

Lancashire Care NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5Z3	The Harbour	Stevenson Ward, Orwell Ward, Churchill Ward, Shakespeare Ward, Keats Ward PICU, Byron Ward PICU	FY4 4FE
RW5CA	Burnley General Hospital	Ward 20, female PICU, Hyndham ward	BB10 2PQ
RW5X1	Royal Blackburn Hospital	Darwen Ward, Ribble Ward, Calder PICU	BB2 3HH
RW5Z2	The Orchard	The Orchard	LA1 4JJ
RW5FA	Ormskirk Hospital	Scarbrick Centre	L39 2JW

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Lancashire Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Lancashire Care NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the acute and psychiatric intensive care units (PICU) services as requiring improvement.

Not all staff were adequately trained to deal with patients in seclusion. We observed use of the seclusion facilities on the two psychiatric intensive care units Byron and Keats and whilst there were care plans in place and staff observing, we found that 20 episodes of seclusion had not been entered into the log on Byron ward. On a follow up visit to Keats ward we found that there had been inaccurate recording of the seclusion start time and when mandatory reviews had been carried out including medical reviews, as per seclusion policy.

Due to the relocation of acute and psychiatric intensive care units to the Harbour, the trust lost a significant number of experienced and qualified staff. This had resulted in significant issues with recruitment and high levels of sickness. Staff recently recruited had not received all their mandatory training and inductions. Some new staff were working on wards before receiving uniforms, or even name badges.

The Trust introduced a no-smoking policy in January 2015. This had been implemented inconsistently. Some wards turned a 'blind eye' and others enforced the policy to the letter. This resulted in difficulties for staff because patients witnessed and heard of others smoking. In addition staff on wards where the ban was being enforced, told us there had been an increase in incidents as a direct result of the ban. We witnessed several such incidents during our inspection.

Staff told us that patients admitted to wards on an informal basis could not leave the ward until a doctor had seen them. Staffing concerns meant people sometimes had to wait to see a doctor. Patients told us this meant they could not go out for a cigarette and, at times, had to wait for a number of hours.

The quality of care plans throughout the trust was inconsistent. We saw care plans at one unit were particularly personalised, holistic, and recovery focused. However, in other areas care plans we reviewed were brief and impersonal, and were neither holistic or recovery focused.

Patient records did not always record patients' views and it was not clear whether patients received a copy of their care records. We found the majority of records reviewed at the Royal Blackburn Hospital did not contain patient views or evidence that patients had been given copies of their care plans.

We did find that a ligature point had been identified at the wards in the Harbour when the windows of the quiet room were opened into the internal courtyard. Some wards had locked the doors however other wards were not aware of the risk. This was escalated to the management team whilst on inspection.

Although the trust had a training schedule in place, staff had not completed all their mandatory training. We examined training records of 193 staff employed and we found only 22 (11%) had completed the required training. Furthermore, we found some staff employed in the trust who had not completed any of the mandatory training.

Information provided by the trust showed staff had not received the expected supervisions and appraisals. Although staff we spoke with told us they had received some supervisions and appraisals these were not carried out in line with the trust policy.

Therapy sessions were held in areas outside the ward. This limited who had access to the sessions. Patients without leave could not attend and patients with leave could only attend if there were enough staff to escort them. Problems with staffing levels meant often there were not enough staff to provide escorts.

We also noted:

Throughout the trust we saw positive interactions between staff and patients. Staff treated patients courteously and with appropriate dignity and respect. Patients' dignity was protected wherever possible and we found medications were administered privately, in treatment rooms where possible.

Patients told us they were involved in decisions about their care and were encouraged to participate in meetings to develop and manage their care and discharge.

Summary of findings

The trust had access to interpreters which they used for patients with communication difficulties or for those for whom English was not their first language. This allowed everybody to be involved in care planning and understand what was expected.

All the wards we visited had information boards which showed patients and their visitors the staff who worked on the wards and also the different uniforms they might see.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Acute and PICU wards at the Harbour had significant issues with recruitment and retention of staff as well as high levels of sickness.
- The trust informed us during their presentation, that the smoke free initiative was a success. During our inspection we found that implementation was inconsistent.
- Required mandatory training had been completed by only 11% of staff and newly recruited staff had not all received inductions. Decreased staffing levels had led to the cancellation of mandatory training.
- We observed use of the seclusion facilities on the two PICU's Byron and Keats and whilst there were care plans in place and staff observing, we found that 20 episodes of seclusion had not been entered into the log on Byron ward. On a follow up visit to Keats ward we found that there had been inaccurate recording of the seclusion start time and when mandatory reviews had been carried out including medical reviews, as per seclusion policy.
- The no-smoking policy introduced throughout the trust was not consistently enforced and there had been a rise in incidents following its introduction
- We did find that a ligature point had been identified at the wards in the Harbour when the windows of the quiet room were opened into the internal courtyard. Some wards had locked the doors however other wards were not aware of the risk

We did however find that:

- All acute wards and PICU's complied with guidance on same sex accommodation.
- That staffing remained an issue at the time of our inspection, but this was being addressed. We also found that leadership at ward manager level at the Harbour (and their previous wards) had been difficult due to vacancies. These posts had now been filled substantively and whilst this had been in the two weeks prior to our inspection, these filled posts had already begun to provide strong leadership to these wards.

Requires improvement



Are services effective?

We rated effective as requires improvement because;

Requires improvement



Summary of findings

- The quality of care plans was not consistent. Care plans at the Royal Blackburn Hospital were brief and were not holistic or recovery focused.
- Supervisions and appraisals were not carried out in line with the trust policy.
- Informal patients were not allowed to leave wards before they had seen a doctor.

We did however find that:

- Patient records were stored securely but were accessible to staff who needed to see them.
- Patients' care and treatment was planned and delivered in accordance with appropriate guidance and legislation.
- Handovers provided gave detailed information to staff about individual patients and any incidents that had occurred since the previous shift.
- Staff working at the trust adhered to the guiding principles of the Mental Health Act Code of Practice.

Are services caring?

We rated caring as good because:

- Throughout the trust we saw staff treated patients courteously and with dignity and respect.
- Staff involved patients' in decisions about their care, as well as meetings and developing their management plans.
- Staff discussed, in detail, patients' medications and any possible side effects they may experience.
- Interpreters were available for patients' with difficulty communicating or those who did not use English as their first language.
- The trust used a patient experience oversight group and experts by experience to oversee the trust service user and carer engagement strategy.
- Wards had information boards which showed photographs and names of staff who worked on the wards. There was also information which identified the various uniforms and the staff roles within the ward.

Good



Are services responsive to people's needs?

We rated responsive as good because;

- There was a clear process in place for admission to wards
- There were a variety of organised activities and patient led activities on all the wards.

Good



Summary of findings

- Occupational therapists spent time on wards arranging activities for patients that would help their recovery.
- All wards allowed secure access to outside areas although only some of these had seating and shelter.
- Patients' diversity and human rights were respected and we saw evidence of staff helping to promote individuality.
- The trust had response teams to ensure help was available to staff during incidents.
- Complaints were recorded and dealt with in an appropriate and timely manner

However, we also found:

- Therapy sessions took place outside the ward. Those patients without permission to leave could not participate.
- Some wards still had dormitory sleeping arrangements which offered little privacy and dignity.

Are services well-led?

We rated well-led good because:

- Ward managers gave good support to ward staff.
- Response teams were in place throughout the trust to support ward staff with incidents.
- Regular audits were carried out to ensure quality of care.

However, we also found:

- Not all staff received adequate training to work on the wards. This put both the staff and patients at risk. Morale was lower than usual because of the additional pressures caused by low staffing levels.
- The lack of qualified staff on Harbour ward meant staff skills and experience mix was unsatisfactory/did not meet requirements.

Good



Summary of findings

Information about the service

Lancashire Care NHS Foundation Trust provided inpatient services for men and women aged eighteen years and over with mental health conditions. These services were provided to people who were admitted informally and patients compulsorily detained under the Mental Health Act. This report looks at all of the acute inpatient wards and psychiatric intensive care units (PICU) provided by the trust.

These services were based across fourteen wards at five different hospital locations;

The Harbour:

- Stevenson and Shakespeare wards were female acute inpatient wards each with eighteen beds.
- Orwell and Churchill wards were male acute inpatient wards each with eighteen beds.
- Keats Ward was a male psychiatric intensive care unit (PICU) with eight beds.
- Byron Ward was a female psychiatric intensive care unit (PICU) with eight beds.

Burnley General Hospital

- Ward 20 is a female acute inpatient ward with 21 beds.
- Female PICU.
- Hyndburn ward is a male 21 bed acute inpatient ward. Temporarily relocated from Royal Blackburn Hospital due to ligature improvement work.

Royal Blackburn Hospital

- Darwen ward is a seventeen bed male acute inpatient ward.
- Ribble ward is a seventeen bed female acute inpatient ward.
- Calder ward is a six bed male psychiatric intensive care unit (PICU).

Ormskirk Hospital

- Scarisbrick Inpatient Unit is a mixed gender unit with 21 beds. 11 beds for male and nine for females.

The Orchard is an eighteen bedded inpatient mixed gender unit.

Our inspection team

Our inspection team was led by: **Chair: Peter Molyneux**

Team Leader: Jenny Wilkes, head of hospital inspection (mental health), Care Quality Commission.

Inspection lead: Sharon Marston inspection manager, Care Quality Commission.

The team that inspected the acute wards and psychiatric intensive care units consisted of 13 people: One inspection manager, two inspectors, one expert by experience, one Mental Health Act reviewer, four nurses, one psychiatrist, one junior doctor, one social worker and one occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited all 13 of the wards at the six hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 21 patients who were using the service.
- Spoke with the managers or acting managers for each of the wards.

- Spoke with 70 other staff members; including doctors, nurses and social workers.
- Interviewed the divisional director with responsibility for these services.
- Attended and observed four hand-over meetings and three multi-disciplinary meetings.
- Looked at 52 treatment records of patients.
- Received two comment cards.
- Carried out a specific check of the medication management on four wards.

Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We received two comment cards from the acute and PICU services and spoke with 21 patients during our inspection.

The majority of patients we spoke with told us that staff treated them well and respected their privacy and dignity. Patients told us they were able to speak to staff about any concerns and they

felt they gave an appropriate level of respect.

Patients told us they were happy with the care and service they received and the support provided to them.

Patients told us they felt safe and that staff looked after them.

Good practice

- The trust had introduced a team information board. These were used throughout inpatient units and during clinical and multi-disciplinary meetings and care programme approach (CPA) reviews. The system linked to a touch screen display, displaying information from the electronic clinical record allowing attendees to view information relating patients. In addition, the system could be used to view information relating to the trust's performance indicators, as well as incidents and lessons learned.
- The Scarisbrick Unit was piloting the alternative therapy intervention project, which was aiming to offer an alternative to hospital admissions by offering daily placements for people in crisis and receiving support from the home treatment team.
- In Burnley, they had developed a clinical practice team which aimed to facilitate clinical assessments and rapid discharges for patients who did not require secondary care mental health services on discharge.

Areas for improvement

Action the provider MUST take to improve

- Ensure recruitment and retention of staff at the Harbour.
- Ensure that the high levels of sickness at the Harbour were addressed..
- Ensure a consistent approach across the wards to the smoke free initiative.
- Ensure compliance to mandatory training.
- Ensure that all new staff receive an induction.
- Ensure that episodes of seclusion are recorded and are accurate as per seclusion policy.

Summary of findings

Action the provider **SHOULD** take to improve

- Consider changes to sleeping arrangements on wards that still had dormitories.
- Continue with the on-going recruitment and retention of staff across the acute and PICU wards.

Lancashire Care NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Stevenson Ward Orwell Ward Churchill Ward Shakespeare Ward Keats Ward PICU Byron Ward PICU	The Harbour
Ward 20 Female PICU Hyndburn Ward	Burnley General Hospital
Darwen Ward Ribble Ward Calder PICU	Royal Blackburn
The Orchard	The Orchard
Scarisbrick Centre	Ormskirk Hospital

Mental Health Act responsibilities

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

We found that staff had a good understanding of the Mental Health Act and there were good systems in place to

ensure the responsibilities of the Mental Health Act were being followed. We were also told there were very positive working relationships with the crisis and bed management teams.

We were, however told of some areas of concern. For example, approved mental health professionals report they often have difficulty accessing section twelve approved doctors until after 5pm.

Detailed findings

There is no out of hours cover for young people meaning young people are often admitted to adult wards if they needed to be admitted.

Mental Capacity Act and Deprivation of Liberty Safeguards

Throughout the trust we found evidence that the responsible clinician had assessed and recorded patients' capacity to consent to care and medication.

Not all staff working for the trust had received training in the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) although this was scheduled as part of the annual mandatory training for staff. The Adult Mental Health Network Level 1 MCA mandatory online training at the time of the inspection was 79.56%. The level 2 MCA face to face training which was essential training was 42.48%.

Staff we spoke with told us they were aware of MCA and DoLS and knew how to access information relating to these if they needed further information.

Where patients on the wards were held under a Deprivation of Liberty Safeguard (DOLS) we found appropriately completed records. Records we reviewed showed that patients' mental capacity to consent to their care and treatment was assessed on their admission and recorded on care records.

Where people were deemed to lack capacity, we saw evidence of best interest meetings being held and patients being supported to make decisions about their health and wellbeing.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environment

The environments of the acute and PICU wards were mixed. The Harbour which housed four acute wards and two PICU wards were new purpose built environments which opened in 2015. These wards were clean and environments were well maintained. The environments at Burnley, Blackburn, the Orchard and Scarisbrick Centre were all older buildings and had challenges when it came to the environment. These were however clean. We viewed the cleaning schedules for these areas and we found them to be appropriate. There had been some investment into the older buildings to modernise and update these, but some were still old wards and had dormitories and shared bathing facilities.

All acute wards and PICUs complied with same sex accommodation. Three pairs of wards at The Harbour (including the pair of PICUs) and the Orchard had “swing” beds that could be used flexibly for male or female patients. These beds remained flexible to the needs of the admissions and still maintained compliance with same sex accommodation guidelines.

Where challenges occurred with observation lines the wards were able to describe how these were adequately mitigated which involved higher staffing, enhanced observations or the use of CCTV.

We inspected all wards and their clinic rooms. These rooms were clean and tidy and all had couches in them. All clinics at the Harbour had a small waiting room attached to them so patients could be invited into this space safely and could have a private discussion about medication with staff. These areas also contained equipment to take physical observations such as pulse and blood pressure. Other wards had replicated this such as Ward 20 at Burnley.

All clinics had resuscitation equipment and emergency drugs including automated external defibrillators and oxygen, were able to check records and regular checks were taking place and these were recorded.

Not all wards had seclusion facilities. The PICU wards at the Harbour Keats and Byron had seclusion facilities. These rooms offered two way communication but not all had clocks available such as Scarisbrick Ward at Ormskirk Hospital. This seclusion facility at Ormskirk hospital also contained a wooden bed base, which had the potential for harm.

Environmental risk assessments were completed regularly and reviewed. We viewed these and ligature risk points had been identified. We did find that a Ligature point had been identified when the windows of the quiet room were opened into the internal courtyard. Some wards had locked the doors however other wards were not aware of the risk. This was escalated to the management team whilst on inspection.

Safe staffing

The provider had estimated a staffing model for the Harbour which was designed to meet the holistic needs of patients and carers. The staffing model reflected the diversity of needs to be met across wards.

Wards we visited at Burnley, Blackburn Ormskirk and Lancaster all reported that staffing was as establishment, the below table shows this in further detail. This however was not the case for wards at the Harbour and these acute and PICU wards had significant issues with recruitment and retention of staff as well as high levels of sickness. When the wards were moved from Chorley and Parkwood Hospital and Ormskirk district general hospital some staff chose not to move to the Blackpool location as it was too far to travel, which had left significant deficits in staffing.

We found that in Burnley, Blackburn Lancaster and Ormskirk that there was limited use of agency and bank staff. However at the Harbour there was higher use of agency and bank and on one particular shift at Byron ward there were only two regular staff on duty on commencement of the night duty out of eight and four of these bank and agency staff had never worked on the ward before. We did speak to senior management at the Harbour

Are services safe?

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and we were informed that significant recruitment had taken place there and they had appointed in excess of 20 staff to fill the outstanding vacancies. There was also recognition that staffing remained an issue at the time of our inspection. We also found that leadership at ward manager level at the Harbour (and their previous wards) had been difficult due to vacancies. These posts had now been filled substantively and whilst this had been in the two weeks prior to our inspection, these filled posts had already begun to provide strong leadership to these wards.

All ward managers we spoke to stated that they felt they had sufficient authority to recruit extra staff should the acuity of the patient group change. We saw this on inspection when patients had become unwell or needed higher levels of observation.

All daily duty logs showed which staff were available to carry out physical interventions and intermediate life support. At the Harbour staff were identified as responders to other wards and these staff would be fully trained in how and when to respond should an incident occur.

Throughout the acute and PICU wards at The Harbour we found a number of staff had not received all the training required to enable them to work on these types of wards. Mandatory training had not been completed by all staff and some staff were recruited having just qualified as nurses.

The trust supplied us with information relating to mandatory training. On Ribble Ward only five of 28 staff had completed all of their mandatory training and one staff member had completed no mandatory training. The Scarisbrick unit had 42 staff with six who had completed all mandatory training and another who had completed no mandatory training. The trust gave us details of 193 staff for the acute and PICU wards at The Harbour. Of these 22 had completed all mandatory training and four had not completed any mandatory training.

Not all newly recruited staff working at The Harbour had been given an induction, although dates for induction had been arranged for later this year. In addition some staff had not been given uniforms or even name badges prior to starting work.

Assessing and managing risk to patients and staff

We spoke with patients on our inspection and all that we spoke to said that they felt safe.

Staff undertook risk assessments on admission and these were updated regularly.

Staff used the enhanced risk assessment tool.

We found some blanket restrictions in place at the Harbour, mainly around the use of plastic cutlery on the PICUs. We discussed this with management on inspection and we were told that there is a full violence reduction programme being undertaken by the management of violence and aggression (MOVA) team and they recognise that the use of plastic cutlery will be reviewed. We also found that on all units at the Harbour they had installed hot water taps, but these were not in use due to not being able to regulate the temperature from them and there was a risk of scalding. We did find that the same tap was being used at The Orchard and the manager there informed them that they had been able to regulate this. Because patients were unable to use this hot water tap at the Harbour there were some difficulties in ensuring that patients had access when required to hot drinks. We also found that on Keats ward the television had been broken by a patient and when we returned to undertake a follow up visit two weeks later this had still not been replaced.

The Trust went smoke free in January 2015 and we were informed in the trust's presentation to us that this had been a successful initiative with patients offered assistance to stop smoking, with the use of nicotine replacement therapies. We however found this not to be the case. We observed patients smoking within the enclosed courtyards at the Harbour with the exception of Byron and Keats and also smoking in Burnley and Blackburn. At the Orchard patients left the grounds to have a cigarette. At the Harbour we also observed staff giving lights to patients and also keeping cigarettes in the ward office. We discussed this issue with management at ward level and they were all clear that they would not engage in any physical interventions to stop patients from smoking and they would not routinely search patients to remove smoking items. We were told that every time a patient did not comply with the smoking ban, they would complete an incident (datix) form. As part of the inspections we asked for a copy of all datix incidents that occurred on the 28 April 2015, when we had observed patients smoking on wards within the Harbour. There were however no logged incidents. We also noted there had been a fire reported on Keates ward following a patient bringing a lighter onto the unit.

Are services safe?

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

We were told the introduction of no smoking across all trust premises has created problems when some patients wanted to leave the unit to go for a cigarette. At the focus groups and in a number of patient interviews we were told that informal patients were being told they could not leave the premises to go for a cigarette. Patients informed us they were being told that when their agreed leave time detailed on their care plans has been used that they were not allowed to leave to go for a cigarette. The patients who told us that were clear that they were not detained under the Mental Health Act. Informal or voluntary patients have the right to leave an inpatient ward if they wish, although there is an expectation that they will discuss this with staff before doing so. Patients told us that staff refused to allow them to leave even when they explained it was just to go for a cigarette and they would then return.

We were told that restraint was only used as a last resort and we observed some incidents where we saw excellent use of de-escalation. These incidents were dealt with swiftly and with minimum interventions. However there were differing numbers of restraint and rapid tranquilisation (RT) across the wards and some figures were high. On Burnley PICU 176 restraint incidents had occurred in the period August 2014-January 2015. Of these 99 were recorded as being prone restraint and of these 43 required the use of RT. On Ward 20 there were 69 restraint incidents, 32 of these were recorded as prone restraint and 17 of these resulted in RT. On Ribble ward there were 36 restraints, 21 in the prone position and of this 12 resulted in RT.

We observed use of the seclusion facilities on the two PICUs Byron and Keats. Whilst there were care plans in place and staff observing, we found that 20 episodes of seclusion had not been entered into the log on Byron ward and numbers did not correlate with other seclusion paperwork. On a follow up visit to Keats ward we found that there had been inaccurate recording of the seclusion start time and when mandatory reviews had been carried out including medical reviews, as per seclusion policy. However we did observe a planned intervention to someone who was in seclusion and this was well managed involving all staff and a de-brief after the intervention.

Staff received training in safeguarding and all staff we spoke with knew how to recognise a safeguarding concern.

Staff were aware of the trust's safeguarding policy. They knew who to inform if they had safeguarding concerns. Safeguarding was discussed at ward team meetings and it was a standing agenda item.

We found high compliance for mandatory training of safeguarding adults, Byron 74%, Churchill 75%, Keats 97%, Orwell 89%, Hyndburn 91%, Calder 88%, Ward 20 96%, Ribble 93%, Darwen 100%, Scarisbrick unit 83%, the Orchard 90%, Shakespeare 91% and Stevenson 86%.

There were good arrangements in place for child visiting ensuring the safety of children.

This followed the policy for children visiting wards and other clinical areas within Lancashire Care NHS Foundation Trust premises. This policy impressed that the child's welfare is paramount and takes priority over the interest of any and all adults, the child's welfare should be safeguarded and promoted by all staff within the hospital, the child's contact with family members should be supported, whenever that contact is in the child's best interest.

Appropriate arrangements were in place for the management of medicines on all of the acute and PICU wards. We reviewed the prescription records of several patients on each ward we visited.

Track record on safety

We received two comments cards from the acute and PICU services and spoke with 21 patients during our inspection.

The majority of patients we spoke with told us that staff treated them well and respected their privacy and dignity. Patients told us they were able to speak to staff about any concerns and they

felt they gave an appropriate level of respect.

There were two serious incidents that had occurred within PICUs and these had been thoroughly investigated. A root cause was identified and there were lessons learnt and some recommendations. Another incident which resulted in the death of a service user, also made some recommendations, and identified that the staff who undertook the resuscitation were not offered a debrief meeting which may have created a missed opportunity for learning. Staff were however offered an incident debriefs and this was supported by a clinical psychologist and staff were further offered support through individual supervision.

Are services safe?

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

Reporting incidents and learning from when things go wrong

We observed a planned intervention and a de-brief following a series of incidents on Keats ward. These were well managed by the senior nurse. We did however find that speaking to some staff at the Harbour they did not feel safe at work. They told us that they received little support and had never been debriefed following incidents.

Ward managers told us they maintained an overview of all untoward incidents reported on their wards. Incidents were

investigated and some managers told us they were made aware of incidents that had occurred on other wards at weekly meetings. They would then feed these back to their staff at local meetings.

As part of the inspections we asked for a copy of all datix incidents that occurred on the 28th April 2015 in relation to patients smoking as we were informed that staff were required to complete a datix if patients were smoking against policy. There were however no logged incidents.

Are services effective?

Requires improvement 

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

Summary of findings

Our findings

Assessment of needs and planning of care

Patients had a comprehensive assessment of their needs upon admission which included a review of their clinical needs, mental health, physical health, nutrition and hydration and spiritual needs. Outcomes of assessments were recorded and individual needs were documented in care records. Regular reviews were carried out and needs updated.

We looked at 52 sets of patient records across all of the acute and PICU wards. Care plans varied in standard. Records to be very detailed, holistic and recovery focussed throughout the Scarisbrick location. At the Harbour location care plans were also holistic and recovery focussed but less personalised. However at the Blackburn Hospital location care plans, although up to date, were brief and mechanistic. Of the five care plans we reviewed none of these were holistic, and four of the five did not show evidence of goals or a recovery focus.

Systems were in place to ensure patients' physical health was appropriately met across the wards. Patients were given a physical health check on their admission to the ward and there were on-going assessments throughout their stay. However on one of the wards in The Harbour one person had told staff several times of severe pain but despite this they were not taken to hospital. This was highlighted during our inspection and arrangements were made for the patient to be seen at the local accident and emergency department.

Regular care plan reviews and multi-disciplinary team meetings were carried out.

There were two sets of patient records, electronic and paper. Throughout the trust these records were secure, with paper records locked in staff offices. Electronic records were held on a system available throughout the trust which ensured staff working across wards were able to access information.

Best practice in treatment and care

We looked at a total of twenty prescription charts across the wards visited. The prescription charts were up-to-date

and clearly presented to show the treatment people had received. Where required, appropriate physical health monitoring was completed and recorded. However, three of the ten charts we examined on Churchill Ward had gaps on one or two occasions where medicines administration, or the reason for non-administration, was not recorded.

We checked form T2s and T3s under the Mental Health Act and all of these were in good order. Nursing staff carried out regular checks on medicine prescription and administration records.

Both wards received support from a specialist mental health pharmacist. Patients were able to speak directly with the pharmacist to help ensure they had the information they needed about their medicines. The pharmacist also completed regular checks of the prescription charts. Should any errors or omissions be noted these were discussed directly with the ward manager at a weekly team meeting, to try and reduce the risk of reoccurrence.

Arrangements were in place for medicines supply and advice out-of-hours and at weekends, but this was not provided by a specialist mental health pharmacist.

Through the review of records and speaking with staff on wards we found people's care and treatment was planned and delivered in accordance with the latest and most up to date guidance, standards and legislation. Staff we spoke with told us they followed best practice guidance issued by the national institute for health and care excellence for the psychological treatment of conditions such as anxiety, and obsessive compulsive disorder. Guidance states that people with these types of conditions be offered alternatives to medication in the first instance. For example the use of cognitive behavioural therapy. We saw patients were given information and support to understand and access these.

Skilled staff to deliver care

Staff working on acute and PICU wards at The Harbour did not always have the necessary skills needed to carry out their roles. For example management of violence and aggression training (MOVA).

When acute and PICU services were moved to their new location at The Harbour the trust lost a number of qualified and experienced staff. The trust has now been through a process of recruiting a substantial number of new staff. Throughout the acute and PICU wards at The Harbour we

Are services effective?

Requires improvement 

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

found a number of staff had not received all the training required to enable them to work on these types of wards. Mandatory training had not been completed by all staff and some staff were recruited having just qualified as nurses.

Staff working in the trust were required to have regular supervisions and appraisals however, information provided by the trust showed these were not being carried out for all staff. Of the wards we inspected none of them had carried out supervision for all their staff. We were told this was due to staff shortages and the subsequent time pressures on staff.

Multi-disciplinary and inter-agency team work

We spent time observing some multi-disciplinary team meetings during our inspection and found these were effective and enabled staff to share information about patients. We saw professionals worked together to assess and plan patients' care and review their progress.

We saw that healthcare professionals such as doctors and occupational therapists regularly attended wards and attended meetings. In addition we found social care professionals attended and participated in meetings which were used to assist with discharge and recovery plans.

We observed handovers on two wards and found they gave staff an opportunity to discuss individuals and their activities throughout the shift. Staff were given detailed handovers and comprehensive information in relation to any incidents that had occurred.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Throughout the trust systems were in place to ensure staff complied with the Mental Health Act (MHA) and adhered to the guiding principles of the MHA Code of Practice. At each of the locations we inspected we reviewed records of patients who were detained under the MHA. In total we looked at 27 records.

For all the records we reviewed, we found all the relevant paperwork was in place and in order. We saw evidence that patients had been asked for their consent to care and this was recorded in patient files. All treatment appeared to have been given under an appropriate legal authority and appropriate records were kept of patients' capacity to consent.

Information was available to all patients and patients had been told about their rights and how to access the tribunal to appeal against their detention. We also saw information showing patients how to contact an Independent Mental Health Advocate was displayed in all the wards we inspected. In addition we saw information showing how patients could contact CQC if they wished.

Systems were in place for authorising and recording Section 17 leave of absence. Records we looked at contained clear information about the amount of leave authorised and where they were able to spend their time during this leave.

We did however find, where people had been admitted to wards as an informal patient, they were not allowed to leave the ward until they had seen a doctor. Where informal patients had tried to leave the ward prior to seeing a doctor, they were then subject to Section 5(2) detention to prevent this.

Good practice in applying the Mental Capacity Act

Not all staff working for the trust had received training in the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) although this was scheduled as part of the annual mandatory training for staff.

Staff we spoke with told us they were aware of MCA and DoLS and knew how to access information relating to these if they needed further information.

None of the patients on the wards were held under a Deprivation of Liberty Safeguard (DOLS). Records we reviewed showed that patients' mental capacity to consent to their care and treatment was assessed on their admission and recorded on care records.

Patients' needs were assessed and care and treatment was planned to meet these. We looked at 52 care records throughout the acute and PICU wards and saw these contained up to date care plans which clearly identified patient needs.

Where people were deemed to lack capacity, we saw evidence of best interest meetings being held and patients being supported to make decisions about their health and wellbeing.

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

We observed staff at each of the units during direct contact with patients and also in a Care Programme Approach meeting (CPA). A CPA meeting is an opportunity to review progress and ensure care remains coordinated toward meeting an individual's needs reviewed. We observed staff to be courteous, compassionate and respectful in their direct interactions with patients. We observed staff in a range of meetings including daily ward meetings, debrief meetings following an incident and during handover meetings. We found the staff were respectful of the patients they were discussing, were able to provide clear, succinct information and demonstrated a good understanding of the patient's needs.

There were two notable exceptions to this. One involved a member of staff who was observed blocking a patient's attempt to enter the ward office. The staff member did not explain why the patient was not allowed in the office or what they would like them to do and we observed them physically guiding / pushing the patient away from the door. On the same ward we observed the same member of staff and two others pulling a patient by the arms. These observations were reported to the nurse in charge who provided assurances that they would take immediate actions relating to the bank member of staff.

We met with 19 patients in focus groups prior to attending the wards and at these the majority of patients gave positive feedback. They described staff attitude and behaviours toward them as positive and that they were treated in a caring way, by staff, who were in the main polite and respectful. We found that this feedback matched with the information provided from the recent Friends and Family data for the trust where 38% of respondents reported being likely or extremely likely to recommend the service to friends and family and a further 11% responded that they did not hold a strong opinion.

We spoke with twenty one patients individually during the inspection. They informed us that the majority of staff were caring and interested in people's well-being and that staff were responsive to any concerns they raised. Patients

described some staff as excellent. Where patients raised specific issues of concern during our inspection they were satisfied that those issues are fed back to the nursing staff for further action or assurance by ward managers.

We reviewed the inpatient services standard operational procedures for acute functional wards (all ages) July 2014. This document indicated "a care plan must refer to the use of leave" but did not say if this extended to detail how much leave an informal patient may have, nor any reference to escorting informal patients away from the ward environment. Nursing staff we spoke with confirmed a requirement for informal patients to comply with the detail of agreed leave from the ward. Several of the staff we spoke with told us in the event an informal person wishes to leave the ward they must be assessed by a doctor prior to this being agreed. This was in evidence at all the wards we visited.

The involvement of people in the care that they receive

Some patients told us they had not been actively involved in drawing up their care plan and they were given a copy of it when completed and others described that they and their families had been fully involved. We reviewed fifty two electronic clinical records and twenty seven paper Mental Health Act records from across the inpatient units. The majority, although not all, of the care plans that we reviewed had evidence that patients, and where appropriate, their carers were involved in creating the care plan and that they were personalised to reflect the patient's specific and holistic needs. Electronic records showed evidence that, where a need had been identified, information leaflets had been provided to carers. We attended a CPA discharge meeting and were able to see how the patient was involved in the development of, and agreement to, a clear management plan to facilitate discharge. Patients and staff that we spoke to told us that the pharmacy staff spend time with patients explaining in detail about their medications and side effects.

At the Blackburn location we reviewed five care plans. There was no record of patient views or record of patients receiving a copy of their care plan in four of these records.

Both staff and patients that we spoke to confirmed there is access to religious leaders either through routine regular contact with the wards or upon request. At the Harbour we were informed there is a dedicated room for contemplation/prayer available to those requiring it and

Are services caring?

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following a completed risk assessment. The room is designed to accommodate multi faith use and has a Qibla indicator to identify the direction of prayer. We saw information leaflets explaining how to access this reflections room. Nursing staff confirmed there was good access to interpreters for translation such as british sign and foreign languages where required.

Each of the ward managers confirmed there some form of meeting jointly between patients and staff. However since moving to the new facility at the Harbour these had not been reconvened with the exception of Churchill ward. The senior management team of the trust informed us that patients and carers had been involved in the development and design of The Harbour and worked with local community arts projects to create the signage and key pieces of art work throughout the unit. A group of carers reported positively on this work also at a forum meeting we attended.

We reviewed the minutes of a number of meetings held by the trust and could see that service users and carers are involved in recruitment at different levels throughout the organisation. We saw that the trust is looking to develop this further through the diversity and equality action plan.

We also saw that the trust has a patient experience oversight group and regular experts by experience sub group. These groups oversee the trust service user and carer engagement strategy.

Each of the wards clearly advertised how to access independent mental health advice and advocacy services and ward staff confirmed regular the local services regularly attend the wards meaning patients were able to easily access services. Patients told us they were shown around the ward when they were first admitted and that this helped them to settle quickly to the ward environment. We saw that all wards had information boards and these contained photographs of the ward team members and their names as well as information identifying their uniforms and role within the ward. Patients confirmed they knew how to access forms to provide feedback or to make complaints.

We saw posters advertising the Harbour carer service had purchased a caravan which families of patients were able to use when people were admitted from out of that area. The ward managers told us that attempts were always made to try to admit people to an area local to where they live but this was not always possible.

Are services responsive to people's needs?

Good 

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

Summary of findings

Our findings

Access and discharge

Admission to acute wards were made either after approved mental health professionals (AMHPs) had carried out a Mental Health Act assessment or they agreed to an informal admission. This ensured people were only admitted when necessary and beds were kept for those who needed them.

We spoke with six AMHPs regarding admissions to wards. All told us there were delays in identifying beds for both formal and informal admissions which meant sometimes people detained under section 136 of the Mental Health Act, were being kept in a place of safety for in excess of 24 hours. AMHP reports which we reviewed showed a record of this. Members of the trust told us they were aware of this concern.

The occupancy rates for acute and PICU wards were high and members of the trust told us that this had been noted on the trust risk register. Throughout the trust there were constant pressures around bed availability and when patients had left the hospital on leave there were times when their beds were filled with new admissions. All ward managers that we spoke to said that there was a bed management system which had an overview of all beds within the trust.

We found there were good links between staff on the wards and community mental health teams, with representatives attending meetings to plan and discuss treatment and discharge plans.

The facilities promote recovery, comfort, dignity and confidentiality

All the wards we visited were bright and clean and had individual rooms and some shared room accommodation, there was a contrast between the new wards and those wards housed in older buildings. The exception to this was Hyndburn Ward that had been decanted to Burnley Royal Hospital. In addition Hyndburn Ward had three bedrooms where the privacy covers on windows were inadequate and allowed people in the lounge area to see when patients were in bed. This was raised with the ward's modern matron during our inspection.

The wards had communal areas which were used by all patients and other smaller rooms which were used as quiet rooms, for interviews or for people to spend time alone doing activities.

Some were still old wards and had dormitories and shared bathing facilities. This was the case on Ward 20 at Burnley where there were thin disposable curtains around each bed which did not allow for much privacy and there was some impact on patient dignity. These curtained bays did however have anti ligature collapsible rails and the curtains assisted with infection prevention. We managed to speak to some patients and they did not mind sleeping in these bays, as they felt that the ward was so good.

All the wards we visited had a selection of leaflets and displays on notice boards which gave patients and their visitors information on a range of matters.

Patients confirmed they have access to their rooms 24 hours a day and access to drinks. Patients at Scarisbrick had access to facilities for making their own drinks. However this was not the case on other wards. PICU wards at The Harbour had removed the facility, and at Burnley patients were denied access to the kitchen area. In addition we found snacks were on offer for patients at Scarisbrick and Burnley but did not see any evidence of this in wards at The Harbour. On Byron Ward we were informed that drink making facilities had been temporarily suspended due to the disruptive and aggressive nature of a specific patient that day.

We saw activities being carried out on all wards in the trust. Some activities were organised and supervised by staff members but we also saw patients participating in independent activities and in conjunction with other patients. At the Scarsbrick unit we were told a number of the activities are service user led.

Staff on the wards reported that activities were available either ward based or through the therapy / activity centres including some provision at weekends and evenings. Staff informed us of the importance of prioritising meaningful occupation in particular in reducing boredom and supporting patients experiencing high levels of agitation and tension.

Occupational therapists spent time with patients on the wards and carried out additional therapy support in other hospital areas. Some patients at the Harbour had difficulty accessing some therapy and activity sessions as they were

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Good 

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off the ward and if a patient did not have any leave they would not be able to attend therapy sessions subsequently restricting their recovery. In addition patients, who wished to use other facilities at The Harbour, such as the gym, were also restricted because they needed a member of staff to accompany them and also valid leave.

Most patients told us staff got involved in activities with patients. We found staffing problems at The Harbour and Royal Blackburn sites meant staff were less able to do this.

All the wards gave patients access to outside space, some of which had shelter and seating.

Meeting the needs of all people who use the service

Patients' diversity and human rights were respected. We saw staff understood, promoted and supported patients and their differences. Staff working in the trust were aware of patients individual needs and tried to ensure these were met. This included cultural, language and religious needs. Patients had access to representatives from different faiths and we were told there was also access to a room which could be used for prayer or religious services.

Patients were given a choice about the meals they wanted and we were told meals took account of people's cultural and physical needs. One person we spoke with told us there was poor choice for vegetarians and the vegetarian meals were not very nice. However there was a minimum of one vegetarian choice on each standard menu across inpatient areas, in addition to this, a choice of sandwiches and salads was also available. If a service user did not like any of the options available to them on the menu then the kitchens could accommodate an alternative request.

The patients told us of the access to activity and occupation within each of the inpatient units. All of the feedback was positive and indicated access to activities away from the ward which is available over seven days per

week. Access to these activities was not affected by staff shortages on the wards. Patients spoke particularly highly of the work undertaken by the Open Doors project at Blackburn.

Listening to and learning from concerns and complaints

The majority of people we spoke with told us that they knew how to make a complaint, although there were one or two who said they didn't know. We found posters and leaflets in wards telling patients how they could raise a concern or complaint and patients were also given admission packs which contained feedback forms. In addition we saw information on how to access the patient advice and liaison service (PALS) and advocacy services.

We spoke with the manager of the Scarisbrick Unit who told us they facilitated a weekly meeting which was used to enable patients to raise specific issues. For example some patients wanted to discuss the introduction of the no-smoking policy.

We were also told the unit had a patient led buddy system for new patients which could be used to stop patients feeling isolated when first admitted to the unit. Patients were also given guidance by staff on dealing with matters that occurred on the ward. For example, how best to support other patients who may be loud or unwell.

We interviewed the ward managers on all the wards we inspected and spoke to them about how they dealt with complaints or concerns. We were told in the first instance an attempt would be made to speak to the complainant to try and resolve the issue. If this was not possible the complaint or concern would be put through the trust complaints procedure to be dealt with. One of the patients we spoke with told us they had raised a complaint and they received a quick response. The person told us they felt their complaint was taken seriously and they had experienced no negative consequences of complaining.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

Vision and values

The staff we spoke to displayed high levels of motivation for the recovery focused work they do and that patients were at the heart of their day to day work. Throughout the unit the trust visions and values were on display. Staff had knowledge of the trust values and some teams described holding a clear vision and that the team work well together to realise their objectives.

Ward managers described positive relationships and high levels of support from modern matrons. There is a regular weekly meeting held across the inpatient services to discuss bed management and to proactively manage bed pressures and work together for solutions. This meeting was a joint one between Burnley and Blackburn.

Across the units the modern matrons, deputy matrons and clinical leads were visible and spent time within the clinical areas. Most staff were aware of the trust senior management team and felt the issues and concerns most pressing on the units would be known to the senior management team.

Good governance

Ward managers described local arrangements for overseeing quality and clinical governance. The trust had implemented a team information board. We saw evidence of these electronic touch screen boards within the acute inpatient units on all the sites we visited. A number of ward managers demonstrated how they accessed the information within it. The electronic clinical record could be directly displayed on to the touch screen. The screens could show initials of inpatients, list of tasks required, tasks completed and this was communicated in to the daily clinical meetings, multi-disciplinary meetings and CPA reviews.

We were informed information within the team information board was also populated from datix such as complaints, incidents and other performance related data. This enabled ward managers and clinical leaders to review wards or unit specific information and could share this with

their teams. The ward managers told us that other detailed performance indicators: such as staff sickness, supervision and appraisal were available to support their managerial role.

Staff we spoke to demonstrated a good understanding of how to report incidents and that they were well supported by their managers to do so. Ward managers described a culture where they were actively encouraged to raise issues and to offer solutions. They demonstrated a good understanding of the risk registers and confirmed that they were actively supported to record things upon it as required. We reviewed a sample of the risk registers and could see the issues staff raised during our inspection were recorded namely staffing and environmental risks, including ligature risks.

We were informed that post incident review investigations were undertaken. We were informed that these were conducted to look at identifying lessons learned and the ward managers stated they were not felt to be punitive. Lessons learned were communicated at all levels within the trust and we saw minutes to a range of meetings where governance and quality issues are routinely discussed: executive quality committee, network quality committee, standards and assurance, network report meeting. We were told there was a fortnightly governance meeting that the ward managers and matrons attend. Ward managers told us they share outcomes and information through the team information board and these could include other organisational changes such as amended policies and procedures within team meetings and supervision.

Leadership, morale and staff engagement

The Harbour opened in March 2015, approximately eight weeks before the inspection. This had been a period of significant change for the staff and patients. Existing acute and PICU wards had been decommissioned and brought together to the new build and facilities at Blackpool. We were told a significant number of staff had resigned from their posts prior to the move. We saw significant staffing challenges at the Harbour in particular the skill mix of those staff. Six staff we spoke told us that on occasions planned escorted leave had been cancelled due to lack of staffing.

We were told that the senior management team had implemented strategies to resolve the staff shortages on each shift. This included moving staff from wards to cover shortfalls of shifts. We were informed that the Harbour was recruiting in excess of 70 posts and significant numbers of

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staff had actively started in post. The management team were over staffing shifts and redeploying the additional staff to the areas with greatest clinical need. The modern matrons demonstrated how they were collating information on a continual basis and making decisions on redeployment. We saw additional staff being deployed to both PICU units at the Harbour for the night shift as a direct response to the clinical pressures. A similar model of an increased number of staff to redeploy to areas with greater clinical need was also observed at the mental health unit Burnley Royal Hospital. The management team there described this as a pro-active attempt to manage staff shortages. Staffing at Scarisbrick Unit was reported to have improved since the closure of the male PICU at the same site approximately eight weeks earlier.

We were told that the trust was focusing its training toward more de-escalation and this was confirmed by the staff we spoke to. The management of violence and aggression lead (MOVA) informed us future training is to be renamed violence reduction training. On the PICU wards staff we spoke to expressed concern that some shifts did not have a minimum of three management of violence and aggression trained staff on duty. The MOVA lead confirmed some new starters commence work prior to receiving the MOVA training. We witnessed an escalating situation whilst on Keats Ward where a new qualified nurse was on her third shift and only two of the staff team were MOVA trained. We witnessed a rapid and effective response from the other wards when the alarm system was activated which resulted in a restraint and removal to a seclusion facility.

A number of staff at The harbour informed us that morale was poor mainly due to the staffing issues and not all wards were as significantly affected. Of the staff we spoke to five told us that morale was beginning to improve. When we returned to visit both PICU units two weeks later some staff told us that there had been significant changes since the appointment of new ward managers and they were able to see some positive changes and an improvement in the support that they receive. At Scarisbrick and Burnley Units morale was described as good within the team and those relationships within the team and toward upward management was positive.

The ward managers from the different inpatient units across the four sites understood requirements for managing staff on sick leave were all able to detail how they support staff on sick leave. We were told there were

few staff on sick leave because of work related stress. Ward managers told us they provide regular line management supervision and appraisal and performance management. We spoke to staff who confirmed the trust employ a cascade model of supervision. All staff that we asked confirmed they receive supervision although not always monthly. A new starter we spoke with told us he had no supervision since commencing in February 2015.

Ward managers had good knowledge of the mandatory training requirements of their staff. The trust provided the following information regarding compliance with mandatory training. The trust target for compliance of training was 85%. It is to be noted that these figures will have been correct to the date they were provided and will not account for subsequent training attended:

Fire - 69%

Equality & Diversity - 88%

Safeguarding Children - 89%

Moving & Handling L1 - 83%

BLS - 42%

Infection Control - 58%

Conflict Resolution - 64%

Health & Safety - 86%

Safeguarding Adults - 84%

Staff told us that they had good access and support to attend training, although three staff told us mandatory training had been cancelled due to staffing pressures when they had been due to attend. Ward managers informed us there was good access to leadership training. Based at Burnley the practice development nurse was rolling out a staff emotional well-being programme to support clinical staff.

Ward managers confirmed they usually hold monthly team meetings but some wards had not had these since prior to the move to the harbour except for Churchill Ward. At Burnley staff told us there had been no team meetings in the previous weeks. We found no reports of bullying or harassment and staff told us they were not aware of any such problems across the directorate. The staff we spoke to knew how to raise concerns and that they would be confident to do so.

Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Commitment to quality improvement and innovation

Qualified staff were aware a number of audits being undertaken within the directorate. These included national audits such as mental health safety thermometer, national audit of schizophrenia and patient-led assessments of the care environment. Staff described audits being conducted within the clinical areas and how the findings were shared within the clinical teams. Ward managers described undertaking monthly audits where checks are undertaken on various indicators including Mental Health Act compliance, reviewing the quality of care plans and risk assessments and completion of the population health information tool. We were informed that issues arising from these are fed back at team meetings and individual supervision sessions using the TIB. Pharmacy staff attended wards daily on week days and review quality of prescribing and monitor compliance against the medication management policies highlighting concerns to ward managers to enable quick remedial actions.

Ward managers informed us that each team has recognised champions identified for a specific lead area, including wound care, safeguarding, physical health, infection prevention, carers and training. We were told champions provide support and guidance to their peers in the area for which they lead.

Each ward holds a daily multi-disciplinary meeting enabling a daily review of patient progress and discussion regarding clinical issues. We were told these meetings facilitated improved patient care and facilitate an earlier discharge. The Scarisbrick Unit was piloting the alternative therapy intervention project. This project aimed to offer a reasonable alternative to hospital admission by offering a daily placement for people in crisis and receiving support from the home treatment team. The intention was to provide increased daily activity and occupation to support patients to avoid a full relapse necessitating a hospital admission. Patients can also be referred for support post discharge from the Scarisbrick inpatient unit. The project was in the process of being evaluated during our inspection. At Burnley a clinical practice team have been developed aiming to facilitate clinical assessments for, and rapid discharges of patients who are not known to existing mental health services and do not require secondary care mental health services on discharge.

We were informed that the trust is to move toward electronic prescribing with pilot sites identified. Staff spoke positively about this new challenge and opportunity to enhance clinical services. We were also informed that the trust is to pilot a return to the three shift system at some future point.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met;

- Seclusion records were not complete and records on Keats were missing.
- Staffing levels on wards were not appropriate for the level of care required by some patients.
- Ligature points were identified in quiet rooms throughout the wards at the Harbour. Some wards had locked the doors however other wards were not aware of the risk.

Regulation 17(2)(b)(c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met;

- There were not sufficient numbers of suitably qualified and experienced staff working on wards.
- Staff did not receive appropriate levels of support to access mandatory training.
- Staff did not receive regular supervision and appraisal

Regulations 18(1)(2)(a)(b)