The Spinney

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We conducted this unannounced focused inspection to review two requirement notices given at our last comprehensive inspection in October 2015. We published our inspection report in February 2016. The requirement notices related to the safe key question which we rated as requiring improvement due to breaches of regulation 9 - person-centred care and regulation 12 - safe care. Following the inspection in October 2015, the provider submitted action plans telling us how they would make improvements. This also covered areas where we had made recommendations.

We inspected The Spinney on 10 and 15 August 2016 to check whether these improvements had been made. We visited all the forensic wards and the psychiatric intensive care unit. We found areas of good practice:

- Managers in the hospital had taken sufficient action to address the requirement notices we issued following the inspection in October 2015.
- Staff completed risk assessments of patients at admission and on an ongoing basis.
- There were new protocols to guide staff on de-escalating patients' disturbed behaviour in the observation lounges.
- Staff and managers monitored the use of high dose antipsychotic medication.

Summary of findings

- There were improved medicine management arrangements with reviews of medicines prescribed 'as required'.
- Wards were clean, well maintained and ligature risks were managed.
- Staffing levels were safe with low levels of sickness and agency use.
- Staff received appropriate mandatory training.
- There were low levels of restraint and where restraint had been used it was monitored by managers.
- There were appropriate lessons learnt following incidents.

As managers at The Spinney had made the improvements within six months from the date of publication of the last report, we re-rated the safe key question from requires improvement to good. Using our aggregation principles, this also led to an overall rating of outstanding for The Spinney as the caring and responsive key questions were previously rated as outstanding and all other key questions rated as good.

However, we also found some areas for improvement:

- Patients on Rivington and Lever wards were subject to restrictions on accessing their bedrooms due to the ward layout. Managers were addressing these restrictions.
- There were small number of delays in doctors attending episodes of seclusion out of hours on Hulton ward and the long-term segregation policy required amendment about our role.
- A small number of patients on high-dose antipsychotics regularly refused health checks and there was limited recording of the benefits and risks of continuing with the regime.
- On some wards, the written ward ligature risk assessment was not readily available to all staff.

Summary of findings

Contents

Outstanding ☆

The Spinney

Services we looked at

- Forensic inpatient/secure wards
- Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to The Spinney

The Spinney is an independent hospital which is run by the Partnerships in Care group. It is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

The hospital provides medium secure, low secure and psychiatric intensive care services for male patients. It has 93 beds split over seven wards. The wards were:

- Shevington ward - a 14 bed medium secure ward
- Hesketh ward - a 15 bed medium secure ward
- Rivington ward - a 16 bed medium secure ward
- Pennington ward - a 10 bed medium secure ward
- Lever ward - a 15 bed low secure ward
- Hindsford ward - a 10 bed low secure ward
- Milford ward – a 3 bed step down ward from the low secure unit
- Hulton ward - a 10 bed psychiatric intensive care unit

All patients were detained under the Mental Health Act. The length of stay varied considerably by ward, with some patients having been admitted for long-term secure care and some new admissions especially on the psychiatric intensive care unit.

The hospital had a registered manager and controlled drugs accountable officer in place at the time of inspection.

We have inspected The Spinney four times since 2010. At the last inspection in October 2015, we found that The Spinney was providing effective services which were well led. We rated care and responsive as outstanding due to the extensive patient and carer involvement initiatives and vocational opportunities. However we rated the safe key question as requires improvement as we found:

- staff did not always complete a risk assessment of patients at admission
- we were concerned about the use of observation lounges on one ward and documentation of this
- staff recorded some instances of seclusion wrongly as long-term segregation
- staff did not always monitor the use of high dose antipsychotic medication in required cases
- staff did not ensure timely review of medication, including duration of treatment and dose required.

We issued requirement notices against regulatory breaches for safe care and person centred care. Following the inspection in October 2015, the provider submitted action plans telling us how they would make improvements. We reviewed the action plans submitted by the provider. On this inspection, we found that those improvements had been made. We found the provider had taken action to address the requirement notices. This meant we were able to re-rate the provider at this inspection as we found they had taken sufficient action to ensure all areas of concern had been addressed and no new regulatory breaches were found.

We have reported on forensic/inpatient secure wards and the Psychiatric Intensive Care Unit (PICU) together within this report due to the relatively low number of beds within the psychiatric intensive care unit.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, a CQC Mental Health Act reviewer and a CQC specialist pharmacist inspector.

Summary of this inspection

Why we carried out this inspection

We carried out an unannounced focused inspection on 10 August 2016 to review two requirement notices given at our last comprehensive inspection in October 2015. We returned on 15 August 2016 to complete the inspection and speak to the registered manager.

When we last inspected The Spinney in October 2015, we rated their services as good overall. We rated The Spinney as requires improvement for the safe key question, good for effective and well-led key questions, and outstanding for the caring and responsive key questions.

Following the inspection in October 2015, we told The Spinney that it must take the following actions to improve its services in the following areas:

- The provider must ensure staff follow procedures around medicines management, including rapid tranquillisation and high dose antipsychotic monitoring.
- The provider must ensure seclusion and long term segregation is correctly recorded.
- The provider must ensure risk assessments are completed at admission.

We therefore issued the provider with two requirement notices that affected the forensic wards and psychiatric intensive care unit.

These related to:

- Regulation 9 - person centred care and
- Regulation 12 - safe care.

How we carried out this inspection

On this focused inspection, we asked the following question

- Is it safe?

Before the inspection visit, we reviewed information that we held about The Spinney and asked a range of other organisations for information Including specialist commissioners.

During the inspection visit, the inspection team:

- visited all wards at the hospital including four medium secure wards, two low secure wards areas, the step down low secure ward and the psychiatric intensive care unit
- looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with 15 patients
- spoke with 20 staff members including ward managers or acting managers, nurses and healthcare workers
- interviewed the hospital director who was the registered manager
- looked at 20 patient records including 20 risk assessments and 20 care plans
- looked at the care records and initial admission documentation of a further nine patients admitted since February 2016
- carried out specific checks of the medication management arrangements and observed two medicine rounds
- looked at 31 prescription charts and the monitoring of 23 patients on high dose antipsychotics
- reviewed 12 seclusion records and ward seclusion registers
- reviewed the care records of two patients who were or had been subject to long-term segregation
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 15 patients across the wards; 13 patients on the forensic inpatient/secure wards and two on Hulton ward, the psychiatric intensive care ward.

Patients commented favourably on the quality of care and support they received, especially the nursing care. They stated that ward staff provided dignified care that

Summary of this inspection

met their needs. Patients told us that they felt safe and that staff kept them safe by managing disturbed behaviour from other patients. Some patients commented on the effectiveness of the treatments and therapies they had undertaken at The Spinney. These treatments helped patients understand their forensic history and help manage and reduce future risks.

Many patients commented that there were sufficient staff to access escorted leave and they got out on leave with the regularity that had been authorised. A small number of patients commented that on occasions planned ward based activities were postponed due to other priorities for staff on the ward. However, there was an extensive range of ward and off ward activities so patients managed to attend most activities during the week. On Rivington ward, one patient commented that there were not sufficient staff to supervise the opening of the ward bedrooms at all times as bedrooms were situated on the first floor. There were plans to address this with a pilot to secure one additional staff member to be allocated to Rivington ward to enable bedrooms to be opened up.

Most patients commented favourably on the cleanliness of the ward with one patient stating that the cleaner on Rivington ward worked incredibly hard to maintain the cleanliness of the ward. Two patients commented on the cleanliness and upkeep of Lever ward stating that it could be improved - commenting that the carpets, bedroom and bathroom areas could be cleaner and tidier. However, during the inspection there was refurbishment of the ward with new flooring being put in the dining room area.

Patients had confidence in ward managers telling us that they listened and would try and resolve issues.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Staff completed risk assessments of patients at admission and on an ongoing basis
- There were new protocols to guide staff on de-escalating patients' disturbed behaviour in the observation lounges.
- Staff and managers monitored the use of high dose antipsychotic medication
- There were improved medicine management arrangements with reviews of medicines prescribed 'as required'.
- Wards were clean, well maintained and ligature risks were managed.
- Staffing levels were safe with low levels of sickness and agency use.
- Staff received appropriate mandatory training.
- There were low levels of restraint and where restraint had been used it was monitored by managers.

However:

- Patients on Rivington and Lever wards were subject to restrictions on accessing their bedrooms at times during the day. This was due to the layout of the wards. Managers were addressing these restrictions.
- There were a small number of delays in doctors attending episodes of seclusion out of hours on Hulton ward. Following our inspection, managers reminded doctors to keep delays to a minimum and to record the reasons for any delay.
- The long term segregation policy required review as it referred to CQC Mental Health Act reviewers being invited to participate in discussions about the continued use of long term segregation for individual patients.
- A small number of patients on high-dose antipsychotics regularly refused health checks and there was limited recording of the benefits and risks of continuing with the regime.
- Whilst staff had a good understanding of the ligature risks, the written ward ligature risk assessments on some wards were not readily available to all staff.

Outstanding ☆

Forensic inpatient/secure wards

Safe — Good

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

The wards provided a safe environment for the care of patients within medium and low secure and psychiatric intensive care environments. There had been significant attention to addressing ligature risks throughout the units. Ligature risks were places to which patients intent on self harm might tie something to strangle themselves. Bathrooms and toilets had anti-ligature tap and shower fittings. Curtain and blind rails were held with strong magnets which made them collapsible. Wardrobe doors had piano style hinges and lipped hangers which prevented patients from using these as a ligature. Staff had a good awareness of the location and management of ligature risks within their own ward areas.

Staff managed ligature risks across the wards well, with ligature risk audits completed and reviewed monthly. Areas which were identified as posing a ligature risk were locked off and opened under staff oversight or supervision such as bathroom areas and staff toilets. The completed ligature risk assessments were sent to senior managers located in the management suite and wards did not always keep a copy locally. Managers accepted the need to keep an accessible copy at ward level as part of dynamic risk assessments. Ligature cutters were accessible on all wards and all staff knew how to access these in an emergency.

Since the last inspection, Milford ward had opened which provided step down facilities from the low secure unit to enable patients to live more independently. Milford ward had a number of safety and ligature risks throughout the unit. The ligature risks included domestic taps, exposed piping and hinge fittings in bedroom wardrobe areas. However these risks were mitigated by

a ligature risk audit and individualised admission assessment processes. These ensured that only those patients who could safely be managed with these risks were accepted for transfer utilising positive risk taking approaches. There was only one patient on Milford ward and care records confirmed that these individualised admission assessments took place prior to admission to Milford ward..

Access into and exiting from the wards and the unit was controlled by staff. The keys to the units were booked in and out by staff using a computerised locked cupboard system. Entrance to each ward was through an air lock door which helped to ensure patients were kept safe. The exception was Milford ward which had its' own direct entrance outside of the secure area. The secure wards had a secure courtyard area to access fresh air. The fencing was well maintained and checked regularly by the security nurse to ensure the integrity of the perimeter fence and prevent patients going absent without leave. Patients on the psychiatric intensive care unit and Lever ward had access to an internal courtyard, under staff supervision.

The wards were clean and well maintained. Patients commented favourably on the cleanliness of the wards. The furniture on the wards was in a good state of repair and was clean. Some of the bedroom areas on Hulton ward were looking tired as they had not been redecorated since the psychiatric intensive care unit had opened. The manager assured us they were on the schedule of redecoration. The wards felt relaxed and comfortable. Two patients commented on the cleanliness and upkeep of Lever ward stating that it could be improved - commenting that the carpets, bedroom and bathroom areas could be cleaner and tidier. However during the inspection there was refurbishment of the ward with new flooring being put in the dining room area.

Seclusion rooms met the requirements of the Mental Health Act Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others, including providing spacious environments with ventilation, heating and lighting managed remotely and integrated intercom systems. Some seclusion rooms had en suite facilities within the room with toilet fitting with partitioned walls and anti-ligature fittings. Staff could discreetly observe patients in the toilet areas if required.

Forensic inpatient/secure wards

There were plans to upgrade the seclusion rooms to provide en suite facilities in the seclusion rooms across the hospital. Clocks were situated so that patients in seclusion could orientate themselves to the time.

Each ward had a well equipped clinic room which was clean and tidy. Medicines were stored securely with access restricted to authorised registered nursing staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The controlled drugs storage cupboard was being replaced and was not secured to the wall on Hulton ward. At the time of our inspection, there were no controlled drugs stored in this cupboard. The cupboard was secured to the wall by the second day of our inspection. Medicines requiring refrigeration were stored appropriately. The clinic rooms and refrigerators were checked daily by nursing staff to ensure that medicines were stored at the correct temperature and were safe to use. The wards had resuscitation equipment, including a grab bag and defibrillator which were checked daily to ensure they were working correctly and would be immediately available in a medical emergency. Audits of the clinic room, refrigerator and resuscitation equipment were carried out regularly. The audits showed good levels of adherence to make sure that medicines were stored safely and emergency equipment was checked and maintained appropriately.

Bedrooms had fire alarms and nurse call systems. Equipment such as fire extinguishers and electric equipment had been checked annually to make sure they continued to operate safely. Ward staff completed a monthly safety and hazard checklist to check a number of areas including health and safety, fire safety, infection control and electrical equipment. Records showed that ward staff were promoting good health and safety practices in their areas and any identified shortfalls or hazards were managed appropriately.

Safe staffing

The wards displayed the actual staffing levels on each ward. The actual staffing levels matched or exceeded the expected staffing levels. Ward managers were empowered to take professional decisions about the staffing needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation. Patients told us that there were sufficient staff on the ward to provide appropriate care and treatment such as named nurse sessions, facilitating escorted leave and attending medical and hospital appointments. Patients on Rivington ward did not have access to their bedrooms at all times as the bedrooms were located on the first floor. The ward manager was looking to reduce the restrictions.

The secure wards had a designated security nurse that carried out checks to ensure that the secure wards operated effectively, and make sure that there were no breaches of the security arrangements. This included ensuring items not permitted or permitted under supervision were accounted for. As a step down unit, patients on Milford ward were afforded more responsibility with access to a wider range of items in keeping with a step down unit and positive risk taking approaches.

Staff told us they felt safe on the wards and supported by colleagues to maintain appropriate relational and actual security arrangements. Staff understood key messages from 'See, Think, Act' which was the national guidance on maintaining appropriate actual and relational security within mental health secure settings. There were 'See, Think, Act' posters around the wards and the hospital providing key reminders to staff and patients about security matters.

The establishment levels for the hospital were 49 whole time equivalent qualified nurses and 77.5 whole time equivalent healthcare workers. There were between 20 and 25 qualified nurses and healthcare workers on each ward. There were good staff to patient ratios on each ward. Across the hospital there were 7.5 nursing vacancies and 6.5 healthcare worker vacancies. On each ward where there were vacancies, there were well developed plans to recruit to these posts. For example there were offers made to fill four of the 7.5 nursing vacancies. Clinical staff turnover rate was 9% for the six months prior to the inspection.

The hospital had its own bank of staff which were staff who were regularly used across the hospital. There was low use of agency staff with 75 shifts filled by agency staff during April to June 2016 – all of these were agency healthcare workers. The hospitals did not use agency nursing staff and utilised overtime and bank nursing staff when required. Between January and June 2016, there were no shifts which had not been staffed or filled by bank or agency staff. The hospital had a sickness rate of 3.5% for nurses and nursing assistants between 1 April and 1 August 2016.

Forensic inpatient/secure wards

Staff and patients across the hospital told us that there were sufficient staff to meet patients' needs. Our observations showed that staff dealt with patients' requests in a prompt and respectful manner. There was friendly rapport between staff and patients across the wards with staff knowing patients' needs well which helped with the relational security aspects of running secure wards. There were multiple activities occurring across the wards including attending to escorted leave requests, running activities and providing clinical care such as medication. Despite the busy nature of the wards and the acuity of the patients on some wards, there was a calm atmosphere. Leave and activities were not routinely cancelled as there were good staff to patient ratios.

The exception was in Rivington ward where one patient commented that there were not sufficient staff to supervise the opening of the ward bedrooms at all times as the bedrooms were situated on the first floor. The ward manager corroborated this as there needed to be two staff present when patients were upstairs. This allocation of staff impacted on the ability to take patients out on escorted leave. Most patients on Rivington ward had extensive escorted leave. Patients had been consulted and agreed that escorted leave was a priority rather than staff allocated to bedroom corridors throughout the day. However there were plans to address this with a pilot to secure one additional staff to be allocated to Rivington ward to enable bedrooms to be opened up in the afternoons. Clinicians were considering the possibility of having agreed risk assessments for patients to access the upstairs bedrooms. Longer term solutions were also being considered such as a capital case being made to install closed circuit television in the upstairs corridor areas for monitoring and to prevent incidents from occurring. The bedrooms on Lever ward were locked off from 9.30 am to 11.30 am to enable cleaning and to encourage patients to attend activities.

Staff worked on a two shift system – working long days and then a shift change provided staff throughout the night. This meant that patients received care from the same staff for longer periods which helped continuity of care for patients. Staff attended effective handovers to ensure they understood the current presentation of patients and could manage risks on the ward.

The mandatory training levels across hospital were appropriately maintained with an average of 95% of substantive staff up-to-date overall with mandatory training. Staff attendance at mandatory training exceeded 90% in most mandatory training subjects. For example, 96% of staff had completed fire safety training, 95% had completed infection control training, 96% had attended the management of violence and aggression training, 92% had attended security training and 96% of staff had completed health and safety training. Eighty seven per cent of all staff including bank staff had completed immediate life support. All of the mandatory training exceeded 75% which meant that the majority of staff received updated training as required. Staff received supervision and appraisal with 92% of staff receiving an annual appraisal over the last 12 months.

Assessing and managing risk to patients and staff

We looked at risk assessments for 20 patients. Patients had up-to-date risk assessments which identified the risks patients posed to themselves or others with risk management plans in place. The historical clinical risk management 20 tool and short-term assessment of risk and treatability risk assessment tools were well completed with detailed information on risks. The historical clinical risk management 20 tool was a comprehensive set of professional guidelines for the assessment and management of risk relating to offending history.

When we inspected in October 2015, we found that in a small number of records, staff had not completed formal risk assessments initially when the patient was admitted to the hospital. This meant that staff were not always aware of a patient's specific risks or how to manage these. We therefore found the hospital breached regulations in relation to providing safe care to patients. The hospital produced an action plan telling us they would ensure staff completed initial risk assessments and they would improve the risk assessment process. They told us they would complete this action by 29 February 2016.

On this inspection we case tracked nine patients who had been admitted since 29 February 2016. We saw comprehensive information on risks was recorded within the pre-admission assessment and when the patient was clerked in to the hospital by a doctor. Nurses completed an escort risk assessment which focussed solely on risks related to leave. The hospital was piloting more comprehensive initial risk assessments for the Partnerships

in Care group. These included more detailed requirements describing risk of self harm and suicide, risks to others, risk to property, previous forensic history, security risks and known triggers.

We found well completed initial risk assessments for 8 out of 9 patients. Only one patient on the psychiatric intensive care unit did not have a risk assessment produced by staff even though they had been at The Spinney for 15 days at the time of our inspection. However the patient did have a comprehensive risk management plan from the hospital were the patient had come from and had received a comprehensive medical examination on admission which included the consideration of risks. The ward manager accepted the need to ensure that this patient's risk management plan was updated. There were appropriate arrangements to ensure risks were considered and reviewed when patients' leave status was reviewed and when they moved to different levels of security. For example when patients moved from low secure care to Milford ward which was the step down unit. On this inspection, we therefore found that improvements had been made to improve the systems and recording of initial risk assessments when patients were first admitted.

Following admission and the initial risk assessment, psychology staff led on completing comprehensive historical clinical risk management 20 tool to identify and manage ongoing risk assessments. Psychology staff made sure they were in place at the first review following admission. These were thoroughly completed and were regularly reviewed.

We saw within patients' care records that patients had a physical health assessment carried out by a visiting GP within 24 hours when patients were admitted to the ward. There was good evidence of ongoing physical health care and checks carried out by the visiting GP, the practice nurse and baseline checks by nursing staff. There were systems to ensure patients' physical health needs were met appropriately across the wards.

When we inspected in October 2015, we found concerns about the management of medicines. These included two patients on high dose antipsychotics with limited evidence of monitoring recorded. Patients on Hulton ward were being continuously prescribed 'as required' medication without formal review. This meant that staff were not always aware of a patient's specific risks or how to manage these. We therefore found the hospital breached regulations in relation to providing safe care to patients. The hospital produced an action plan telling us they would improve the medicines management arrangements, produce and oversee a database of patients on high dose antipsychotics and ensure staff completed reviews of as required medication. They told us they would complete this action by 25 February 2016.

On this inspection, we looked at the systems in place for medicines management. We assessed 31 prescription records and spoke with nursing staff who were responsible for medicines administration. Across the hospital, the medicine administration records were well completed with no gaps in the medicines charts. There were appropriate records kept of the receipt in and disposal of medicines to ensure that appropriate stock and individual patient medication was monitored. The hospital had pharmacy arrangements with a national chain of pharmacists with occasional emergency back up through a local pharmacist using private prescription. Nursing staff did not identify concerns with the availability of medication and stock medication including out of hours. We found one minor instance of unclear prescribing and one episode of non-critical patient medication not being available which were passed on to staff at the hospital. Patients on Milford ward had a lockable cabinet to store their medication as part of their self-management of medicines in a step down unit.

Audits of medicine cards were carried out regularly across the wards. The audits showed good levels of adherence to proper and safe management of medicines. Where there were minor issues identified in the audits, these were quickly addressed. For example one audit highlighted that allergy information for one patient on one ward was missing from the medicines chart and this was quickly addressed. There was good uptake of mandatory safe administration of medicines level two training - 92% of relevant clinical staff were up to date with this training.

We case tracked 23 patients who were on high dose antipsychotics. A database was kept so that managers could oversee the use of high dose antipsychotics and a monitoring form was completed for each patient on high dose antipsychotics. This monitoring form included a much improved recording system of known risk factors such as heart, kidney or liver problems for each patient. The database and monitoring form recorded the calculation of the percentages of each antipsychotic compared to the

maximum British National Formulary recommended dose of antipsychotics for each patient. The British National Formulary was a reference book that contains authoritative information and advice on prescribing medicines including indications, contraindications, side effects, and recommended doses. The rationale for continued use of high dose antipsychotics were recorded including details of previous relapses in patients' mental health when reductions in medication had been tried.

There was good evidence of physical health checks for these patients led by the practice nurse to ensure any adverse effects were monitored and appropriate action taken. There were a small number of patients on high-dose antipsychotics who regularly and routinely refused physical health checks. Managers at the hospital accepted the need to include a fuller detailed recording of the risks and benefits of continuing on high dose antipsychotics in these cases. We found that where checks were essential to continuing on a particular medicine (such as Clozapine and Lithium) that these checks occurred.

We also saw improved reviews of 'as required' medication. This also included patients being prescribed 'as required' medication within levels recommended by British National Formulary guidance and these medicines were reviewed when they were no longer required or when there were changes to the recommended doses outlined in the British National Formulary.

On occasions, patients may be prescribed medicines known as rapid tranquillisation to help with extreme episodes of agitation, anxiety and sometimes violence. We saw information about the use of rapid tranquillisation and the provider had an up to date policy covering this type of treatment. Following rapid tranquillisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate. The corresponding care records for patients who had been given rapid tranquillisation showed clearly that these observations had been recorded. On this inspection, we therefore found that improvements had been made to improve the systems and recording of medicines and the use of high dose antipsychotics.

There was a clear list of items not allowed on the secure and PICU wards, which were kept in security cupboards with access to these items under supervision. There was an appropriate balance between managing risks within the secure and PICU environments and an appropriate level of positive risk taking. This was achieved through ensuring proper regard to relational security such as ensuring good knowledge of individual patients and appropriate staffing levels. When patients moved to Milford ward, they had ready access to a wider range of domestic and personal items in keeping with a step down unit.

During the six month period from 1 January 2016 to 30 June 2016, there were 134 incidents of restraint on 42 patients across The Spinney. Most restraints occurred on Hulton ward which accounted for 66% of restraint episodes.

Of all of the restraint incidents, 28 involved face down or prone restraint. National guidance from the Department of Health called Positive and Proactive Care states that prone restraint should be avoided where possible. This is because there are dangers with prolonged prone restraint such as patients being at higher risk of respiratory collapse. There was information displayed to inform staff that prone restraint should only be used as a last resort and for the shortest possible time.

The hospital monitored the use of prone restraint to ensure it was only used when necessary and for the shortest period. The audit of prone restraint identified that prone restraint episodes were for very short periods and were mainly used due to the unexpected unintentional descent to the floor when patients were first restrained, as part of a controlled descent in the prone position to administer intra-muscular injection to patients or to enable staff to exit the seclusion room safely.

Patients on Rivington ward did not have access to their bedrooms at all times as the bedrooms were located on the first floor. The ward manager was looking to reduce the restrictions. There were plans to address this with a pilot to secure one additional staff member to be allocated to Rivington ward to enable bedrooms to be opened up. There was a reducing restrictive practice group that regularly met to look to reduce and remove restrictive practice across the hospital in keeping with the varying levels of security operating at The Spinney.

When we inspected in October 2015, we found that in a small number of records, records did not clearly state how observation lounges were being used to manage patients' disturbed behaviour. We were concerned that patients may be prevented from leaving and therefore were in de facto seclusion without the safeguards. We therefore found the

hospital breached regulations in relation to providing safe care to patients. The hospital produced an action plan telling us they would ensure staff would undergo refresher training on seclusion practice and the use of the observation lounges would be monitored. They told us they would complete this action by 30 June 2016.

On this inspection we case tracked patients who presented management problems and spoke to staff. The hospital had introduced a new refreshed new protocol to guide staff on de-escalating patients' disturbed behaviour in the observation lounges. This informed staff that if the patient was prevented from leaving the observation lounge that the safeguards of the Mental Health Act Code of Practice should be used.

We spoke to staff on the particular wards where we identified concerns around de facto seclusion in the observation lounges. Staff were clearer about the requirements when the threshold of seclusion was met, had changed their practices and received updated training. This was corroborated by the records we saw where no concerns about de facto seclusion were identified. The provider oversaw and reviewed the use of long term segregation. We therefore did not identify any concerns with patients being secluded in the observation lounges.

The hospital had refreshed their seclusion training to ensure that staff had a good understanding of the requirements for seclusion as detailed in the Mental Health Act Code of Practice. Ninety two per cent of staff had received refreshed training. We found staff had a good understanding of seclusion and the need to safeguard patients by ensuring that the review requirements of the Mental Health Act Code of Practice were met. For example, staff had a good understanding of the need to ensure patients were afforded the safeguards of seclusion if patients were prevented from leaving a particular area due to their disturbed behaviour.

There were 25 episodes of seclusion with 22 patients being secluded at The Spinney for the period January to June 2016. These episodes occurred on four wards with Hulton ward (the psychiatric intensive care unit) using it the most with 17 episodes of seclusion. Records of seclusion showed that many of the safeguards and reviews required when seclusion was used were met. The reasons for seclusion were clearly recorded and observations of patients were recorded every 15 minutes as required.

However, it was not clear that the Mental Health Act Code of Practice requirement that a doctor attended within one hour following a period of seclusion was being met on Hulton ward when seclusion was initiated out of hours. Two out of twelve episodes of the seclusion records showed significant delay in the time from when the doctor was informed to when they attended. Records did not explain the reasons why the doctor was not able to attend within the time frame prescribed in the Code of Practice. This meant that it was unclear if patients placed in seclusion received a timely medical review. Following our inspection the lead consultant psychiatrist wrote to the out of hours medical team to highlight the shortfall and remind the clinicians of their responsibilities to ensure patients received a timely medical review when they were placed in seclusion.

There were seven episodes of long term segregation involving three patients at The Spinney between January and June 2016. All episodes of long term segregation occurred on Hesketh ward. Four out of seven episodes were for eight days or less; the longest period of segregation was for 32 days. In these cases the patient was nursed in a separate area which was often their bedroom. They were prevented from having contact with their peers due to their presentation over a continuing period rather than an isolated incident of disturbed behaviour.

Records showed that the reviews occurred when patients were placed on long-term segregation such as nursing, medical and multidisciplinary reviews. When patients were in long term segregation over a sustained period, independent reviews were carried out by nursing and medical staff from another Partnerships in Care hospital in the North West. In one case, whilst the rationale for separating this patient from other patients was recorded, there was no clear indication of why segregation rather than seclusion was indicated as the segregation was initiated following an incident rather than a planned regime to manage ongoing disturbed behaviour. Whilst most of the records showed that the review requirements of the Code of Practice were met, on one episode there was a short delay in informing the appropriate authorities such as the safeguarding team at the local authority and the funding commissioners.

The provider's long term segregation policy dated December 2015 stated that a CQC Mental Health Act reviewer would be invited to individual patients'

multidisciplinary team meetings when patients were placed in long term segregation. The hospital managers accepted that we do not get involved in individual patient care in this way and would liaise with the corporate head office to consider removing or amending this section to better reflect our duties to keep under review the operation of the Mental Health Act.

Staff understood their responsibilities in reporting safeguarding concerns. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial and regular refresher training. Across the hospital 94% of staff were up-to-date with their safeguarding adults training and 93% were up-to-date with safeguarding children training. Staff we spoke with had a good understanding of safeguarding procedures and what to do when faced with a safeguarding concern. The hospital had notified us of safeguarding alerts in a timely manner. At the time of the inspection there were three outstanding safeguarding incidents which involved local authority oversight or intervention. In each of these cases it was clear that the hospital had taken appropriate action to safeguard vulnerable patients.

The wards had systems to deal with foreseeable emergencies including medical emergencies. We saw the emergency equipment and ligature cutters were accessible. Staff were trained in the prevention and management of violence and aggression with an uptake rate of 96%. Records showed that emergency equipment was checked regularly to ensure it was fit for purpose. Staff were equipped with alarms and would use these to call for assistance from other team members and there were systems in place for responding to an emergency.

Social workers employed by the hospital assessed the appropriateness of children visiting patients. They liaised with relevant authorities and made the arrangements for child visiting where this was deemed to be in the best interests of the child. There were visiting and child visiting rooms off the ward areas so children could visit patients at the hospital without having to go on the wards.

Track record on safety

We looked at the incidents that had occurred recently at this hospital. All independent hospitals were required to submit notifications of incidents to us. The hospital had notified us of appropriate relevant events including safeguarding incidents and incidents which involved the police. There had been no never events at this hospital since our last inspection in October 2015. Never events

were events that were classified as so serious they should never happen. In mental health services, the relevant never event within hospital settings was actual or attempted suicide of a patient due to the failure to install functional collapsible shower or curtain rails.

There had been seven serious incidents in the past six months prior to this inspection; of these, two incidents were notifiable to us. The incidents included two minor breaches of hospital security arrangements, one episode of assault on staff by a patient, two episodes of self harm by patients, one medicines management incident and one incident of staff failing to secure timely medical assistance. There had been no episodes of patient going absent without leave since our last inspection in October 2015.

Managers had taken appropriate action to manage these incidents. The provider had notified us of the two incidents that they were required to so that we could be informed of important events and consider whether we needed to seek further information or take action. Following a significant medicines error which involved the misidentification of a patient, action was taken to prevent a reoccurrence and to retrain and performance manage staff involved.

There had been one expected death of a patient at The Spinney since our last inspection. Following the inquest in to this death, the coroner and family praised the end of life care that the hospital provided and no concerns were raised about the care and treatment that the patient received.

A range of performance indicators were monitored through a computerised dashboard which provided information for each ward including patient details, Mental Health Act key dates, observations levels, seclusion and long term segregation use, incidents, leave episodes, care planning and risk assessments in place, evidence of recent physical health checks and other key performance and safety data for each ward. This could be accessed centrally by higher managers in the Partnerships in Care group. Governance arrangements were in place to ensure there were appropriate reviews of the dashboards, incidents and

complaints, and action on audits. For example the hospital's operational clinical governance group met monthly to discuss the hospital's incidents, alerts, updates and lessons learnt.

Reporting incidents and learning from when things go wrong

Staff knew how to report and record incidents. Incidents were reported on an electronic incident recording system. Senior managers, doctors and ward managers attended a daily morning handover meeting where incidents were reviewed and actions planned. Once a week, the handover reviewed actions overall to ensure a broad view of issues across the hospital and incidents were maintained. We saw as part of the audit process incident and critical data was collated into a ward dashboard which enabled ward and senior managers to understand safety data across their clinical areas.

Staff had good awareness of relational security such as promoting good therapeutic relationships and knowing patients well which reduced triggers and identified early warning signs to prevent incidents from occurring.

When incidents occurred there was a debriefing session, which looked at what led up to the incident and helped staff consider issues that had arisen, how staff reacted and how things could be done differently next time. Incidents were considered as an organisational responsibility rather than as individual staff failure.

We saw that there was a system to ensure lessons had been learnt, for example, there was a regional newsletter which provided alerts and informed staff of safety lessons which had occurred at The Spinney and in other services regionally provided by Partnerships in Care. This included lessons learnt around the security of records, security incidents, monitoring patient's presentation prior to leave being granted, staff's role in complying with any restraining orders on patients and the importance of clear handwriting and signatures when completing care records and forms. The newsletter was widely available and well known by the staff we spoke with. Staff talked about the newsletter and what they had learnt from reading it.

We saw that the hospital had flagged up an incident of poor information from another hospital which led to one patient being inappropriately admitted to The Spinney. The patient was secluded following a significant incident and then transferred to higher levels of security. The hospital alerted the commissioners of services to address the poor information they had received from the referring hospital.

Managers and staff were aware of their responsibilities in relation to duty of candour which required staff to be open and offer an apology when an incident occurred resulting in patient harm. There had been two incidents which met this threshold at the hospital. In each case, the patient and the family were offered an explanation, an apology and support as required by the duty of candour regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should make sure that completed environmental ligature risk assessments are accessible on the wards as part of dynamic risk assessments.
- The provider should ensure that the restrictions faced by patients on Rivington and Lever wards accessing their bedrooms due to the ward layout are reviewed.
- The provider should ensure that the delays in doctors attending episodes of seclusion out of hours on Hulton ward are kept to a minimum and, where there are delays in the doctor's attendance, there is a record kept of the cogent reasons for the delay and subsequent failure to meet the standard within the Mental Health Act Code of Practice.
- The provider should review their long term segregation policy where it states that a CQC Mental Health Act reviewer will be invited to individual patients' multidisciplinary team meetings when patients were placed in long term segregation.
- The provider should ensure fuller consideration and recording of decisions about the analysis of the risks and benefits of continuing on a high-dose antipsychotic regime for patients who regularly and routinely refused physical health checks.