

Lancashire Care NHS Foundation Trust

Wards for older people with mental health problems

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	Austen ward, Dickins ward , Bronte ward, Wordsworth ward	FY44FE
RW5CA	Burnley General Hospital	Ward 22	BB10 2PQ

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?

Inadequate



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	6
Information about the service	10
Our inspection team	10
Why we carried out this inspection	10
How we carried out this inspection	11
What people who use the provider's services say	11
Good practice	11
Areas for improvement	12

Detailed findings from this inspection

Locations inspected	13
Mental Health Act responsibilities	13
Mental Capacity Act and Deprivation of Liberty Safeguards	13
Findings by our five questions	15
Action we have told the provider to take	31

Summary of findings

Overall summary

We rated wards for older people with mental health problems as requires improvement because:

- On ward 22, Department for Health guidance on same sex accommodation as well as the MHA Code of Practice was not being followed, as access to reach bathroom and toilet areas meant patients had to walk through communal areas occupied by either sex, which opened out onto the main ward communal area.
- The wards did not have current and up to date ligature risk assessments and environmental risk assessments had not been completed on ward 22. The CQC have received assurance that the trust have put in place actions to address these issues with an action plan in place to complete the ligature risk assessments on each ward.
- Ward 22 had identified insufficient levels of nursing staff on duty during the day from January 2015 – March 2015. Bronte, Wordsworth and Dickens wards also identified this during March 2015.
- On ward 22 patients were unable to summon assistance throughout the ward as alarm call bells were not fitted in most of the patient areas. However, a push button (anti-ligature) staff alert system was installed in all unobservable areas (toilets and bathrooms).
- We identified concerns about staff not receiving mandatory training; both of which increased risk to patients and staff.
- On ward 22, we observed staff placing aprons around most patients without any explanation or asking the question if they wanted an apron around them. This meant that some patients were not treated as an adult. We also saw blinds were not used in the male dormitory to protect patients' privacy and dignity as staff and visitors when entering the ward area were able to see into this area.
- Governance structures and performance management did not always operate effectively to assure staff had completed their mandatory training. The governance structures in place for the older adult wards were in their infancy and had not been fully embedded.
- The trust used high numbers of bank and agency staff on their wards.

- Individual wards were able to submit items onto the trust risk register in relation to staffing issues however, on ward 22 the trust had not addressed the deficit of replacing permanent staff. The risks described by the staff on ward 22 were not understood by their managers/leaders.

However we also found

- Staff demonstrated they understood safeguarding procedures and incident reporting; and we saw that debriefing and support was available to all staff, after a serious incident had taken place.
- Patients had up-to-date risk assessments in place that were regularly reviewed. The wards they were on sought to create an environment that reduced restrictive practise.
- On admission to a ward, patients had a comprehensive assessment of their needs, and systems were in place to assess and monitor physical health and nutritional needs.
- Patient information was available to staff, it was stored securely, and was readily accessible. Staff used this information to effectively plan people's care and make sure that when patients were discharged, all necessary and relevant information was available.
- There was evidence of staff following guidance and best practice; an example of which was their reviewing the use of antipsychotic medication for dementia.
- Staff were observed being responsive and respectful to patients, and demonstrated that, where possible, patient were participating in the planning of their care. A review of patient notes also showed that advanced decisions were recorded for some patients.
- Patients were supported and encouraged to maintain their independence.
- Staff sought feedback from patients and carers, and openly shared information on what they had done in response to the feedback.
- The wards provided activities for patients during the week and at weekends; and made adjustments for people (both patients and ward visitors) who had physical disabilities.
- Complaints processes were clear and staff demonstrated they actively responded to issues raised by patients and their carers.

Summary of findings

- Staff demonstrated that they knew the organisations visions and values, and were supportive of them. They also knew who their senior managers were and said that that they had a visible presence on the wards.

Summary of findings

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

Are services safe?

We rated wards for older people with mental health problems as inadequate for safe because:

- DoH and the MHA Code of Practice guidance on same sex accommodation was not being followed on ward 22. The privacy and dignity of patients was not always maintained. Access to reach bathroom and toilet areas meant patients had to walk through an area occupied by either sex in the main ward area.
- All of the wards we visited did not have a ligature risk assessment in place.
- Nurse call systems were not available in most patient areas on ward 22. Patients were unable to summon assistance if needed in bedroom and patient areas on ward 22. However, a push button (anti-ligature) staff alert system was installed in all unobservable areas (toilets and bathrooms).
- Environmental risk assessments had not been completed on ward 22.
- Insufficient nurse staffing levels had been highlighted on ward 22's risk register although there had been no resolution of this problem.
- Ward 22 had insufficient levels of nursing staff on duty during the day against the trust figures provided during January 2015 – March 2015. Bronte, Wordsworth and Dickens wards had also identified this in March 2015.
- Many staff had not received training in life support techniques and they were not up-to-date with other elements of their mandatory training.
- The majority of staff did not have a current Performance Development Review (PDR) and there were concerns about supervision and completion of mandatory training.

However;

- Attempts were made to book agency and bank staff who were familiar with the wards.
- There had been an increase of between 150% - 294% of care staff working on the wards for older people.
- Patients had up-to-date risk assessments in place which were regularly reviewed.
- Staff demonstrated that they understood safeguarding procedures and incident reporting.
- Staff debriefing and support was available to all staff after a serious incident had taken place.

Inadequate



Summary of findings

Are services effective?

We rated wards for older people with mental health problems as good for effective because:

- Patients had a comprehensive assessment of their needs on admission.
- Systems were in place to ensure physical health problems were assessed and monitored.
- Patient information was stored securely and was readily accessible to staff who needed it.
- The use of antipsychotic medication for dementia was being reviewed in line with guidance and recommendations.
- Malnutrition universal screening was completed for all patients as well as weekly weight and Body Mass Index (BMI) recording and physical health screenings.
- There were regular and effective multidisciplinary meeting in place for all of the wards we visited.

However;

- Numbers of staff receiving Mental Capacity Act and Mental Health Act training were low.

Good



Are services caring?

We rated wards for older people with mental health problems as requires improvement for caring because:

- On ward 22, we observed staff placing aprons around most patients without any explanation or asking the question if they wanted an apron around them. This meant that some patients were not treated as an adult.
- On ward 22 blinds were not used in the male dormitory to protect patients' privacy and dignity as staff and visitors when entering the ward area were able to see into this area.
- Staff were mostly observed being responsive and respectful to patients.
- Where possible, patients were participating in the planning of their care. They were also supported and encouraged to maintain their independence.
- Patients had access to advocacy services and were using them.
- The wards sought feedback from patients and carers and provided a 'you said, we did' response.
- Advanced decisions were in place for some patients.

Requires improvement



Are services responsive to people's needs?

We rated wards for older people with mental health problems as good for responsive because:

Good



Summary of findings

- There was a bed available on the Psychiatric Intensive Care Unit (PICU) if needed.
- Wards had quiet rooms where patients could meet visitors.
- Activities were provided during the week and at weekends.
- All wards made adjustments for people who had physical disabilities.
- Complaints processes were clear and staff demonstrated they actively responded to issues raised by patients.

However

- Bed occupancy was and had been above 85%, for the last 12 months and patients returning from leave would occasionally have to move to other wards because a bed was not available in the ward they were on leave from.
- Blinds that were in place to provide some privacy to patients from staff and visitors entering the ward area were not used on ward 22.

Are services well-led?

We rated wards for older people with mental health problems as requires improvement for well-led because:

- Staff did not receive appropriate supervision and annual appraisals.
- The ward matron on ward 22 did not have the authority to appropriately refuse admissions.
- The arrangements for governance and performance management did not operate effectively as these were in their infancy in their monitoring of performance on the older adult inpatient wards.
- Governance structures did not assure that staff had completed their mandatory training, received regular supervision and appraisal.
- The trust used high numbers of bank and agency staff on their wards.
- Individual wards were able to submit items onto the trust risk register in relation to staffing issues however, on ward 22 the trust had not addressed the deficit of replacing permanent staff. The risks described by the staff on ward 22 were not understood by their managers/leaders.

However

- Staff were aware of the organisation vision and values and supported these.
- Staff knew who their senior managers were, and managers were visible on the wards.

Requires improvement



Summary of findings

- Staff took part in clinical audits.

Summary of findings

Information about the service

The wards for older people with mental health problems provided by Lancashire Care NHS Foundation Trust are provided at two locations, the Harbour and Burnley general hospital site.

More recently the trust have opened the Harbour location (April 2015) based on the outskirts of Blackpool. They have closed and moved most of the older people's wards from various locations throughout the Lancashire area into the Harbour, which is now the main site. They have also reduced their provision of care for older patients with a mental health problem. They have one other ward in the East area of Lancashire, which is based at Burnley general hospital (ward 22). There are plans in place to close ward 22 and move these inpatient facilities to Blackburn in the future.

The Harbour has four wards providing care and treatment for older people. Two of these wards Austen (female patients) and Dickens (male patients), provide advanced care, assessment and treatment of individuals requiring a

focus on mental health conditions where there is also physical health co-morbidity, vulnerability or risk related to being at a later point in their life. These wards provide 18 beds on each ward.

The Harbour also provides two dementia care units Bronte (female patients) and Wordsworth (male patients). The wards provide 24 hour assessment, treatment and care to people who have dementia. These wards have 15 beds on each ward.

Burnley General hospital ward 22 is an 18 bed mixed ward for male and female patients with acute mental health issues such as depression, anxiety, bi-polar disorder and schizophrenia. There are also some patients with a diagnosis of mild to moderate dementia.

The trust older people's wards have previously been inspected by CQC and were found to be compliant with the regulations. This is the first comprehensive inspection at these locations.

CQC's Mental Health Act reviewers inspected Ward 22 on 7 January 2015.

Our inspection team

Our inspection team was led by: **Chair:** Peter Molyneux, South West London and St Georges NHS Trust

Head of Hospital Inspection: Jenny Wilkes, Care Quality Commission.

Team Leader lead: Sharon Marston, inspection manager (mental health), Care Quality Commission.

Lorraine Bolam, inspection manager (community health services), Care Quality Commission.

The inspection took place over three days from 28 April – 30 April 2015.

The team included CQC inspectors and a variety of specialists: The team that inspected the wards for older people with mental health problems consisted of eight people spread out over the five wards we visited, these included: one experts by experience, one inspector, one Mental Health Act reviewer, two nurses, a pharmacist, one psychiatrist 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.

Summary of findings

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?
- 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 five of the wards at two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients.
- checked all five clinic rooms.
- spoke with 19 patients who were using the service and six carers and or family members. collected feedback from four patients using comment cards.
- spoke with the managers or acting managers for each of the wards.

- spoke with 36 other staff members; including doctors, nurses, psychologists, physical health matron, occupational therapists, a community nurse, a violence reduction specialist, safeguarding lead and pharmacists.
- interviewed the senior matron with responsibility for these services.
- attended and observed one hand-over meeting and nine care programme approach meetings which included multi-disciplinary meetings.
- observed a staff 'huddle' meeting.
- completed a short observational framework inspection (SOFI) on one ward we visited and observed lunch being served on three wards.
- looked at 30 care records including risk assessments.
- The pharmacist looked at 21 treatment cards.
- looked at 23 treatment records of patients.
- carried out a specific check of the medication management on three 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 spoke with patients and their relatives. Most were positive about their experience of care on the older adult mental health wards. They told us that they found staff to be caring and supportive, and most people were involved in decisions about their care where they were able to.

At the end of the inspection we collected four comment cards from ward 22 only. These gave mostly positive reviews about the ward and positive feedback about the staff. Two patients made negative comments about the no smoking policy in place.

Good practice

- We found on Wordsworth ward restrictive care plans were in place to address and meet any identified risks where any 'hands on' intervention or support was needed to provide personal care to patients.
- Dickens ward was piloting an observational baseline and on-going monitoring tool. This was developed for

use with patients who had difficulty in self-reporting their anti-psychotic side effects. Its purpose was to help ensure that side effects are recognised and appropriate action is taken.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

The trust must

- Ensure that ligature risk assessments are carried out. This is because on ward 22 we identified ligature risks throughout the ward. No ligature assessments had been completed on all the wards we visited to identify and manage any risks to patients using the service.
- Ensure that the privacy and dignity needs of patients are met. This is because on ward 22 we found the Department of Health guidance on same sex accommodation and the Mental Health Act Code of Practice was not being complied with. Access to reach bathroom and toilet areas meant patients had to walk through an areas occupied by either sex in the main ward area.
- Ensure there are a sufficient number of nursing staff on duty at all times and who have received appropriate supervision, training and appraisal to enable them to carry out their duties.

Action the provider **SHOULD** take to improve

The trust should

- Make sure that where facilities have items in place to protect patients' privacy, they are used. This is because we saw that blinds and doors on ward 22, were not used and people visiting the ward could see through to where the patients were.
- Review the patient mix on ward 22, and provide more autonomy to the matron to make admission decisions. This is because at the time of our visit the matron on ward 22 was unable to make definitive ward admission decisions. Staff also felt that the patient mix on ward 22 meant that it was not always easy to keep patients safe. Ensure that on ward 22 the risk register is reviewed in relation to the reduced RMN staffing levels and three depleted band three support workers temporarily redeployed.
- Continue to monitor the use of bank and agency staff being used.
- Review, implement and monitor staff training and appropriate supervision and/or appraisals.
- Review the effectiveness of running bed occupancy rates of over 85% on older people's inpatient wards.

Lancashire Care NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Austen ward, Dickens ward, Bronte ward, Wordsworth ward.	The Harbour
Ward 22	Burnley General 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 where patients were detained under the Mental Health Act 1983 (MHA), legal paperwork was present in the patient files.
- There was evidence that patients were advised of their rights and we saw that patients were reminded of their rights on most of the wards.
- There was an independent mental health advocacy service available to all patients.
- Staff had not always received the training required in relation to the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Records indicated there were significant gaps in training staff had received.
- The trust were applying for Deprivation of Liberty Safeguards (DoLS) applications for individual patients where needed.
- There was a policy on the Mental Capacity Act including DoLS which staff were aware of and could refer to if needed.

Detailed findings

- We saw that patients were supported to make decisions for themselves before they were assumed to lack the mental capacity to make a decision.

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

We rated wards for older people with mental health problems as inadequate for safe because:

- DoH and the MHA Code of Practice guidance on same sex accommodation was not being followed on ward 22. The privacy and dignity of patients was not always maintained. Access to reach bathroom and toilet areas meant patients had to walk through an area occupied by either sex in the main ward area.
- All of the wards we visited did not have a ligature risk assessment in place.
- Nurse call systems were not available in most patient areas on ward 22. Patients were unable to summon assistance if needed in bedroom and patient areas on ward 22. However, a push button (anti-ligature) staff alert system was installed in all unobservable areas (toilets and bathrooms).
- Environmental risk assessments had not been completed on ward 22.
- Insufficient nurse staffing levels had been highlighted on ward 22's risk register although there had been no resolution of this problem.
- Ward 22 had insufficient levels of nursing staff on duty during the day against the trust figures provided during January 2015 – March 2015. Bronte, Wordsworth and Dickens wards had also identified this in March 2015.
- Many staff had not received training in life support techniques and they were not up-to-date with other elements of their mandatory training.
- The majority of staff did not have a current Performance Development Review (PDR) and there were concerns about supervision and completion of mandatory training.

However;

- Attempts were made to book agency and bank staff who were familiar with the wards.
- There had been an increase of between 150%- 294% of care staff working on the wards for older people.
- Patients had up-to-date risk assessments in place which were regularly reviewed.

- Staff demonstrated that they understood safeguarding procedures and incident reporting.
- Staff debriefing and support was available to all staff after a serious incident had taken place.

Our findings

Safe and clean environment

- The layouts of Austen, Dickens, Bronte and Wordsworth wards enabled staff to observe most parts of the ward, area with the exception of patient bedrooms and some of the garden areas. CCTV was fitted throughout the ward areas. The layout of ward 22 meant that staff could not observe all parts of the ward area. The female only lounge and the activities room were separated by doors and could not be observed. Both male and female patients could access these areas and staff were not always present. The bedroom dormitory areas could not be observed, and again both male and female patients could enter these areas. This meant there was a risk to individual patients, because staff were not always present in these areas, and they could not see what was going on. Environmental risk assessments were completed regularly on Austen, Dickens, Bronte and Wordsworth ward. These were not available nor completed for ward 22.
- At the Harbour location, Austen, Dickens, Bronte and Wordsworth wards did not have an up to date ligature audits in place. The Harbour had identified on their risk register that there were various ligature risks on the older adult wards and proposed dates had been planned by the trust to complete these. Appropriate actions to manage these risks had been highlighted. These included daily environmental checks being carried out by the ward manager/deputy, and a safety and security nurse managing and assessing the risks. Ward 22 did not have a ligature risk assessment in place. During our observation of ward 22, we identified various ligature points in the female lounge and in the main lounge/communal area. These included TV wiring, door

Are services safe?

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closures and door hinges. We saw that patients were being managed on high levels of observation throughout the ward due to the levels of risk and acuity on the ward.

- Male and female sleeping areas were separated on Austen, Dickens, Bronte and Wordsworth wards. These wards provided single sex accommodation. All bedrooms were single rooms and had en-suite facilities.
- Ward 22 did not comply with DH guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) code of practice. Ward 22 had one male and two female dormitory type bedrooms as well as four male single rooms being used. One of the female dormitories was situated next to the four single male bedroom areas. This meant that both male and female patients' privacy and dignity were not protected; as access to reach bathroom and toilet areas meant patients had to walk through communal areas occupied by either sex, which opened out onto the main ward communal area. During our visit, we saw both female and male patients in their nightwear wandering throughout the ward area. Some patients were exposing themselves to the opposite sex due to their disinhibited behaviours.
- Emergency equipment, including automated external defibrillators and oxygen, was in place. It was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Ligature cutters were also available on the wards visited. Medical devices and emergency medication were also checked regularly.
- Many staff had not received training in life support techniques. Figures provided by the trust identified that only one out of the five wards inspected (Bronte) had achieved between 80 and 83% compliance for being trained in resuscitation (basic life support and intermediate life support). Austen, Dickens, Bronte and Wordsworth and ward 22 had identified gaps in their training with figures ranging from 30% compliance to 79% for both areas of life support. This meant that patients were not always protected to receive the care and treatment response they would need if a medical emergency was to arise.
- The wards we visited were clean and tidy and the furnishings were clean and in good order. Most of the bedrooms we looked at the Harbour had been personalised with photographs of patient family

members. Some of the ward areas appeared sterile and institutional as a result of the newly opened hospital. Profile beds were available for patients who had physical health needs as well as pressure relieving mattresses, hoists and assistive baths.

- Although signage was in place at the Harbour the wards signage would be difficult for visually impaired patients to read as they were transposed onto a grey background.
- Austen, Dickens, Bronte and Wordsworth wards all had access to outside space/garden areas that were attached to the wards. We saw these gardens were well used by patients during our visit and patients could access these freely with staff support where risks had been identified. Ward 22 was located on the first floor of a building and patients were unable to freely access outside space or a garden area. During the inspection, we observed some patients accessing the hospital grounds independently as well as being accompanied by staff.
- The medicine fridge temperature was checked daily on all the wards we visited. Equipment and hoists had been checked and were maintained. Stickers were visible on the equipment and these identified the dates they had been checked as well as the next due date.
- Austen, Dickens, Bronte and Wordsworth wards had access to alarm and nurse call systems throughout the ward areas with nurse call systems available in bedrooms, bathrooms and all patient areas. These wards had a safety and security person identified who noted patient, staff and visitors whereabouts on the ward as well as completing general observations of patients. Ward 22 only had nurse call alarms in bathroom and toilet areas. We found no nurse call systems were available in bedroom dormitories or single rooms. This meant that patients in the ward and bedroom areas were unable to summon or call for assistance in the case of an emergency or other assistance that may be required. Nurses had access to personal alarms and when activated would identify the area they were in so that other staff were able to respond.

Safe staffing

Are services safe?

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- The wards we visited had sufficient numbers of qualified nurses and healthcare assistants on each shift during our visit. The trust informed us staffing levels had been increased as a result of over recruitment in anticipation of the three shift patterns commencing in June 2015.
- Information requested following the inspection identified that ward 22 in January 2015 had 1308 planned hours for registered nurses with only 846 being filled an average of 65%. February had planned hours for registered nurses during the day as 1181 hours with only 729 being filled, this was an average of 62%. In March 2015, the figures were 1307 with only 982 being filled and average of 75%. The figures also identified that in January 2015 to March 2015 that the use of care staff ranged from 150%-294%. This meant that ward 22 had been insufficiently staffed with qualified nurses although there had been an increase in care staff. This was also reflected in March 2015 on Bronte, Wordsworth and Dickens wards for qualified nursing staff being present during the day, which was between 51%-71%.
- Ward 22 had identified on their risk register that there was insufficient staffing levels of registered mental health nurses (RMNs). This had been on their risk register from 05 February 2013 and had a next review date of 04 May 2015. The risk register we reviewed recommended corrective action to address this, however, no action had been taken at the point of our inspection. From information, we requested following our inspection the trust informed us that there should be four RMNs on days and two RMNs on at night throughout the week and weekends. The trust confirmed that due to staffing issues, there was only one RMN on at night, four health care assistants (HCA) during the night and five HCA during the day. The trust should continue to review and monitor their risk register in relation to the RMNs they have on duty on ward 22.
- The datix incident reports from 11 November 2014 – 12 April 2015, identified 20 incidents where staff shortages and staffing issues had caused concerns on this ward. This meant that staff and patients were placed at risk as a result of this.
- We saw minutes of the trust hard truths/safer staffing meeting 9 April 2015. These monthly meetings updated attendees at the trust of the development of the 'safe care module' to support staff. The meetings also addressed and reviewed the trust action plan in place around staffing issues. Some concerns had been raised regarding the bank staff system in place, which included the booking of staff and particularly the booking of preferred/specific staff. This meant the trust was monitoring their staffing issues across the trust as well as the outcomes being fed up to the trust board.
- Wordsworth ward had made requests for bank and agency staff with bank staff having filled an average of 55% between January and March 2015 and 49% agency staff. Ward 22 made a total of 870 requests with an average of 37% of these being filled by bank staff and 49% being agency staff. These figures meant that large numbers of bank and agency staff were being used and also identified that some shifts were not being fully covered.
- Wordsworth and ward 22 also had the highest sickness rate out of all five wards with 15% sickness absence on both wards.
- We saw that ward 22 especially had a large number of staff on the ward during our visit. On speaking with staff and the matron, this had been the result of the levels of acuity on the ward and the mix of functional and dementia patients and levels of enhanced observations required to keep patients safe. These additional staff were mostly filled by agency and/or bank staff.
- We saw no examples of escorted leave being cancelled.
- We saw there were enough staff to carry out physical interventions on the wards we visited.
- Across most of the wards, staff told us that medical cover and support was readily available. There were junior doctors and consultants on site during the day and on call at night. A consultant was present on all wards and for weekly ward rounds and huddle meetings at the harbour wards we visited. The trust monitored and recorded access to doctor cover via their datix incident recording. Where staff were unable to access cover from a doctor, this was recorded and escalated via their clinical governance structure.
- Records showed that most staff were not up-to-date with all statutory and mandatory training and there were identified gaps at all of the locations and wards we

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visited. Austen ward had a total compliance rate of 76% for staff being trained in mandatory subject areas. Wordsworth 63%, Dickens 66%, Bronte 77% and Ward 22 only 64%.

Assessing and managing risk to patients and staff

There were 34 episodes of restraint with (two) prone at Ward 22 in the period from January to March 2015. Figures requested and provided for Austen, Dickens, Bronte and Wordsworth showed no restraint was used.

- The current policy around restraint was being updated to support the trust adoption of good practice guidance in this area. All staff had to complete training on physical interventions, which was refreshed on an annual basis. Evidence provided by the trust told us that not all staff had completed the trust's five day mandatory training followed by a yearly three day refresher. The trust had appointed a violence reduction specialist nurse who oversaw training at the Harbour, and throughout the trust, there was a network of trainers available. The trust informed us that there had been some issues in training all of their new staff due to access problems at the Harbour, and this had been escalated to the head of patient safety. We found the staff training incorporated theory based dementia care and the least restrictive principles, where prone restraint was used a post incident review was implemented.
- We saw the trust were implementing "Positive & Proactive Care: reducing the need for restrictive practices", which was published by DoH in April 2014. This set out a blue print for organisations to follow as a means of introducing a prevention and reduction model for restrictive practices. The trust had adopted a policy to reduce the prone restraint used within their trust and this had been approved by the quality and safety sub-committee (December 2014). The trust had a corporate action plan for reducing restrictive practices.
- The trust has a policy on enhanced observation and therapeutic engagement policy, and procedure in place as well as policy, on the management of violence and aggression and rapid tranquilisation policy. The trust also has a policy in place to address advanced statements of wishes and feelings: a collaborative approach towards effective aggression management. Staff we interviewed reported that restraint was used as a last resort. The wards we visited at the Harbour had introduced 'engagement observations', where enhanced observations were required for patients. These were introduced to positively promote to staff that where observations were taking place, staff should positively engage with patients.
- We reviewed 30 risk assessments and saw that patients had up-to-date risk assessments in place. These had been regularly reviewed and updated reflecting any change in risk level or after incidents. A 72 hour risk screening tool was completed on admission in line with advancing quality measures for each patient.
- Incidents were also logged on an incident reporting system and reviewed by ward managers and matrons. Information was also captured on the trust patient safety thermometer, a report of physical healthcare that captured information in relation to harm free care for people aged 65 and over in mental health services, as well as the datix incident recordings.
- Across the wards, doors were locked. There were signs in place next to most ward exits indicating that informal patients were able to leave when they wished, after informing and discussing it with the ward staff. Patients at the Harbour were issued with a leave pass.
- We also saw that Deprivation of Liberty Safeguards (DoLS) had been applied for on the wards we visited.
- Staff said debriefing sessions were available to discuss what went well and what might be improved following any physical interventions.
- Management of violence and aggression (MOVA) team provided training to all staff for the wards we visited. We found the Harbour dementia wards Bronte and Wordsworth, provided staff response teams to each other's wards if staff were needed in an emergency. The advanced care wards Austen and Dickens wards responded to emergencies on the PICU ward and vice versa if needed. Violence reduction training incorporated a new training programme for staff, which removes planned prone restraint and has a greater focus on prevention and de-escalation.
- Rapid tranquilisation was infrequently used on the older people's wards. Where it was used, it was recorded on their datix incident reporting system, and reviewed by ward managers and matrons at the hospital.

Are services safe?

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

- Staff across all wards should receive mandatory safeguarding training. The figure for staff safeguarding level one adult training ranged from the lowest being 77% on Wordsworth ward to 90% on ward 22. Safeguarding children level one training records showed a range of 88% of staff on Dickens ward and the lowest being 77% on Wordsworth. Safeguarding level two identified large gaps in staff's mandatory training uptake with the largest gaps being Bronte ward only having 24% of their staff trained and the highest of five wards being 53% on ward 22. Staff were able to tell us how to identify and report a safeguarding incident. The wards we visited at the Harbour had a safeguarding lead who attended the wards weekly. This meant staff were able to discuss any issues or concerns they had about safeguarding patients on the wards. We saw information available that the trust were able to identify where safeguarding alerts had been made on the older adult wards.
- A clinic pharmacist from Monday to Friday supported all the wards. 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. Nurses administered most medicines, but following assessment, patients at the Harbour wishing to self-administer medication were supported to do so. Medicines self-administration was not assessed or supported on ward 22.
- Medicines including controlled drugs were securely stored and emergency medicines were regularly checked to ensure they were available if needed.
- Staff were aware of the risk of falls and pressure ulcers within the patient group and managed most risks accordingly. There was evidence in the care plans of assessing physical health needs on admission, and regular patient reviews were taking place. There was evidence of discussion in the multi-disciplinary team about both physical and mental health needs of all patients. A patient safety thermometer was another way the trust were collating data to look at the prevention of pressure ulcers, venous thromboembolism, urinary tract infections and use of catheters.
- Falls assessments had been completed for all of the patient records we reviewed and where a risk had been identified. We found on all wards we visited there was a lack of assistive technology to enable staff to be alerted

to immediate patient falls. During our visit this was discussed, arrangements were made and implemented; to immediately loan equipment needed where there had been a patient assessed need.

- Both the Harbour location and ward 22 at Burnley general hospital had access to child visiting rooms within the hospitals. Bronte ward had adapted their ward meeting room into a child friendly room.

Track record on safety

Due to the Harbour wards only being operational from March/April 2015, the data submitted was limited. The trust was monitoring clinical incidents on the wards and the matrons and senior matrons had sight of these. The number of open incidents from March 2015 – 27 April 2015, were:

- Wordsworth 67
- Austen ward 6
- Dickens ward 17
- Bronte 13
- Ward 22 5

Reporting incidents and learning from when things go wrong

- There had been no serious incidents reported during this time frame nor any never events. All of the staff we spoke with were aware of what to do when reporting incidents through the electronic reporting system.
- During our observations on the wards, we saw staff who were open and transparent with patients and carers who were visiting their relatives and or friends.
- Staff received feedback from investigations and incidents in various ways. The trust developed 'newflash', a trust wide email system sent to staff to raise awareness of breaking news within the trust. Important updates and time sensitive information has also been cascaded to staff in this way. Another way the trust provided feedback and learning was by inviting staff to a 'dare to share' event, this was rolled out in January 2015. It provided staff with an honest account of where there had been inadequate care, and the lessons the trust had learnt to improve patient care.
- Staff debriefing and support was available to all staff after a serious incident had taken place.

Are services effective?

Good 

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

We rated wards for older people with mental health problems as good for effective because:

- Patients had a comprehensive assessment of their needs on admission.
- Systems were in place to ensure physical health problems were assessed and monitored.
- Patient information was stored securely and was readily accessible to staff who needed it.
- The use of antipsychotic medication for dementia was being reviewed in line with guidance and recommendations.
- Malnutrition universal screening was completed for all patients as well as weekly weight and Body Mass Index (BMI) recording and physical health screenings.
- There were regular and effective multidisciplinary meeting in place for all of the wards we visited.

However;

- Numbers of staff receiving Mental Capacity Act and Mental Health Act training were low.

Our findings

Assessment of needs and planning of care

- Care records we reviewed confirmed that patients had a comprehensive assessment of their needs on admission to the wards. These included their clinical, mental and physical health, well-being, and nutritional and hydration needs. A 72 hour care/risk plan was developed following admission to the ward.
- There were systems in place to ensure patient physical health needs were monitored. On admission, or within 24 hours of admission, the admitting nurse completed a falls risk assessment. The wards had access to a physiotherapist who visited the wards to assess new patients, and where the initial falls assessment indicated the need to further assess.
- Care records we reviewed across all five wards contained personalised and some very detailed care plans. An example of this was at the Harbour, where patients had been transferred from their previous hospital locations to the Harbour and had care plans in

place on transfer. All of the wards used different care plans. On Austen and Dickens ward, we saw detailed, personalised and holistic care plans in place. On Ward 22, we saw care plans were in place, although the detail and personalised plans were not as clear and easy for staff to understand to the other wards we visited. The senior matron overseeing the older people's wards was aware of this and confirmed the older people's wards would review the care plans being used. Bronte ward care plans were written in the first person and were patient centred. On Wordsworth, we found restrictive care plans were in place to address and meet any identified risks, and where any 'hands on' intervention or support was needed to provide personal care. We also saw that where this had happened, the patient's capacity to consent had been assessed. We found patient's capacity to consent was assessed on admission to the wards and this was recorded appropriately. We also saw that patients were supported where possible to make decisions for themselves before they were assumed to lack the mental capacity to make a decision.

- All information about patients was stored securely and was accessible to staff via their electronic recording system. We found some information was paper based but with plans to scan all information onto their system in time. This meant that where patients were discharged from hospital under the care of community teams, up to date records were accessible.

Best practice in treatment and care

- The use of antipsychotics for patients with dementia was being reviewed. We found the trust had used an off-licence antipsychotic medication and the consultant psychiatrist had discussed this with the family. This meant that off license use of antipsychotics in dementia was being reviewed to reduce the use of antipsychotic medication for patients with a dementia, as recommended in the Banerjee report 2008.
- Psychology was available across all five wards we visited should patients need to access psychological therapies.
- Malnutrition Universal Screening Tool (MUST) was completed for all patients admitted to the wards and weekly body mass index checks and weights were

Are services effective?

Good 

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.

recorded. We saw that referrals to speech and language teams were made and discussed during a multidisciplinary team meeting we attended. Physical health screening had also been done.

- We found wards at the Harbour had key staff identified as champions, who had enhanced knowledge in certain aspects of care. These included champions for; carers, safeguarding, infection control, dementia, and activities. These staff had the responsibility to feedback and update the huddle groups (staff meeting groups) on any specialised training and or trust meetings they had attended to enhance and share their learning.
- We saw clinical staff had participated in clinical audit within the trust. Wards providing older adult mental health care had completed various audits these included; nutrition, observation levels, venous thromboembolism, Mental Capacity Act 2005, physical healthcare and falls audits.
- The advancing quality alliance was used by the trust to improve the safety and quality of healthcare to patients thus improving their outcomes. These were a standing agenda item on the ward governance meetings.
- Dickens ward was piloting an observational baseline and on-going monitoring tool, developed for use in patients who have difficulty in self-reporting their anti-psychotic side effects, to help ensure that these are recognised and appropriate action taken.

Skilled staff to deliver care

- We found a full range of mental health disciplines and workers provided input onto the wards. These included occupational therapists, psychologists, pharmacists, speech and language therapists' social workers, pharmacists and community staff including discharge coordinators.
- Staff were qualified and had the skills they needed to carry out their roles effectively, although not all mandatory training had been completed. Staff we spoke with were mostly positive, motivated and passionate about providing good quality care.
- Staff had not received regular supervision and or appraisal. Staff received a trust corporate induction on starting with the organisation. Figures provided by the trust identified gaps in staff having received an appraisal. As of the 19 May 2015, Dickens ward had only

completed one staff appraisal out of 42. Austen ward at the Harbour had the highest figures with 19 out of 45 staff having received an appraisal. Ward 22 identified nine out of 43 staff had received an appraisal.

Multi-disciplinary and inter-agency team work

- There were regular and effective multidisciplinary meetings in place for all of the wards we visited. The Harbour had developed daily ward 'huddles', where all staff met to discuss any issues relating to the ward and patient care. Wordsworth and Dickens held regular care programme approach (CPA) meetings, best interests meetings and monthly debrief meetings. Governance meetings were held weekly and these included the consultants and ward managers. A dementia governance group was held monthly. We also saw meetings were held for patient relatives and carers. Austen and Bronte wards had a regular timetable of meetings held on the wards. Ward 22 had a daily multidisciplinary team meeting with full reviews on patients weekly, a weekly pathways meeting, fortnightly governance meeting and a weekly matron's surgery. All wards had meetings for staff named 'your time'.
- We observed nine multi-disciplinary team meetings/CPA meetings, which took place on a weekly basis. We found most patients were invited to attend. However, at one meeting we observed on ward 22, the meeting had been planned at the same time a patient was receiving planned treatment off the ward. We found the meetings were effective in sharing information about patients, reviewing and updating their progress and monitoring discharge arrangements. Different professionals worked together effectively to assess and plan people's care and treatment.
- Effective handovers took place on the wards when shifts changed. This meant that staff were updated about patients' care and safety on the wards. At the Harbour, staff who were allocated as the safety and security worker (SAS) handed over to the next staff member allocated. They checked who the staff responders were should an incident occur, and checks were made on patients and the environment. We found only staff who had received updated MOVA training were identified as a SAS worker. Ward 22 updated staff during shift handover. Patient observations and staffing arrangements were made by the matron and/or ward manager and staff were informed at these meetings.

Are services effective?

Good 

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.

- There was comprehensive information retained on each patient to ensure that all members of the nursing and multidisciplinary team were kept up to date on current issues and future discharge arrangements.

Adherence to the MHA and the MHA Code of Practice

- We found that where patients were detained under the Mental Health Act (MHA), legal paperwork was present in the patients' files. We checked 13 MHA documentation files at the Harbour wards we visited.
- There was evidence that patients were advised of their rights in accordance with section 132. We saw that patients were reminded of their rights on most of the wards.
- There was an independent mental health advocacy (IMHA) service available to all patients. The trust operated an opt out system whereby patients would be automatically referred to the IMHA unless a patient with capacity objected.
- There was information about an informal patient's right to leave the wards and these were displayed on most wards apart from Austen ward.
- Information provided to CQC identified that where staff required level two MHA training there were gaps in staff being trained. Examples of this were on Wordsworth ward where 18 staff were identified as requiring this training. We found no staff had received this. This was also the case at ward 22 where out of ten staff identified none had completed the training.
- Administrative support was available on the wards we visited and the MHA lead circulated updates to individual wards to advise the wards of patients MHA status.

Good practice in applying the MCA

There were two levels of MCA training available for all staff identified as requiring it. Records showed significant gaps in training staff had received:

- For the five wards we visited, the percentages of staff who had received MCA training level one ranged from 37% - 76% and level two from 18 % to 40%.
- On Wordsworth ward, 20 out of 38 staff had received MCA level one and only eight out of 38 had completed level two.
- On Bronte ward 14 out of 38 had received MCA level one and only eight out of 38 had completed level two.
- Only one psychiatrist out of six had completed their level one MCA training and none had completed level two.
- We looked at twenty-one prescription charts on three older people's wards. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, the relevant legal authorities for treatment were in place and monitored by the ward pharmacist and nursing staff. However, we saw one example at Burnley hospital, where a patient had been assessed as lacking capacity but was consenting to treatment. We discussed this with the doctor and ward pharmacist in order that this would be reviewed at the next meeting.
- There were nine DoLS applications made in the last six months and these were made when required. Six of these were on Wordsworth ward.
- There was a policy on the MCA including DoLS which staff were aware of and could refer to if needed.
- We saw that best interests meetings were held within a multidisciplinary setting with family members present to recognise the importance of the person's wishes, feelings, culture and history.

Are services caring?

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

Summary of findings

We rated wards for older people with mental health problems as requires improvement for caring because:

- On ward 22, we observed staff placing aprons around most patients without any explanation or asking the question if they wanted an apron around them. This meant that some patients were not treated as an adult.
- On ward 22 blinds were not used in the male dormitory to protect patients' privacy and dignity as staff and visitors when entering the ward area were able to see into this area.
- Staff were mostly observed being responsive and respectful to patients.
- Where possible, patients were participating in the planning of their care. They were also supported and encouraged to maintain their independence.
- Patients had access to advocacy services and were using them.
- The wards sought feedback from patients and carers and provided a 'you said, we did' response.
- Advanced decisions were in place for some patients.

Our findings

Kindness, dignity, respect and support

One carer at the Harbour we spoke with said, "This is the NHS at its very best, the staff are brilliant they wouldn't work here if they weren't dedicated, I have no concerns".

We received four comment cards from ward 22 comments reported;

I have received the best care possible; the staff have been so kind and caring. I would have liked the doctors to explain a little more about my treatment but otherwise I have no complaints except the smoking policy.

In general, the care I received is excellent and most of the staff work as a team to provide the help I need to live and enjoy a normal life once moved. The activity nurses have helped me to prevent mundane and routine tasks and

attitudes setting in. My key nurse is spending time with me and pursues key links with other medical services that I require. I found it difficult to cope when my bed was not guaranteed whilst on short-term leave.

My care on ward 22 has been excellent. Members of staff have been so kind and obliging. Activities on the ward have been good and adequate for my needs, thank you.

I have been happy with all the care given by all the members of staff on ward 22 the activities have been excellent, keeping me from thinking of a smoke which I am not happy with the non-smoking policy. I should have the choice; smoking is the only pleasure I have.

- Wordsworth ward staff reported that due to high levels of personal care needs on this ward; meaningful activities had not always been implemented, and there was limited input from the occupational therapist (OT) on this ward.
- We completed a short observational framework for inspection (SOFI) on Bronte ward a tool used during the inspection where observations of patients with limited communication takes place. We observed staff and patient interactions and engagements. We saw staff were warm, encouraging, caring and supportive with patients on this ward.
- We observed a lunchtime on ward 22. We observed staff placing aprons around most patients without any explanation or asking the question if they wanted an apron around them. This meant that some patients were not treated as an adult and were not respected. We did however mostly observe good interactions with patients. Staff were patient, calm and were genuine and honest with patients on this ward.
- We saw that some patients on ward 22 had removed their clothes in the main ward areas as well as in a male dormitory area. These areas were accessible to female patients on the wards and the male dormitory could be observed by anyone entering the ward. There were blinds in place on the dormitory wards that could have been used to protect patient dignity, but these were not used in the male dormitory area during our inspection.
- Ward 22 provided for male and female patients who were acutely unwell, had a functional illness and had a

Are services caring?

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

diagnosis of dementia. This meant that patients who had been admitted for depression and or self-harm were mixed with patients who were acutely unwell, sexually disinhibited and often confused.

- We saw patients had 1-1 time with staff and time was made available by staff to sit and talk with patients on most wards.

The involvement of people in the care they receive

- Patients were provided with a welcome pack on admission to the wards.
- We saw most patients were involved and participated, where possible, in their care planning. Patients and their carers were seen to be invited to their care programme approach meetings and were also part of the multidisciplinary team meetings. The records we reviewed indicated that patients had been involved and provided with a copy of their care plan. We saw family members and/or carers were also involved and consulted in patient reviews.
- Patients were encouraged to maintain their independence where possible, and were able to access drinks and snacks on the wards. The Harbour provided an opportunity for patients to wash their own clothes and had access to a functional kitchen off the ward. We saw patients being encouraged to set tables ready for dinner on some wards we visited.
- There were information leaflets available about the service and some wards provided a welcome pack for patients on admission.
- We saw patients on all of the wards had access to advocacy and this was clearly displayed on all of the wards we visited. Information was freely available to support patients, relatives and carers. Information was also provided about drop in groups (matron's surgeries, your time meetings) where patients and carers people could discuss their concerns with the ward matrons.
- Patient advice and liaison services (PALS) were available as well as the trust complaints process. We found complaints were also discussed at patient forums at the Harbour location. Friends and family tests had recently been implemented across the wards from January 2015, to capture comments about the care the patients and their families experienced.
- We saw information displayed, 'you said we did' throughout the wards in relation to patient and carer feedback. This meant the trust were listening and acting on comments and feedback to improve their services.
- Records we looked at confirmed advanced decisions were in place for some patients and staff were able to provide examples of these.

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

We rated wards for older people with mental health problems as good for responsive because:

- There was a bed available on the Psychiatric Intensive Care Unit (PICU) if needed.
- Wards had quiet rooms where patients could meet visitors.
- Activities were provided during the week and at weekends.
- All wards made adjustments for people who had physical disabilities.
- Complaints processes were clear and staff demonstrated they actively responded to issues raised by patients.

However

- Bed occupancy was and had been above 85%, for the last 12 months and patients, returning from leave would occasionally have to move to other wards because a bed was not available in the ward they were on leave from.
- Blinds that were in place to provide some privacy to patients from staff and visitors entering the ward area were not used on ward 22.

manage this patient mix and to keep people safe; this was not always conducive to maintaining patients' privacy and dignity nor provided a therapeutic environment due to the mix of patients.

- The matron and clinical lead advised us that they were not able to make autonomous decisions about who was admitted onto the ward. Reported issues in relation to ward 22, were access to beds in the local catchment areas; due to inpatient beds being reduced and wards being closed throughout Lancashire. Bed management was also an issue reported to us with a number of patients living with dementia being admitted to this ward with acutely unwell and depressed patients. The matron and the clinical lead both advised that where they had stated they were unable to admit a person with dementia onto ward 22 due to the levels of acuity and other patient need and had no autonomy to overrule this. This meant that levels of staff on the ward were high to keep people safe and the patient mix was not conducive to patients' privacy and dignity needs with patients being admitted with schizophrenia and or a depressive illness as well as dementia.
- A consultant psychiatrist for ward 22 had proposed a model of care for the ward, which we reviewed. It clearly identified concerns about meeting the needs of a mixed patient group with both functional and organic mental disorders. The proposal recommended having only three beds for patients with a mild to moderate dementia, to enable staff to meet all patient needs. This model had not been adopted, and it was reported that patients had been admitted to ward 22, as no other beds were available in the local catchment area. The alternative was to be admitted to the Harbour hospital, which took a minimum of two and a half hours to travel from Burnley to Blackpool, by public transport one way.
- The trust had reconfigured their services for older patients at the Harbour location by separating patients with functional and organic disorders onto different wards, so that their differing needs could be met.
- The Harbour wards had only recently opened in March-April 2015 and figures provided identified Austen had the highest bed occupancy of 108% in March, and 110% in April. The trust provided figures of bed occupancies for all of their older adult wards for this period and most had bed occupancy of more than 85%.

Our findings

Access and discharge

- The average bed occupancy for January to March 2015 on Ward 22 was;
 - January 2015 - 99%,
 - February - 97%,
 - March - 95%
 - April - 95%.
 - July to December 2014 - 99%.
- Ward 22 was the only inpatient ward for older people in East Lancashire however, the advanced care and dementia beds at the Harbour provided cover for the whole of Lancashire, although LCFT do try and find the bed closest to home for individuals. As a result there was pressure to admit a mix of patients with functional and organic mental disorders onto the one ward. Staffing levels would need to be increased in order to

Are services responsive to people's needs?

Good 

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

- Most wards provided access to a bed for patients returning from leave but occasionally patients had to move to other wards where a bed was available. This meant that patients who were on leave, but not actually discharged, might not be able to return to the ward or bed they left if they needed to. Staff confirmed to us that patients were not moved at inappropriate times during the day, and often involved community staff and care coordinators to assist in patient discharge.
- A bed was available on the psychiatric intensive care units (PICU) if this was needed to provide a more intensive care package. Both the Harbour location and Burnley location had access to this to enable the patient to maintain contact with their family and friends if needed.
- The trust maintained a delayed transfer of care (DTC) spread sheet to monitor progress of patients being discharged. Outside of the organisation, the older peoples' inpatient directorate met with teams outside of the organisation to discuss issues around patient discharge delays. Data we reviewed showed adults within the community network had experienced delayed discharges due to patients awaiting nursing home placement and awaiting public funding. These were identified as two of the highest breaches from January – March 2015.
- All of the wards had a separate dining room area and assistive adaptations were available. Ward 22 had no signage or menus to inform patients what the options were throughout the day. Patients had made comments about the quality of the food at the Harbour. As a result of this, the food menus had changed. We found patients made their decision about their choice of food the day before, although on Bronte ward they were able to make a decision about soft and pureed diets on the day. Patients were given a choice of food including vegetarian options. Patients could access hot and cold drinks, and had access to snacks with any risks managed on an individual basis.
- Patients were able to personalise their bedrooms at the Harbour however, at ward 22 the layout of the wards were mostly dormitory style, which limited personalisation. These dormitories had been separated by partitions and curtains to afford some privacy. However, on entrance to the ward area where the male dormitory was situated; it provided no privacy or dignity for patients, because blinds were open to the main corridor and doors were also open that allowed full view of patients. Patients had access to lockable storage on all of the wards we visited.
- Weekly activity programmes for patients were advertised on all wards. However, these were not always in a size or format that would be suitable for patients with a visually impairment, or where pictorial formats may be more suitable for some patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had communal areas and quiet rooms, which could be utilised, as private interview rooms. There was a room for family visiting on Bronte ward, and the other wards had access off the wards to a room, which were suitable for children visiting. All wards had access to an activities room; Ward 22 had an activities room located in the female area of the ward and a female quiet lounge. There was a good range of information across the wards for patients and/or carers on notice boards and via a selection of leaflets.
- The Harbour wards Austen, Dickens, Bronte and Wordsworth, all provided good access to outside space and garden areas. Ward 22 did not have access to a garden area, being situated on the first floor of a building. Although patients could access the hospital grounds.
- Patients had good access to occupational therapy and dedicated activity workers/health and well-being teams. There was mixed activities across the wards we visited, and some patients were asked on admission what activities they liked to do. The activities were varied and age appropriate on the wards we visited. At the weekends, we were told, the majority of wards had activities carried out by the ward staff. Ward 22 had some activities planned and delivered at weekends, although this was not every weekend. The Harbour wards had plans in place to extend the health and well-being cover over the weekend period.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Good 

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

- All of the wards we visited provided adjustments for patients and visitor who required disabled access; with access to assistive bathrooms and profile beds. Bronte and ward 22 provided bold colour toilet seats and grab rails to aid recognition.
- Across the wards, we saw that the choice of foods to meet patient's cultural and religious needs was available. All wards we inspected had access to local interpreting services; and these could be arranged for patients to access during admission or for any meetings where an interpreter was needed.
- The trust provided some access to appropriate spiritual support for patients. This was via a service level agreement with a local acute hospital pastoral care team, and an individual agreement with a Roman Catholic priest at the Harbour location. Information provided by the trust informed us they had had some engagement with a wide multi-faith group, to advise about a contemplation room. However at the Harbour, the trust informed us that going forward, a new business case may be required to increase the pastoral care for all patient spiritual support. The trust informed us this was an on going discussion, and pastoral care would be made available for all religions and belief systems as requested. Staff at the Harbour informed us there was access to a multifaith room on site.
- We asked the trust for their complaints data for each ward we visited, from January 2015 – 27 April 2015. The information provided indicated there were no complaints in this period for all five of the wards we visited.
- During our inspection, CQC received a complaint, which we directed to the trust about one of the wards at the Harbour. This was dealt with immediately and arrangements made with the complainant to discuss and investigate their concerns.
- Staff told us they tried to address patients' concerns informally as they arose. We observed staff responding appropriately to concerns raised by relatives and carers of patients using the service. Staff were aware of the formal complaints process and knew how to signpost people as needed to the patient advice liaison service (PALS), as well as their own complaints process.
- We talked to some staff about the Duty of Candour for NHS bodies. Staff were able to show us how they would escalate concerns via their own whistleblowing procedures; as well as via access to 'dear Derek', an online form where all staff can raise concerns with a board member.
- Improvements had been made to the quality of care as a result of concerns raised at ward level; these were displayed around the wards under the heading 'You said, we did'. This meant patient and visitors were able to see what changes and improvements had been made on each ward in response to their concerns raised.

Listening to and learning from concerns and complaints

Are services well-led?

Requires improvement 

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

We rated wards for older people with mental health problems as requires improvement for well-led because:

- Staff did not receive appropriate supervision and annual appraisals.
- The ward matron on ward 22 did not have the authority to appropriately refuse admissions.
- The arrangements for governance and performance management did not operate effectively as these were in their infancy in their monitoring of performance on the older adult inpatient wards.
- Governance structures did not assure that staff had completed their mandatory training, received regular supervision and appraisal.
- The trust used high numbers of bank and agency staff on their wards.
- Individual wards were able to submit items onto the trust risk register in relation to staffing issues however, on ward 22 the trust had not addressed the deficit of replacing permanent staff. The risks described by the staff on ward 22 were not understood by their managers/leaders.

However

- Staff were aware of the organisation vision and values and supported these.
- Staff knew who their senior managers were, and managers were visible on the wards.
- Staff took part in clinical audits.

Our findings

Vision and values

- Staff were aware of the trust's vision, values, and the trusts five year plan (strategic planning framework) 2014 - 2019. Most staff were motivated and dedicated to give the best care and treatment they could to patients in receipt of inpatient care in Lancashire. Staff were supportive of the changes to the older peoples inpatient care; but some shared concerns about the lack of suitable beds and the levels of acuity on some wards.

- Most staff were aware of who their senior managers were within the trust. Staff reported they knew who their matrons and senior matrons were, all of whom were accessible had a presence on the wards we visited.

Good governance

- The older adult's mental health services sits within the adult community network. The Harbour has a governance structure in place, and although it was in its infancy; this will encompass patient led forums, multidisciplinary ward governance, and co-production meetings as a basis for the operational structure.
- Wards at the Harbour have governance meeting monthly, and weekly updates have been sent to individual wards to update staff on various issues. Some of the topics included in the weekly update were reminders to staff about booking their supervision, training and any environmental issues. The senior matron had planned weekly drop in meetings so that staff could discuss, confidentially, any issues they had.
- Ward systems and governance structures did not assure that staff received their mandatory training, supervision and appraisals. Wordsworth and ward 22 have the lowest compliance rates for training completed over the five wards we visited. Overall, compliance for training at Wordsworth was 63% and 64% on ward 22. Figures provided by the trust identified gaps in staff having received an appraisal with compliance rates ranging from 2% - 42%, for the five wards we visited as of the 19th May 2015.
- Although requested, we did not receive any information about staff supervision from the trust. Staff reported mixed messages throughout the wards we visited about supervision. Some staff stated they had received supervision, although this was not consistent on all the wards we visited.
- The trust was aware of the high use of agency and bank staff on their older adult inpatient wards. Information we reviewed identified the high use of bank and agency staff especially on ward 22 and on Wordsworth ward. At the Harbour, arrangements had been made to block book 10 additional staff for the hospital site, half of whom were qualified. This was in addition to booking

Are services well-led?

Requires improvement 

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.

bank or agency as needed on a daily basis. The hospital had made arrangements to undertake this, and to request regular staff until the posts advertised had been recruited into.

- Staff expressed their concern about ward 22 and the high use of bank and agency staff being requested on a daily basis. Data provided identified and confirmed the high use of these staff. Staff also expressed some concerns around the acuity and mix of patients on this ward. This meant that although the trust were monitoring their staffing numbers and had increased their staffing levels with bank and agency staff, the risk remained from February 2013 as highlighted on the ward 22's risk register. They had identified insufficient RMNs were available to carry out all appropriate roles and from November 2014 there were depleted by three x band three staffing numbers on ward 22 due to redeployment.
- We saw clinical staff had participated in clinical audit within the trust. Wards providing older adult mental health care had completed various audits. These included nutrition, observation levels, venous thromboembolism (VTE), Mental Capacity Act 2005, physical healthcare and falls audits.
- Staff on the wards we visited reported incidents, and managers reviewed and instigated any escalation and or investigation. These were reported on and discussed at ward level and were documented within the clinical governance meetings.
- Lessons learnt were disseminated to staff by the trust, so that any findings from investigations were learnt from and improvements made. All of the wards we inspected had documented and displayed what patients and or carers had said on their 'you said we did' boards. This meant the trust were reviewing and responding to service user feedback. The trust had a complaints process in place for patients and their carers to access.
- We found the ward managers at the Harbour wards we visited, had sufficient authority to make decisions and were supported by matrons and a senior matron. However, it was reported to us that the matron at ward 22 did not have sufficient authority to refuse patient admissions when the ward was at an acute/high stress stage, and were using large numbers of bank and

agency staff. This provided no authority for the matron to assess and manage the on going risks with the mix of patients with a dementia type illness and patients who were acutely unwell.

- It was reported to us that all the wards had access to administrative support

Staff had the ability to submit items to the ward risk register. The trust risk register identified staffing levels as an issue, as well as ligature risk assessments. This was consistent with our findings, especially on ward 22 in Burnley. The trust had described their risks in relation to staffing; the issues being recruitment, sickness and turnover. The trust also reported the impact this would have on their staff, these included:

1. Ward acuity/high stress environment;
2. Skill mix (balance of experienced/inexperienced staff;
3. Lack of capacity to take breaks;
4. Stress anxiety and low morale;
5. Impact on care planning and record keeping;
6. Use of temporary staffing;
7. Lack of opportunities for meetings and supervision;
8. Significant flow and capacity pressures;

- Some of the issues above had been reported on their incident reporting system; however, there was no solution in place to address the on going issues on ward 22. This may have been because of the Harbour hospital opening, and plans being in place to relocate ward 22 to another area in Lancashire.
- Staff sickness absence on the five wards we visited was high, the highest was on Wordsworth ward and ward 22, and this was being monitored by the trust.
- Staff were aware of the whistleblowing process if they needed to use it, and we saw staff speaking to patients and families in an open and transparent manner. The trust had also provided varying opportunities for staff to be able to raise issues within the trust by providing matron drop in clinics and 'dear Derek' an online tool where staff could post any concerns they had.
- All staff had been informed about the Duty of Candour although not all of the staff we spoke with were able to tell us about this.

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- We saw staff at the Harbour wards were encouraged to provide feedback and input into the developments of the older people's wards. However, ward 22 was disconnected from the main provision of services and were not listened to.

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 18 HSCA (RA) Regulations 2014 Staffing
We found the registered person did not ensure there were a sufficient number of nursing staff and who had received appropriate supervision, training and appraisal to enable them to carry out their duties.

How the regulation was not being met

At ward 22 Burnley general hospital we found high amounts of bank and agency staff being used with 807 requests from January 2015 to April 2015 and 118 of shifts not being filled. The risk register also highlighted lack of RMN cover and staff redeployment. We found staff had not always received supervision and or appraisals. The trust also confirmed that there was only one RMN covering at night when there should have been two.

Ward 22 had insufficient levels of nursing staff on duty during the day against the trust figures provided for the period of January 2015-March and Bronte, Wordsworth, Dickens in March 2015 also.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We found the registered person had not protected people against the risks of inappropriate or unsafe care and treatment by means of assessing the risks to the health and safety of persons by ensuring the premises used are safe.

How the regulation was not being met

At ward 22 Burnley general hospital and the older adult wards at the Harbour, we found no ligature risk assessment had been completed to identify and manage any risks to persons using the service. We saw there were

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Requirement notices

many identified ligature risks throughout the ward areas. There were no call alarms fitted on ward 22, in patient areas to allow patients to summon assistance if needed to ensure their care and treatment was provided in a safe way.

Regulation 12 (1) (a) (b) (d)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

We found the registered person had not protected people against the risks of having their privacy and dignity needs met.

How the regulation was not being met

At ward 22 Burnley general hospital, we found breaches in compliance with the Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) which could compromise the dignity and privacy of patients. Because access to reach bathroom and toilet areas meant patients had to walk through communal areas occupied by either sex which opened out onto the main ward communal area.

Regulation 10 (1) (2) (a)