most paper records, such as observation charts, were scanned into the electronic care record.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had detailed policies and standard operating procedures for the management of medicines. This was monitored locally and through the trust's governance procedures.

Staff reviewed each patient's medicines regularly. Medicines were prescribed by a doctor, or a non-medical prescriber. Medicines were reviewed in regular multidisciplinary team meetings, which included a pharmacist.

Staff completed medicines records accurately and kept them up to date. Prescription charts were currently on paper. Managers told us that there were plans to implement an electronic prescribing and medicines administration system. Any medicines errors were recorded as incidents and appropriate action was taken. Medicines were administered by nursing staff, who were required to complete a competency assessment.

Our findings

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely in accordance with national guidance. Pharmacy technicians routinely visited the wards and checked medicines storage and stocks. Monthly audits were carried out by a pharmacy technician. These had identified some relatively minor issues, which were usually resolved by the following month. Staff could access a range of medicines out of hours through a central storage point, and had access to an out of hours pharmacist. Paper prescription charts were stored in staff-only areas.

Staff followed national guidance to check patients had the correct medicines when they were admitted or they moved between services. Medicines reconciliation was carried out by a pharmacy technician.

Staff learned from safety alerts and incidents to improve practice. The trust has a medicines safety subgroup that oversees medicines, and ensures alerts and incidents are shared with staff.

Staff followed trust policies when considering prescribing sodium valproate. There is specific guidance regarding the prescribing of sodium valproate for women of childbearing age, due to potential risks to the foetus. The trust had clear processes to consider, prescribe and monitor the use of sodium valproate. They were overseen by a lead perinatal psychiatrist and were reviewed as a standing agenda item in the medicines' safety subgroup. The trust had a register of patients who were currently prescribed sodium valproate, and there was a risk assessment form on the electronic care record. Managers had shared updated information in response to future changes to the national guidance.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff followed trust policies on the use of rapid tranquilisation and high-dose antipsychotic therapy. Staff had completed national benchmarking audits as part of the Royal College of Psychiatrists' Prescribing Observatory for Mental Health (POMH). This included prescribing of antipsychotic medicines including high-dose antipsychotic therapy, and the prescribing of sodium valproate. Staff also carried out audits and reviews of the use of controlled drugs and antimicrobials (such as antibiotic). There had been delays in completing some of these audits due to pharmacy vacancies.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE (The National Institute for Health and Care Excellence) guidance. Staff used a recognised tool (National Early Warning Score or NEWS2) in the electronic care record to monitor patient's physical health observations such as blood pressure and temperature. Staff followed the trust's processes for enhanced monitoring for patients who were prescribed clozapine, or who had been given rapid tranquilisation.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. All incidents were reported electronically. Managers had a summary of monthly incidents for each ward, broken down by type, and with comparisons for each month. These were colour coded to highlight if there had been a significant increase or decrease. The number of incidents over the previous year varied between wards, and ranged from 207 incidents on Riverwood ward to 600 on Beech ward. This included incidents of all types and severity. Incidents were graded for severity, with most graded as no harm and minor severity, with some as moderate and serious. The most common types of incidents across all the wards were self-harm followed

Our findings

by physical violence, although the number of incidences of these varied between wards. Staffing was the third most common incident on two of the wards. The most common incident on Juniper ward was falls, this ward had both working age and older adults, so was likely to have some more physically frail patients. Juniper ward had a weekly falls and physical health 'huddle' where all patients were reviewed.

Staff told us that sometimes there were debriefs after serious incidents, but not always. They generally felt supported by their local team and managers. Managers collected information about debriefs following incidents with both patients and staff. This varied from ward to ward and month to month, as did the level of incidents. Debriefs occurred with both groups just under half the time.

Managers investigated incidents thoroughly. Incidents and themes were reviewed through the trust's governance system. The trust was moving towards the introduction of PSIRF (Patient Safety Incident Response Framework) later in the year. PSIRF is a national change in approach to responding, learning from and embedding changes following incidents.

Staff received feedback from investigations of incidents, both internal and external to the service. Staff received a monthly learning from incidents bulletin from the trust. This contained learning about incidents in the trust and in other services. This included information about patient safety incidents, deaths and inquests, specific issues such as falls, and training.

There was evidence that changes had been made as a result of feedback. For example, following a patient fall it was identified that there was not a formal process for referring a patient for physiotherapy. A process for this was added to the electronic care record as part of the physical healthcare and falls assessment.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff generally felt supported by managers, particularly their local managers. Each ward had a ward manager, and some also had a resource manager. The ward manager had overarching responsibility for the ward with a clinical focus. The resource manager focussed on staffing, training, budgetary and administration aspects of the ward.

Each site had a matron, and additional senior clinical support had been introduced or was planned depending on the size of the site. This included additional matrons and practice development nurses to support clinical care improvements, particularly for new or less experienced staff.

Managers had access to training, and told us they felt supported in their roles. This included by immediate managers, and by other departments such as finance and human resources.

Our findings

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Staff were aware of the trust values, and said they used them in their everyday work.

The trust's stated vision was: "working in partnership to improve health and wellbeing by providing high-quality, person-centred care." This was achieved by following the trust's values, known as the "6 Cs", which were: care, compassion, competence, communication, courage and commitment. The trust's values-based recruitment framework outlined the behaviours that were expected, and not expected, from staff under the 6 C headings, and interview questions were under these categories. The trust's appraisal system also incorporated the 6 Cs.

Culture

Most staff felt respected, supported and valued, particularly by their teams and local managers, and were able to raise their concerns.

Most staff told us they felt able to raise their concerns with managers, particularly at a local level. However, some staff did not feel able to speak out, and others thought they could raise concerns but they were not listened to, or that information wasn't shared with them. Staff were aware of the trust's whistleblowing policy.

Staff were generally positive about their teams and local managers and thought they worked well together. However, staff told us they found the staffing pressures difficult to work with, and thought this had impacted on morale. Staff had mixed views about how supported they felt by the wider trust and higher level managers.

Patients were generally positive about staff, with most finding them available, approachable and respectful. Some patients said there were not enough staff and their one-to-one time did not always happen, but most said there was someone to talk with if they needed support. Patients had mixed views about how involved they were in their care. Some patients felt very involved and informed, but others less so.

Governance

Our findings from the other key questions demonstrated that governance processes were in place, but they were not always effective.

At the last inspection we found concerns about the use of seclusion on Mulberry ward. These concerns had previously been identified by the trust but limited action had been taken for an extended period. We issued a warning notice for this and told the trust it must take action. At this inspection we found that the trust had taken action to address this, which included improvements in identifying, recording and monitoring the use of seclusion, particularly in non-designated seclusion rooms. However, although the recording of episodes of seclusion had improved, it was not yet embedded. There was not a robust process for identifying and addressing gaps in seclusion records. There were similar issue with observation records, which were not recorded consistently, and there was no monitoring to identify and resolve this.

The provider had a clinical and corporate governance structure for monitoring quality and performance. The acute and PICU wards were part of the Specialist Mental Health Group governance structure. Information was shared from the wards to various groups under the separate quality, people and operational committees which fed into the board of directors. The groups under the committees also fed into the clinical networks, clinical engagement and leadership forums and the acute care and first response services patient safety oversight group. Audits and incidents fed into the relevant groups and were monitored and discussed. The trust had groups for monitoring specific areas such as medicines.

Our findings

The trust had established processes to review ongoing challenges, such as staffing levels and pressures on beds. Local managers reviewed staffing within their own units and across the patch, and looked ahead to try and ensure they had sufficient staff. Staffing challenges were reviewed through the trust's governance structure and there was a multi-level approach. This ranged from using messaging groups at ward level to arrange temporary shift cover, to daily meetings to review staffing levels for the day and week, to business continuity measures, to overarching changes to staffing and recruitment and financial commitments to temporary and permanent staffing changes.

There were ongoing processes for implementing and monitoring mandatory training. The trust had taken action to address the difficulties of releasing staff to carry out training. However, not all staff were up to date with all their mandatory training.

Management of risk, issues and performance

The trust maintained a risk register that identified key risks across the trust. This was monitored and reviewed regularly through the trust's governance processes. The register showed that risks remained high in some areas despite the controls in place. The highest risks were primarily related to staffing vacancies and their impact, and to the availability of beds for patients to be admitted to. Staff at ward level could escalate concerns when required, and staff concerns reflected those on the risk register.

The trust had processes for dealing with emergencies that could impact on the provision of the service. Business continuity plans had been implemented across the service due to staffing difficulties. Business continuity is broadly when non-essential activities are reduced or stopped. This was supported by a framework to review and take action to manage the immediate situation, and plans for the future.

Information management

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. However, information was not always consistently recorded in the same place, which could make it difficult to monitor that it had been completed correctly.

The trust had implemented several templates within the electronic care record to make it easier for staff to find and record information, and for checks to be made of this. This included a template for recording episodes of seclusion, and for ensuring that all the necessary reviews and checks had been carried out. A page of potential physical healthcare checks with links to individual tabs/assessments was part of each patient's electronic care record.

Observation records were recorded on paper, and later scanned into the electronic record system. Staff recorded information on the observation records inconsistently, and it was not easy to monitor their use. The trust was developing an observation application that would ensure all staff recorded key information in the same way, and that would be entered directly into the electronic record.

Learning, continuous improvement and innovation

Brooklands ward was part of the North West Coast Reducing Restrictive Practice Improvement Collaborative programme that started in November 2021 and was part of the Mental Health Safety Improvement Programme.

Brackendale Ward had recently joined the Advancing Quality Alliance (AQuA) North West Mental Health Improvement Collaborative (a membership organisation within the NHS) which focused on improving physical health for people with severe mental illness.

Our findings

The wards were not currently part of any national accreditation scheme. However, as part of an ongoing improvement project, the PICU wards were benchmarking themselves against the Royal College of Psychiatrists' Standards for Psychiatric Intensive Care Units.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff to provide safe and effective care for patients (Regulation 18(1)).
- The trust must ensure that all staff have completed their mandatory training (Regulation 18(2)(a)).
- The trust must ensure that the premises used for seclusion are suitable for the purpose for which they are being used (Regulation 15(1)).
- The trust must ensure that observation and seclusion records are routinely reviewed to ensure that any gaps are quickly identified and addressed (Regulation 17(1)(2)).

Action the trust Should take to improve:

- The trust should ensure that the ongoing work to remove and mitigate against environmental risks is kept under review, so that patients are cared for in a safe environment (Regulation 15).
- The trust should ensure that all patients are screened for venous thromboembolism (VTE) on admission, in accordance with national guidance (Regulation 12).
- The trust should consider the potential impact of fixed/predictive times in its intermittent observation policy.
- The trust should ensure that following incidents all patients and staff are given the opportunity to review and discuss what has happened.

Our inspection team

The team that inspected the service comprised 2 CQC inspectors, 3 Mental Health Act reviewers and a regulatory co-ordinator.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance