Greater Manchester Mental Health NHS Foundation Trust

Wards for older people with mental health problems

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inadequate**

Our findings

Wards for older people with mental health problems

Requires Improvement 

We carried out this unannounced focused inspection because we had concerns about the quality of services at one location. This inspection was carried out to consider the safety of the wards and the care and treatment being provided to patients at Woodlands hospital.

Woodlands hospital is an older adult inpatient facility located in Little Hulton, Salford. There are three wards on the site: -

- Delamere Ward, a 15-bed ward for female patients, predominantly those who are living with dementia or a functional mental illness such as bipolar disorder or schizophrenia.
- Hazelwood ward, an 18-bed ward for male and female patients, who are living with a functional illness, for example bipolar disorder, schizophrenia.
- Holly ward, a 17-bed ward for male patients living with dementia.

We focussed our inspection on specific key lines of enquiry within the safe domain.

Following this inspection, the trust was served with a Section 29A warning notice as the Care Quality Commission formed the view that the quality of health care provided within this service required significant improvement. The trust was required to take immediate action to make improvements within this service.

The services at Woodlands hospital were last inspected in 2017 as part of an inspection of wards for older people with mental health problems across the trust.

We visited all three wards at the Woodlands site on the evening of 16 November 2022 and during the day on 17 November 2022.

We rated the service as inadequate. We found concerns including:

- Ward environments were not safe, with issues with broken furniture and fittings, ligature risks not mitigated and alarm systems which did not always work.
- Clinic room checks were not always undertaken regularly, including resuscitation equipment checks and cleaning and servicing of equipment.
- There were concerns about medicines management, including safe storage and checks of controlled drugs, medicines fridges left unlocked including one which contained food and drink. In the prescription charts we reviewed, medicines were not signed for on several dates, including critical medicines in the form of anticoagulants. On Holly ward we found most liquid medicines did not have the date they had been opened recorded. Two bottles of medicines were passed their disposal date and still in use.

Our findings

- The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Staff turnover and sickness rates were high. We had significant concerns about lack of qualified nurse cover, with frequent occasions where one nurse was allocated to more than one ward and registered nurse associates allocated as the nurse in charge.
- Staff had not completed all mandatory training needed for this service, including life support training, moving and handling training, prevention of violence and aggression training and safeguarding training. Not all staff received training in understanding the Mental Capacity Act or Mental Health Act, despite needing a basic level of understanding and awareness of these. Safeguarding training was not delivered at a sufficient level for support staff.
- Patient notes were not comprehensive and not all staff could access them easily. The electronic records system and incident reporting system were not accessible for many bank and agency staff. This meant they were unable to access care plans, risk assessments and progress notes, or to enter their own records.
- Care documentation, including risk assessments, care plans, falls risk assessments and patient handover records, were not well completed, and there was no document that staff could rely upon to gather essential information about the patients in their care. This was particularly concerning given the staffing pressures on the service and high use of temporary staffing.

Is the service safe?

Inadequate 

Safe and clean care environments

Wards were not all safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff could not observe patients in all parts of the wards. Bedroom corridors were not observable from the main ward area on any of the three wards. Staff checked ward areas regularly. Wards used parabolic mirrors where there were blind spots or recesses within corridors.

There was one ward, Hazelwood ward, which provided mixed sex accommodation. There were separate male and female corridors but nothing stopping patients walking into bedroom areas if not seen by staff, with no physical separation of corridors. There was a separate female only lounge on the ward.

There were potential ligature anchor points in the service. The trust risk and safety team completed ligature risk assessments, but these did not guide staff sufficiently. Where ligature risks were identified, there were no specific actions to guide staff or mitigate these. On all three wards, the patient group was assessed as medium risk, despite some patients being admitted who were a significant suicide risk. The risk assessments were inconsistently assessed, with the same risks rated differently as moderate or high within the same assessment. Some environmental issues with fixtures and fittings had been identified as a significant risk in other services within the trust, with remedial actions planned, but in this service, they were just noted. Risks were not clearly identified, for example, there were multiple references to frames, but no clarity of whether this was door frames, picture frames or walking frames. There were no remedial actions or plans to reduce risks in any of the three wards. Risk mitigation was often noted with a set sentence that there were good staffing levels or skills mix but this was not always the case.

Our findings

Staff had access to alarms and some patients had easy access to nurse call systems. On Delamere ward, the patient alarm panels were situated next to each bed. We tested these and they worked, with an audible alarm and light above the door or the room where assistance was needed. On Holly ward, these had been deactivated and the ward manager said the staff completed zonal observations instead.

Staff used sensor alarms to detect movement and trigger an alarm for patients at risk of falls, but staff told us these were not always reliable. Two serious incident reports referred to the system failing to sound. We also noted an incident during the week we inspected where the alarm had failed to sound. The most recent investigation from May 2022 noted that staff were trained when the system had been installed but many staff had left. Actions to address this were to arrange training by the end of 2022 and to develop a standard operating procedure by March 2023.

Maintenance, cleanliness and infection control

Ward areas were not all clean, well maintained, well-furnished and fit for purpose.

Delamere ward environment was poor. Two shower rooms had evidence of damp and water ingress. One shower room had a broken dining chair being used as there was no shower chair. Radiators in bathrooms were rusty. One assisted bathroom had a non-working bath, but no notices on the door or equipment to tell staff this was not in use. In the other assisted bathroom, multiple pieces of equipment and two bags of personal belongings were being stored. Stained bedside crash mats were also being stored in this bathroom.

In Delamere ward's day room, most of the chairs had rips or splits in the covers and a tub chair outside a patient's room had split seams where the padding was exposed.

On Delamere ward bedroom furniture in several rooms was chipped or missing veneer. Not all Delamere ward bedrooms had wardrobes, we spoke to two patients who had no wardrobe, one was storing clothes in suitcase under bed, the other was using drawers. Fixtures and fittings varied around the ward, with some rooms having higher specification anti-ligature fittings, but patients were not matched to these rooms by risk.

On Holly ward two bedside tables were damaged and most bedside tables had been removed. Nine of the bedrooms visited on Holly ward had no personalisation or personal effects in them and were described as bare. Two bedrooms smelt strongly of urine.

In one of the bathrooms on Holly ward plastic bags full of clothes were noted in the bath. The other bathroom was locked pending replacement of a bath.

Most wards had limited rooms with en-suite bathrooms, so toilets and bathrooms were on communal corridors.

On Delamere ward there was equipment which wasn't working including: a hoist bath, the macerator/disposal unit for bedpans, the waste disposal sink in the sluice which was leaking, and the office door lock was not working properly.

On Hazelwood ward, the visitors/family room was being used for storage, including bed head and base boards, music equipment, exercise equipment, office supplies and furniture.

Seclusion room (if present)

There were no seclusion rooms at this service. During this inspection, we became aware of two patients whose care could constitute seclusion, and we asked the trust to review these patients care.

Our findings

The trust agreed that one patient's care was seclusion which had not been previously recognised, and steps were taken to ensure that care provided followed the trust policy and the Mental Health Act code of practice.

The trust told us that a working group was being established to look at seclusion on later life wards, and this work will be undertaken alongside the roll out of the updated seclusion policy which had been recently revised.

Clinic room and equipment

We checked the clinic rooms on Holly and Hazelwood ward. Nurses were not completing checks of equipment as per the trust policy.

On both wards resuscitation equipment checks were meant to be completed every day. No checks were documented for Holly ward for 1/11/22, 12/11/22 or 15/11/22 for resuscitation equipment or the emergency box. On Hazelwood ward checks were not completed on 30/10/2022, 11/11/2022 or 15/11/2022.

On Holly ward the daily glucometer checks had not been completed in November 2022 with each entry marked "no glucometer".

On Hazelwood ward sharps boxes were not dated when opened. There were no clean stickers used to indicate when items had been cleaned and were ready for use. Medical device cleaning was scheduled for once per week, but had been completed once in August, once in October and once in November 2022.

On both wards, clinic equipment including thermometers and ECG machines, were overdue for servicing. On both wards the medicines fridges were unlocked and contained medicines. The medicines fridge on Hazelwood ward had food and drinks stored inside. Temperature monitoring of fridges and clinic rooms was not being completed every day.

On Holly ward, the first aid box did not contain the same contents listed on the lid, and contained additional items which were past expiry date, including intravenous fluids and dressings.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe.

This was because of a combination of vacancies, sickness and low staffing levels per shift.

We were particularly concerned about arrangements for qualified nurses and noted regular occasions where preceptorship nurses were left in charge of shifts.

We reviewed staffing rotas for all three wards from 24 October – 20 November 2022.

On seven occasions the nurse in charge was a registered nurse associate. The nursing associate role is designed and intended to work as part of a team, where nursing and leadership of nursing is led and managed by a registered nurse.

There were 34 occasions in six months (1 May - 31 October 2022) where a nurse at Woodlands held the keys for 2 wards. This meant one registered nurse was responsible for at least 33 patients.

Our findings

The service had high vacancy rates. Across all three wards just under 25% of posts were vacant. Half of the band 5 posts on Holly and Hazelwood wards were vacant.

The service had high rates of bank and agency nurses. Between 1 May 2022 and 31 October 2022 bank and agency staff filled 656 shifts to cover sickness, absence or vacancy for qualified nurses. Between 1 May 2022 and 31 October 2022 bank and agency staff filled 4805 shifts to cover sickness, absence or vacancy for nursing assistants.

The service did book bank qualified nurses for regular work and agency nurses more rarely. Managers tried to ensure that bank and agency nurses worked with a permanent qualified nurse.

The service had high rates of bank and agency nursing assistants.

Managers requested staff familiar with the service and there were staff who were working regular bank or agency shifts. However, for some of the shifts we looked at, there were staff working only one shift within the ward that week.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw two qualified nurses during this inspection who had received no induction before starting their shift. Staff were prompted by a manager during our inspection to show one member of staff around the ward who had not worked there before.

The service had high turnover rates with an upward trend over the last 12 months. During the month of October 2022, the turnover rate was 16%.

Managers supported staff who needed time off for ill health. Levels of sickness were high. Over the last 12 months, the lowest rate of sickness was 12% in April, May and August 2022 with sickness rates over 20% during January and October 2022.

Ward managers could adjust staffing levels according to the needs of the patients. Managers were able to book additional staff, often to assist with planned clinical observations. However, these bookings were not always filled. The safe staffing levels (the minimum number of staff required per shift) for these wards had reduced since our last inspection. There had been no change in ward function which accounted for this, but since our last inspection Hazelwood ward had three more beds and Delamere ward had two more beds, without additional staffing resource.

Patients did not have regular one- to-one sessions with their named nurse. Patients may have had their escorted leave or activities cancelled due to staffing, however this was not recorded or monitored by the trust. The service did not always enough staff on each shift to carry out any physical interventions safely.

Staff did not share key information to keep patients safe when handing over their care to others. We attended handovers on all three wards. The shift leader on one of the wards was a nurse who had moved from another ward and was not familiar with the patients. On all wards staff read from handover sheets but these were not well completed, and it was not clear how often the key information on these (where completed) was updated, for example, detention status, physical health needs, mobility.

Medical staff

The service had enough daytime medical cover and a doctor available to go to the ward quickly in an emergency.

Our findings

There was on-call medical support during the evening and night. Staff contacted the nurse led Hospital at Night team based at another site for advice and they attended for some issues, but staff told us that in practice they would call an ambulance if they had concerns.

Mandatory training

Staff had not all completed and kept up-to-date with their mandatory training.

Qualified nurses completed immediate life support training, with compliance across all three wards at 77%. However, only four staff on Holly ward had completed this (67%) and seven staff on Delamere ward (78%). For basic life support training, which only support workers completed, less than two thirds of staff (62%) across three wards were up to date. On Delamere ward, only 35% of staff were up to date with this training and on Holly ward 64% of eligible staff had completed this.

When looked at this in terms of whole ward staffing, only half of all staff on Delamere ward (13 of 26 in total) had completed life support training. Similarly, on Holly ward, only 22 staff out of a total 36 staff had completed required life support training.

The importance of nursing and medical staff being appropriately trained in life support techniques was outlined in the National Institute for Health & Care Excellence NG10 guidance. This includes the need for staff trained in immediate life support and a doctor trained to use resuscitation equipment to be immediately available to attend an emergency if restrictive interventions might be used. All of these wards used restrictive interventions, including restraint and rapid tranquillisation. This was more concerning given the low levels of basic life support completion on wards where high levels of restrictive interventions were reported.

Managers did ensure that there was a minimum of one ILS responder at Woodlands on each shift.

Moving and handling inpatient training had been completed by 68% of staff overall at the hospital, with ward-based completion at 54% for Delamere ward, 74% for Hazelwood ward and 76% for Holly ward.

In terms of prevention of violence and aggression training, 78% of staff across all three wards had completed this, however, only 60% of staff on Delamere ward were up to date with this.

Across all three wards 74% of staff were up to date with fire safety awareness training, however only 59% of staff on Delamere ward had completed this.

Infection prevention training had a completion rate of 73% across the three wards, however only 58% of staff on Delamere ward had completed this.

Safeguarding adults and children training was only completed at level 3 by qualified nurses, but completion overall for this was 60% for adult training and 79% for children's training. For level 2 safeguarding training, 79% of staff had completed the adult training and 80% the children's training.

Only qualified nurses completed Mental Capacity Act training, and over the three wards only 64% of staff had completed this. Similarly, only qualified nurses completed Mental Health Act training and overall 82% of staff eligible had completed this.

Our findings

Across the three wards, 63% of staff had completed falls prevention training, with only 46% of staff on Delamere ward having completed this.

The mandatory training programme was not comprehensive and did not meet the needs of patients and staff.

The trust was only providing training in the Mental Capacity Act and Mental Health Act to qualified nurses. The Mental Capacity Act (MCA) applies to everyone who works in health and social care and is involved in the care, treatment or support of people aged 16 and over who are unable to make all or some decisions for themselves. In this setting support workers were working regularly with people with impaired or fluctuating capacity, meaning this training was essential. Most patients across these wards were detained under the Mental Health Act, but most of the staff looking after them had received no training to understand the Act.

The intercollegiate guidance on safeguarding refers to all mental health staff being trained to level 3 in safeguarding children and adults, but the trust was only training support workers to level 2.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool.

We reviewed six care records. All contained the trust format risk assessments, but none were fully completed, with sections blank, content in incorrect places and poor or no formulation.

We reviewed falls risk assessments; some were well completed but two on Holly ward were predominantly a list of incidents rather than providing guidance for staff. One patient's falls risk assessment included using cot sides on the bed, however in the handover attended, staff were told not to use these. The provider had a falls prevention and management policy which reflected best practice guidance and offered practical support for staff.

We reviewed multidisciplinary care plans and found these did not provide sufficient guidance to staff in how to care for patients, including their physical health needs, mobility and pressure risks. Care plans often contained generic content, for example, a description of diabetes, rather than person specific details about diabetic monitoring, diet, treatment and escalation.

Management of patient risk

Each ward had patient handover sheets where information could be gathered during the shift. These were not fully completed for patients, for example, on all handover sheets the patient's pressure needs, physical health and falls risk were blank. Some patients with mobility needs or use of aids had this information recorded but some did not. The handover sheets covered a week of shifts over 2 pages. Some shift summaries were blank, frequently summaries were a list of tasks completed, including frequent use of "m/d/f" for medicines, diet and fluids. There were few entries, particularly on Hazelwood or Delamere ward, relating to mood or mental state or individual time spent with patients. Some statements on handover sheets were subjective and judgemental, for example, "needs boundaries", "manipulative", "histrionic", "wandersome"; one patient's entire shift is summarised as, "occasionally rude".

On Holly ward in some patients' rooms there was a monitoring chart called a "body map" where staff would record any skin changes, marks etc in a table format (rather than a traditional body map which is usually a front and back image of an adult where notes can be made about location and appearance of any marks, pressure areas, bruising etc).

Our findings

Staff completed food and fluid charts for patients on all three wards, but these were not fully completed, and it was not clear how this information was checked by registered nurses and escalated if necessary. When we visited in the evening, we saw fluid charts with no entries since lunchtime. Food and fluid charts contained a prompt for staff to record any need for thickened fluids or diet consistency, but these were not completed.

Staff told us they relied on the handover between shifts predominantly to guide them in a patient's care and risks. Support staff told us they did not access the electronic patient records and temporary staff were unable to access these.

On all three wards, whilst patient information was collected in a range of ways, including monitoring sheets, "body maps" on Holly ward, handover sheets, progress notes and care plans, none of these provided information needed in one place to be assured that staff were aware of key risks so they could provide safe care for patients.

On Holly ward, in each patients' bedroom, a laminated one-page profile included information about significant family members and friends, previous occupations, hobbies and interests and favourite foods, drink, music, films, books. This provided staff who may not know the person well with important information to assist them to engage in meaningful conversations.

Use of restrictive interventions

There had been 208 episodes of restraint in the last 12 months across all three wards, the majority of these were on Holly ward (144 incidents). Of these, nine instances involved the use of prone restraint. The use of prone restraint is no longer regularly used in mental health settings because there is significant risk of positional asphyxiation which can lead to death.

In the last 12 months, there had been 71 incidents where patients were given rapid tranquillisation.

Staff did not recognise when care provided was so restricted as to constitute seclusion or segregation. The trust agreed that one patient's care was seclusion which had not been previously recognised, and steps were taken to ensure that care followed the trust policy and the Mental Health Act code of practice.

There were blanket restrictions on the wards we visited. On Delamere ward, patients could not use the kitchen, and the activity room and garden were locked. On Hazelwood ward, the garden was locked, and a notice told patients to ask staff if they wished to go outside. On Holly ward the garden was locked. There was no signage indicating how informal patients would be able to leave the wards and all wards had locked front doors.

Safeguarding

Staff received training on how to recognise and report abuse, but this was not always at the level appropriate for their role.

Safeguarding adults and children training was only completed at level 3 by qualified nurses, but completion overall for this was 60% for adult training and 79% for children's. For level 2 safeguarding training, 79% of staff had completed the adult training and 80% the children's training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

We saw incidents reported to safeguarding authorities appropriately.

Our findings

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff did not have easy access to clinical information and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were not comprehensive and not all staff could access them easily.

The electronic records system and incident reporting system were not accessible for some bank staff and agency staff. This meant they were unable to access care plans, risk assessments and progress notes, or to enter their own records. Staff told us these would be handwritten to be added to the systems by other staff. This meant that records were not always complete, and we saw in the progress notes on Delamere ward that there were some days with only one progress note, rather than information from each shift.

Following this inspection, the trust put in place measures to enable temporary staff to access these systems.

Records were stored securely.

Medicines management

We reviewed four prescription cards on Holly ward and checked clinic rooms on Holly and Hazelwood wards.

Staff mostly followed systems and processes to prescribe and administer medicines safely. In the prescription charts we reviewed, medicines were not signed for on several dates, including critical medicines in the form of anticoagulants. One patient had unsigned for doses of anticoagulant twice in the week prior to the inspection, along with two unsigned doses of a medicine for high blood pressure and one dose of a medicine for psychosis. Another patient had three days of unsigned for anticoagulant when the dose changed. For patients prescribed medicines to be given covertly there was no information with the prescription card about the practicalities of administering this.

One patient's second opinion authorisation (T3) did not cover all medicines being prescribed. Another patient had old consent forms in their medicine file, despite no longer being detained under the Mental Health Act.

Doctors completed medicines records accurately and kept them up-to-date. Prescription cards were well completed, including records of weight, blood monitoring and essential information and allergies.

Staff did not store and manage all medicines safely. On Holly ward we found most liquid medicines did not have the date they had been opened recorded. Two bottles of medicines were passed their disposal date and still in use, one a medicine to treat heart failure and one a medicine used for anxiety. The lid for one liquid medicine was missing and a medicine syringe barrel was used as a makeshift stopper.

Following inspection, we reviewed the last 12 months of controlled drugs audits for all three wards. These showed on all wards daily checks not being completed and issues with recording orders, checking liquids and one instance of medicines missing.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. In the prescription charts we reviewed, there was no excessive or inappropriate use of medicines to control behaviour.

Our findings

Track record on safety

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. However, we were aware that many temporary staff could not access the incident reporting system when we inspected, and we could not be assured that all incidents were therefore being reported.

We were not assured that staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong. The trust provided figures relating to eight incidents which met the duty of candour threshold over the last 12 months. Whilst the trust recorded that discussions had taken place with families following incidents, we were not assured that face to face meetings took place where possible or that a written apology and details were being provided in writing.

The service completed 72 hour reviews following incidents and more indepth investigations were completed by investigation teams using root cause analysis. We reviewed eight 72 hour review reports and two investigation reports. Of the 72 hour review reports, we noted one incident which was not fully explored with a review focusing on the response rather than the incident and one incident which had no safeguarding actions identified. Other reviews were well completed with action plans included. There were repeated themes including: care plans not being reviewed or being up to date including falls and observations plans, escalation of physical health concerns, and issues relating to clinical observations, including adherence to the policy and confusion around levels of observations in place.

Whilst there were action plans, there was little evidence that actions had led to sustained improvement, for example, there were actions to audit care plans which had been completed, but these were poorly completed and out of date at this inspection. The service managers told us of changes being made to the care plan format to be more specific to this patient group.

The trust had several quality improvement initiatives which had involved the Woodlands site, including a series of initiatives across all older adult wards to improve falls prevention and a current trust-wide project aimed at improving awareness and care of deteriorating patients.

Our findings

Areas for improvement

- The service must ensure that all staff receive training and guidance in the use of the sensor alarm system (Regulation 12(1))
- The service must ensure that all environmental risks are identified, acted on and updated to make environments safe. Environmental risks must be shared with staff and documentation must clearly detail how risks are minimised and managed. (Regulation 12(1)(2)Regulations 17(1)(2)).
- The service must review all blanket restrictions currently in place at the service to ensure patients are cared for in the least restrictive manner, including informal patients (Regulation 12(1)(2)
- The service must ensure that clinic room checks, including resuscitation equipment checks and controlled drugs checks are completed as per policy. The trust must ensure that clinical equipment and medical devices are cleaned and serviced at appropriate intervals and the service must ensure that medicines fridges contain only medicines (Regulations 12(2); Regulation 17 (1)(2))
- The service must ensure that medicines are stored and administered correctly (Regulations 12(2))
- The service must ensure that staffing establishment levels reflect the needs of patients and staff. Establishment levels must be reviewed regularly, and staffing levels must enable good continuity of care. The service must ensure that all staff have all the appropriate training to perform their roles safely and effectively. (Regulations 18(1)(2); 17(1)(2)).
- The service must ensure that all staff complete records professionally and objectively (Regulation 17(2))
- The service must ensure that governance processes operate effectively, and that performance and risk are managed well. (Regulations 17(1)(2)).
- The service must ensure that systems and processes, such as audits of the service provided, are completed accurately and findings acted upon (Regulation 17(2))

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a CQC inspection manager.

This section is primarily information for the provider

Enforcement actions

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	S29A Warning Notice
Treatment of disease, disorder or injury	
Diagnostic and screening procedures	