

Lancashire Care NHS Foundation Trust

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

## Quality Report

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Date of inspection visit: 5 to 14 September 2016

Date of publication: 11/01/2017

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5CA	Burnley General Hospital	Dunsop Ward Edisford Ward Hodder Ward Stock Beck Psychiatric intensive care unit	BB1 3BL
RW5FA	Ormskirk Hospital	Scarisbrick Unit Lathom Suite Psychiatric intensive care unit	L39 2JW
RW5AA	Royal Blackburn Hospital	Calder Psychiatric intensive care unit Darwen Ward	BB2 3HH

# Summary of findings

		Hyndburn Ward Ribble Ward	
RW5Z2	The Orchard	The Orchard	LA1 4JJ
RW5KM	The Harbour	Byron Psychiatric intensive care unit Churchill Ward Keats Psychiatric intensive care unit Orwell Ward Shakespeare Ward Stevenson Ward	FY4 4XQ

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

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

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 acute wards for adults of a working age and psychiatric intensive care units as good because:

- There was good risk management. Patients had their risks assessed on admission and on an ongoing basis. Ligature risk assessments and reviews of the environment had been carried out.
- The service reviewed staffing levels daily. Staffing levels were adjusted to meet the need of each ward. There was an ongoing programme of recruitment to vacancies. Wards used regular bank and agency staff where possible.
- Buildings were clean and well maintained. There were regular checks of equipment and maintenance records were in place. There were appropriate health and safety checks.
- There was good management of medication. Prescribing was in line with National Institute for Health and Care Excellence guidance. Pharmacists attended each ward daily to review prescribing and medication management. A new electronic prescribing system was being introduced. Staff were positive about the new system.
- There was good use of de-escalation techniques across the wards. Staff had worked with the trust's violence reduction team to lower incidents of violence and aggression on the wards. Rapid tranquilisation and seclusion were used appropriately.
- Patients received input from a range of mental health professionals. There was a multidisciplinary approach to the delivery of care. Staff reported good working links with other services within the trust and external organisations.
- There was good adherence to the Mental Health Act and Mental Capacity Act. Mental Health Act administrators provided input into each ward and provided daily updates on the status of each patient. Patients had access to advocacy services and were aware of their rights under mental health legislation.

- Patients were generally positive in the feedback they provided. Staff were considered caring and compassionate and the majority of patients were happy with the care they received. However, some patients reported a negative experience and raised concerns over staff capacity and attitude.
- There was a centralised process to manage bed availability and admissions. This helped the service make maximum use of its resources. Out of area placements and delayed discharges were monitored.
- Patients had access to a range of information. Translation services were available if required.
- There was a governance framework to support the delivery of care. An audit programme was in place. Adverse incidents were reported and reviewed. Staff were able to submit items to a risk register. Wards received monthly performance reports.

However:

- Compliance with mandatory training was below the trust target.
- There was a suspended ceiling in place at Stock Beck psychiatric intensive care unit which posed a potential ligature risk to patients.
- Formal clinical supervision was not happening in line with the trust policy.
- Compliance with basic life support and immediate life support training was low.
- There was some inconsistency in the recording of monitoring of patients following the administration of rapid tranquilisation. We also found some gaps in the recording of observations on some wards.
- Three wards had dormitory sleeping arrangements. This impacted upon patients' privacy and dignity.

# 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:

- Compliance with basic life support and immediate life support training was low. Average compliance with basic life support was 59%. Average compliance with immediate life support training was 41%. This meant that staff trained in immediate life support might not be immediately able to attend an emergency if required.
- Compliance with mandatory training was low. Seven of the 17 wards had a mandatory training compliance rate below 75%. However staff we spoke with demonstrated a good knowledge of their roles and responsibilities and were competent to carry them out.
- The level of qualified staff meant that ward managers were not always able to fulfil managerial roles due to the need to provide clinical cover. Staffing levels meant that staff did not always have capacity to access training or team meetings.
- There was a suspended ceiling in place at Stock Beck psychiatric intensive care unit which posed a potential ligature risk to patients.
- There was inconsistency in the recording of monitoring of patients following the administration of rapid tranquilisation.
- There was inconsistency in the recording of observations on some wards.

However:

- Wards were clean and well maintained. Wards complied with guidance on same sex accommodation.
- Seclusion rooms allowed clear observation, two way communication and had toilet and shower facilities. Seclusion rooms met Mental Health Act code of practice requirements.
- The service was proactive in managing staff resources to provide care. Staffing levels were reviewed daily and adjusted in line with acuity on the wards. The safecare system was used to monitor staffing and there was oversight from senior management. The trust was actively recruiting to vacancies.
- There was good use of de-escalation techniques across the wards.
- There was good medication management on wards. Pharmacists attended wards daily and reviewed prescribing. Medication stock levels were monitored and medication was stored appropriately.

Requires improvement



# Summary of findings

- Staff were knowledgeable around safeguarding and understood trust policies and procedures in this regard. There were good links with local safeguarding bodies.
- Serious incidents were investigated using root cause analysis. Incident reports were comprehensive and included action plans.

## Are services effective?

We rated effective as good because:

- Patients received input and care from a range of mental health professionals.
- Medication was prescribed in line with National Institute for Health and Care Excellence. There was good monitoring of prescribing by the pharmacy department.
- There was a programme of audit and service improvement.
- There were regular reviews of care in multidisciplinary meetings. There were effective handovers between shifts.
- There were good links and working relationships with other teams and services both within and external to the trust.
- There was good adherence to the Mental Health Act and Mental Capacity Act. Mental Health Act administrators inputted into each ward. They provided daily updates on the status of each patient.

However:

- Formal clinical supervision was not occurring in line with the trust policy. However, staff were supported and able to seek help.
- Appraisal rates were low across the service. This was due to a new appraisal system that had been introduced in April 2016. As a result, appraisal rates had been reset and annual compliance rates would not be available until April 2017.

Good



## Are services caring?

We rated caring as good because:

- Staff treated patients with kindness, dignity and respect. We observed positive interactions between staff and patients during our inspection.
- There was an admission process which informed and orientated patients to the ward and service.
- Feedback from patients was generally positive. The majority of patients felt that staff were empathetic and caring.
- There was access to independent advocacy services, which were advertised on the wards.

Good



# Summary of findings

However

- Some patients we spoke with were not positive about staff. We received negative feedback from 28% of the comment cards completed by patients. They raised concerns about staff capacity and attitude.

## Are services responsive to people's needs?

We rated responsive as good because:

- There was a central bed management hub to oversee the allocation of available beds.
- There was a range of facilities and activities available to patients. However, the delivery of activities was dependent upon staff capacity.
- There was a range of information available for patients on wards.
- Patients had access to spiritual support.
- There was access to translation services including face to face, telephone and document translation.
- There was a process in place to manage complaints. Staff were aware of the policy supporting the complaints process.

However

- Three wards had dormitory sleeping arrangements. This impacted upon patients' privacy and dignity.

Good



## Are services well-led?

We rated well-led as good because:

- There was a governance structure to support the delivery of care. There were systems to monitor compliance with mandatory training, supervision and appraisal.
- Staff we spoke with were aware of the trust's vision and values.
- There were centralised processes to monitor bed management, staffing levels and delayed discharges.
- Ward managers received regular performance reports and had access to live performance data.

However:

- Not all teams were holding regular team meetings.
- Compliance with mandatory training, supervision and appraisal was low.

Good





# Summary of findings

## Information about the service

Lancashire Care NHS Trust provides acute inpatient wards and psychiatric intensive care units to the population of Lancashire. The service provides care to men and women aged eighteen years and over with a mental health illness. Services are provided to patients who are admitted informally and patients who were compulsorily detained under the Mental Health Act. The service is based across 17 wards at five different locations. These are:

The Harbour is a purpose built mental health facility located in Blackpool. The Harbour includes four adult mental health wards and two psychiatric intensive care units.

The Orchard is a standalone 18 bed mixed sex mental health unit located in Lancaster.

The Scarisbrick Centre is located at Ormskirk District General hospital. The Scarisbrick Centre includes a 21 bed mixed sex acute ward and a four bed psychiatric intensive care unit.

Burnley General hospital houses three acute wards and one psychiatric intensive care unit.

The Royal Blackburn hospital houses three acute wards and one psychiatric intensive care unit.

The service is organised into four localities. These are Chorley and South Ribble, East Lancashire, North Lancashire and West Lancashire.

Wards that serve the Chorley and South Ribble locality are located in the Harbour. They are:

Byron, a six bed female psychiatric intensive care unit

Churchill ward, a 18 bed male acute ward

Shakespeare ward, a 18 bed female acute ward

Wards that serve the East Lancashire locality are located at the Royal Blackburn hospital and Burnley General hospital. They are:

Calder, a six bed male psychiatric intensive care unit based at the Royal Blackburn hospital

Darwen ward, a 17 bed male acute ward based at the Royal Blackburn hospital

Hyndburn ward, a 20 bed female acute ward based at the Royal Blackburn hospital

Ribble ward, a 12 bed male assessment ward located Royal Blackburn hospital.

Dunsop ward, a 22 bed female acute ward located at Burnley General hospital

Edisford ward, a 12 bed female assessment ward located at Burnley General hospital

Hodder ward, a 21 bed male acute ward located at Burnley General hospital

Stock Beck, a four bed female psychiatric intensive care unit based at Burnley General hospital

Wards that serve the North Lancashire locality are located in the Orchard and the Harbour. They are:

The Orchard, a 18 bed mixed sex acute ward

Keats, a eight bed male psychiatric intensive care unit located at the Harbour

Orwell ward, a 18 bed male acute ward located at the Harbour

Stevenson ward, a 18 bed ward located at the Harbour

Wards that serve the West Lancashire locality are located at Ormskirk District General hospital and at the Harbour. They are:

Scarisbrick inpatient unit, a 21 bed mixed sex acute ward located at the Scarisbrick Centre

Lathom Suite psychiatric intensive care unit, a four bed male psychiatric intensive care unit based at the Scarisbrick Centre

The CQC last inspected the service in April 2015 as part of a comprehensive inspection of Lancashire Care NHS trust. The service was rated as requires improvement. We found the following breaches of regulation:

Regulation 17 Good governance

Regulation 18 Staffing

# Summary of findings

## Our inspection team

Our inspection team was led by:

Chair: Neil Carr OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Inspection Managers: Sharon Marston and Nicola Kemp, Care Quality Commission

The team that inspected acute wards for adults of working age and psychiatric intensive care units included six CQC inspectors and six specialist advisors. These included two consultant psychiatrists, two mental health nurses, an occupational therapist and a psychologist.

## Why we carried out this inspection

We inspected this core service as part of our ongoing 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?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the trust's acute wards for adults of working age and psychiatric intensive care units, asked a range of other organisations for information and sought feedback from patients at focus groups.

We carried out announced visits between 5 and 15 September 2016. We visited 13 acute adult admission wards and four psychiatric intensive care units. During the inspection visit, the inspection team:

- visited all 17 of the wards across the five locations and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 42 patients who were using the service

- spoke with four family members and carers of patients
- spoke with the managers or acting managers for each of the wards
- spoke with 78 other staff members; including doctors, nurses, support workers, pharmacists and clinical psychologists
- attended and observed 14 care review meetings, one admission review, two hand-over meetings and a bed management hub meeting.

We also:

- collected feedback from 29 patients using comment cards
- looked at 78 treatment records of patients
- looked at 130 prescription charts
- carried out a specific check of the medication management on the wards we visited
- looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of findings

## What people who use the provider's services say

We spoke with 42 patients and gathered feedback from 29 comment cards. Feedback from patients overall was positive. Patients told us that staff were caring, compassionate and interested in their wellbeing. However, not all patients were positive and some expressed concerns over staff capacity and attitude.

Patients reported that the activities they accessed were beneficial; however, some patients told us that leave and activities had been cancelled due to low staffing levels. Overall patients were positive about the care they were receiving.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to improve

- The trust must ensure that staff have an appropriate level of training in basic life support and immediate life support training in line with National Institute for Health and Care Excellence guidance NG10 (Violence and aggression: short term management in mental health, health and community settings).
- The trust must remove the potential ligature risk posed by the suspended ceiling at Stock Beck psychiatric intensive care unit.

### Action the provider **SHOULD** take to improve

#### Action the provider **SHOULD** take to improve

- The trust should ensure that clinical supervision is delivered in line with the trust policy.
- The trust should ensure that staff are compliant with mandatory training requirements.

- The trust should ensure staff receive annual appraisals.
- The trust should ensure there is consistent recording of monitoring of patients following the use of rapid tranquilisation.
- The trust should ensure there is consistent recording of observations of patients.
- The trust should ensure staffing levels are sufficient to support the delivery of activities and leave.
- The trust should ensure that environmental ligature risk assessments are available on wards and capture all risks.
- The trust should ensure that local team meetings take place.

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
Dunsop Ward	Burnley General Hospital
Edisford Ward	Burnley General Hospital
Hodder Ward	Burnley General Hospital
Stock Beck Psychiatric intensive care unit	Burnley General Hospital
Scarisbrick Inpatient Unit	Ormskirk Hospital
Lathom Suite Psychiatric intensive care unit	Ormskirk Hospital
Calder Psychiatric intensive care unit	Royal Blackburn Hospital
Darwen Ward	Royal Blackburn Hospital
Hyndburn Ward	Royal Blackburn Hospital
Ribble Ward	Royal Blackburn Hospital
The Orchard	The Orchard
Byron Psychiatric intensive care unit	The Harbour
Churchill Ward	The Harbour
Keats Psychiatric intensive care unit	The Harbour
Orwell Ward	The Harbour

# Detailed findings

Shakespeare Ward

The Harbour

Stevenson Ward

The Harbour

## 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.

Average compliance with Mental Health Act training across the service was 43%. However, staff demonstrated a good knowledge of the Act. Care and treatment was generally delivered in line with the Mental Health Act and code of practice. Mental Health Act administrators supported staff and provided daily updates on patients' legal status,

renewal dates for their sections and reminders when patients were due to have their rights read to them. However, we found one example where a patient's right were overdue and one example when an informal patient had not been able to leave the ward for 24 hours.

Patients had access to independent mental health advocacy services. Patients we spoke with were aware of their legal status under the Mental Health Act and understood their rights.

## Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provided two Mental Capacity Act training modules to staff. The average compliance across the service for level one training was 78%. The average compliance across the service for level two training was 41%.

Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act and the five statutory principles. Staff were able to seek guidance from a central team within the trust. There was a Mental Capacity Act policy in place.

Patients had their capacity assessed however; this was not always clearly recorded in care records. Patients were supported to make their own decisions in line with the principles of the Mental Capacity Act.

There was a policy around Deprivation of Liberty safeguards. Staff were able to seek advice from a central team. Staff we spoke with demonstrated a good knowledge of Deprivation of Liberty safeguards and were able to explain when they would be made.

# 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

## Our findings

### Safe and clean environment

Wards based at The Harbour, The Orchard and Ormskirk hospital were located in modern purpose built facilities. However, wards based at Burnley General hospital and the Royal Blackburn hospital were located in older buildings which were not purpose built. These environments posed a greater challenge for staff and the delivery of care. This was due to their layout and available facilities.

Scarlsbrick inpatient unit and the Orchard were both mixed sex wards. They were compliant with guidance on same sex accommodation. Male and female sleeping areas were separate. Members of one gender did not need to pass the bedrooms of the opposite gender to access bathing facilities. There were separate male and female lounges available. All other wards were single sex wards.

Wards we visited were clean and well maintained. Cleaning records were up to date and demonstrated that the wards were cleaned regularly. We observed domestic staff cleaning ward areas during our visit. Domestic staff told us they were supported in their role. Wards had completed patient led assessments of the environment. The trust provided scores for wards at the Harbour (98%), the Scarlsbrick Unit (96%) and the Orchard (96%). The average rate across the three sites was 97%. The national average is 98%. Patient led assessments of the environment are self-assessments undertaken by NHS and other health care providers. They include at least 50 members of the public known as patient assessors. They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services.

Equipment, furniture and décor were in a good condition and well maintained. Electrical equipment had been tested in line with portable appliance testing regulations. However, there was furniture on Calder ward that required replacing. This had been identified by the trust infection prevention and control specialist nurse. The issue was addressed during our inspection.

Wards adhered to infection control principles. There were hand sanitisers and appropriate personal protective equipment available to staff. We saw guidance on proper

handwashing techniques displayed by sinks in both bathroom and kitchen areas. We observed staff following good infection control practice during our visit. Support was available from the trust infection control team and specialist infection control nurses.

The layout of wards meant that staff were not able to observe all parts of the ward. However, this was managed by the use of convex mirrors, CCTV and enhanced staff observations. Staff we spoke with displayed a good knowledge of blind spots on their wards and were aware of the risks associated with them. Each ward had an identified safety and security nurse. This nurse carried out half hourly checks of the environment. This was in addition to the observations staff carried out on patients.

There were ligature points on wards that we visited. A ligature is a place to which patients intent on harming themselves might tie something to strangle themselves. Wards had ligature risk assessments in place. However, the ligature assessment from Ribble ward was not available on the ward in hard copy. In general, the ligature risk assessments we reviewed captured the visible ligatures on wards. Ward managers and staff had knowledge of ligature points on their wards and the associated risk. Risks were managed through enhanced observation levels. However, on Hyndburn ward we identified a multi-function room where the window handles were potential ligature points. Patients had free access to the room to watch television. This had not been captured on the ligature risk assessment. At Stock Beck psychiatric intensive care unit there was a false ceiling in the communal area. The area was under constant observation. There had been one incident when a patient had tried to access the ceiling space but staff intervened.

All wards had access to clinic rooms. Clinic rooms were clean, tidy and well organised. The rooms were well equipped and had facilities for monitoring patients physical health. This included blood pressure monitors, electrocardiogram machines and weighing scales. However, not all of the clinic rooms had an examination couch. Hyndburn and Darwen ward did not have sufficient room in their clinic rooms for an examination couch. This meant that patients were examined in their bedrooms instead. Resuscitation equipment including automated

# Are services safe?

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external defibrillators and oxygen were available and regularly checked in all clinical areas. However, we found a six day gap in the records for resuscitation equipment on Stevenson ward. Emergency drugs were checked regularly; they were all up to date and were easily accessible.

Not all of the wards we visited had a seclusion room in place. There were seclusion facilities on Keats and Byron psychiatric intensive care units at the Harbour. These facilities could be utilised by other wards in the location if required. Staff on those wards were able to escort patients to the seclusion facilities without having to enter public areas.

At Burnley General hospital there was a seclusion room available on Stock Beck psychiatric intensive care unit. This was used by all four wards based at the hospital. This meant that patients on Edisford and Hodder wards who required seclusion had to be brought down from the first floor to the ground floor using a lift. Patients on Dunsop ward were on the ground floor but had to be escorted across to Stock Beck. Patients from all three wards who were accessing seclusion facilities had to be escorted past the main public entrance to the building. Staff explained there was a procedure to support this. This included the use of control and restraint teams if required to escort the patient. Staff went ahead to clear public areas in order to protect the privacy of clients being transferred into seclusion.

At the Royal Blackburn hospital there was a seclusion room available on the Calder psychiatric intensive care unit. This was utilised by all four wards based at the hospital. This meant that patients on Darwen, Hyndburn and Ribble ward who required seclusion had to be escorted through to Calder psychiatric intensive care unit. Staff on Hyndburn and Ribble ward explained that this meant escorting patients in a lift and through nine double doors to access the seclusion facility. There was a procedure in place to support this including the use of control and restraint teams if required to escort the patient. Staff went ahead to clear corridor areas in order to protect the privacy of clients.

There was a seclusion room in the Lathom Suite psychiatric intensive care unit at Ormskirk hospital. Patients on Scarisbrick inpatient ward could access the facility if

required. However, the Scarisbrick inpatient ward also had an extra care area, which they used in the first instance to manage agitated patients. There was an extra care area and a seclusion room at the Orchard.

Seclusion rooms and extra care areas contained clocks that were visible to the patient. This helped patients orientate to the time of day. Facilities had appropriate two way communication systems in place. This enabled patients and staff to talk and interact. There were toilet and bathing facilities available to patients in seclusion. Staff were able to observe patients whilst they were in seclusion. However, in the seclusion room on Byron psychiatric intensive care unit there was a blind spot. This was mitigated by CCTV.

Staff on each ward had access to personal alarms whilst on duty. Staff we spoke to knew how to activate the alarms and how to respond. Alarms were signed in and out centrally. There was monitoring and maintenance of alarm systems. Not all wards had nurse call systems in patient bedrooms.

## Safe staffing

Prior to the inspection, the trust provided us with staffing data. This reflected staffing levels in April 2016. As part of the inspection, we asked for updated data to better reflect the current position. The May 2016 data is recorded below:

Scarisbrick inpatient unit

Establishment levels for qualified nurses (whole time equivalent): 15.7

Establishment levels for nursing assistants (whole time equivalent): 11.5

Qualified nursing vacancies (%): 48%

Nursing assistant vacancies (%): 5%

Lathom suite psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 10.4

Establishment levels for nursing assistants (whole time equivalent): 12.2

Number of vacancies for qualified nurses (whole time equivalent): 0

Number of vacancies for nursing assistants (whole time equivalent): 0

The Orchard



# Are services safe?

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Establishment levels for qualified nurses (whole time equivalent): 15.8

Establishment levels for nursing assistants (whole time equivalent): 18.4

Qualified nursing vacancies (%): 10%

Nursing assistant vacancies (%): 0

Byron psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 16

Establishment levels for nursing assistants (whole time equivalent): 19

Qualified nursing vacancies (%): 47%

Nursing assistant vacancies (%): 12%

Churchill ward

Establishment levels for qualified nurses (whole time equivalent): 16

Establishment levels for nursing assistants (whole time equivalent): 19

Qualified nursing vacancies (%): 18%

Nursing assistant vacancies (%): 19%

Keats psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 16

Establishment levels for nursing assistants (whole time equivalent): 19.

Qualified nursing vacancies (%): 26%

Nursing assistant vacancies (%): 0

Orwell ward

Establishment levels for qualified nurses (whole time equivalent): 16

Establishment levels for nursing assistants (whole time equivalent): 19

Qualified nursing vacancies (%): 27%

Nursing assistant vacancies (%): 9%

Shakespeare ward

Establishment levels for qualified nurses (whole time equivalent): 16

Establishment levels for nursing assistants (whole time equivalent): 19

Qualified nursing vacancies (%): 40%

Nursing assistant vacancies (%): 23%

Stevenson ward

Establishment levels for qualified nurses (whole time equivalent): 16

Establishment levels for nursing assistants (whole time equivalent): 19

Qualified nursing vacancies (%): 22%

Nursing assistant vacancies (%): 33%

Dunsop ward

Establishment levels for qualified nurses (whole time equivalent): 15.7

Establishment levels for nursing assistants (whole time equivalent): 11.5

Qualified nursing vacancies (%): 47%

Nursing assistant vacancies (%): 39%

Edisford ward

Establishment levels for qualified nurses (whole time equivalent): 20.7

Establishment levels for nursing assistants (whole time equivalent): 13

Qualified nursing vacancies (%): 28%

Nursing assistant vacancies (%): 10%

Hodder ward

Establishment levels for qualified nurses (whole time equivalent): 15.7

Establishment levels for nursing assistants (whole time equivalent): 10.5

Qualified nursing vacancies (%): 42%

Nursing assistant vacancies (%): 0%

Stock Beck psychiatric intensive care unit



# Are services safe?

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

Establishment levels for qualified nurses (whole time equivalent): 10.4

Establishment levels for nursing assistants (whole time equivalent): 12.2

Qualified nursing vacancies (%): 30%

Nursing assistant vacancies (%): 10%

Calder psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 10.4

Establishment levels for nursing assistants (whole time equivalent): 12.2

Qualified nursing vacancies (%): 50%

Nursing assistant vacancies (%): 0

Darwen ward

Establishment levels for qualified nurses (whole time equivalent): 15.7

Establishment levels for nursing assistants (whole time equivalent): 11.5

Qualified nursing vacancies (%): 36%

Nursing assistant vacancies (%): 2%

Hyndburn ward

Establishment levels for qualified nurses (whole time equivalent): 15.7

Establishment levels for nursing assistants (whole time equivalent): 11.5

Qualified nursing vacancies (%): 44%

Nursing assistant vacancies (%): 42%

Ribble ward

Establishment levels for qualified nurses (whole time equivalent): 20.7

Establishment levels for nursing assistants (whole time equivalent): 13

Qualified nursing vacancies (%): 50%

Nursing assistant vacancies (%): 22%

Bank and agency use varied across the wards. The trust provided data, which showed in the period between the 1

November 2015 and 30 April 2016, there were 668 shifts filled by bank staff and 128 shifts filled by agency staff. There had been 231 shifts that had not been filled. Wards used a regular cohort of bank and agency staff to cover shifts. Where possible wards used the same bank and agency staff to provide continuity of care to patients. Staffing levels for the wards and psychiatric intensive care units were set and monitored using a system called SafeCare. SafeCare was an electronic staffing system, which was based on the Hurst Model for Staffing. SafeCare was a live system, which assessed acuity and dependency on each ward and allowed management to review and refine staffing requirements. Wards also sent in daily reports that recorded the planned and actual number of qualified and unqualified staff on the ward. The report also captured comments on ward acuity and activity. SafeCare raised red flags if planned or actual establishments were low. If staffing levels on a ward had been raised as a red flag this was escalated to the executive director of nursing and quality and the deputy director of nursing. There was a weekly meeting held to plan staffing levels in advance. The meeting considered information from wards on patient acuity, activity levels and use of observations. Wards had access to bank and agency staff. Where possible managers tried to use bank and agency staff that were familiar with the ward.

When staffing levels were low, wards worked collaboratively to meet need and also adjusted roles. For example, ward managers and modern matrons completed clinical shifts. However, this had an impact on their ability to complete their managerial duties such as supervision. The trust was proactively recruiting to vacancies and vacancy rates were reducing. Six recruitment drives had been held since April 2015. Further recruitment programmes were under way. The trust had over recruited to nursing assistants in some areas to increase staffing levels.

Wards operated different daily shift structures. The Scarisbrick unit, the Orchard and wards based at Burnley General hospital and the Royal Blackburn hospital operated a two shift model. Wards based at the Harbour were established for a three shift model. However, due to vacancies they were operating a hybrid shift pattern. Staff at Ormskirk hospital working on the Scarisbrick inpatient unit and Lathom Suite were also responsible for staffing the locations health-based place of safety when in use.

# Are services safe?

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

The trust provided data to show staff sickness levels in the period April 2015 to April 2016. The average sickness rate across the 17 wards was 9%. This is above the England average of 4%. The highest sickness rate was on Orwell ward (17%). The lowest sickness rate was Calder psychiatric intensive care unit (2.5%).

Whilst there was always one qualified staff member on duty there had been instances across the ward when that individual was the only qualified staff member on the shift. This meant if they were involved in other duties, for example, medication rounds there may not be a qualified staff member in communal areas.

Patients we spoke to told us that they were able to speak to nursing staff when they needed to. Patients had one-to-one time with key workers and this was recorded in care notes. However, both staff and patients told us that on occasions one-to-one sessions had to be postponed. This was due to staffing levels and activity on the ward. When this occurred, a new session was held as soon as possible.

Staff and patients that we spoke to told us that escorted leave and activities were occasionally delayed or cancelled. This was due to acuity on the ward and level of staffing. However, this was not a common occurrence and was not always related to staffing levels. Occupational therapists, health and well-being workers and restart and recovery teams provided activities on different wards. The trust was unable to provide specific figures for the number of times leave or activity had been cancelled. However, they stated the adult mental health network would consider gathering this data on a regular basis and reporting on the issue to the quality group.

Medical cover was available both day and night for all wards. Consultants and junior doctors were allocated to wards and based on site during the day. Out of hours, an on-call rota provided cover. Staff were able to access a psychiatrist in an emergency.

The trust provided a programme of mandatory training to staff. The overall compliance rate for the service was 77%. There were seven wards where compliance was below 75%. They were:

Ribble ward, 74%

Churchill ward, 71%

Orwell ward, 70%

Keats psychiatric intensive care unit, 69%

Hyndburn ward, 69%

Byron psychiatric intensive care unit, 64%

Stevenson ward, 63%

Staff received basic life support (resuscitation) training and immediate life support training as part of the mandatory training programme. However compliance with this training was low. The average compliance rate with resuscitation training was 59%. Only two wards had a compliance rate over 75%. They were Calder psychiatric intensive care unit and the Orchard. The average compliance rate with immediate life support training was 41%. None of the wards had a compliance rate above 75%. National Institute for Health and Care Excellence guidance CG10 (Violence and aggression: short term management in mental health, health and community settings) states that staff trained in immediate life support and a doctor trained in resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used. Compliance with immediate life support training meant there was a risk to patients who might have required assistance following a restrictive intervention.

## Assessing and managing risk to patients and staff

We reviewed 78 care records across the 17 wards. In general, risk assessments were of a good quality, comprehensive and up-to-date. However, we found that one record did not have a fully completed risk assessment present. We found that nine of the 78 risk assessments were overdue for a review.

On the psychiatric intensive care units, there were some blanket restrictions in place. However, these were proportionate to the nature of the client base. For example, patients did not have free access to their bedrooms during the day. Staff used a swipe card to open bedroom doors. Blanket restrictions are restrictions on patients' freedom that apply to everyone rather than being based on individual risk assessments. Restrictions that were in place had been risk assessed.

Most patients were detained under the Mental Health Act 1983. Informal patients were able to leave the wards. Staff would speak to informal patients prior to them leaving. This enabled them to review patient risks. However, we

# Are services safe?

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spoke with one patient who had been unable to leave the ward for 24 hours. They told us this was because a doctor had to assess them. It was unclear under what authority they had been detained.

The trust had a policy for searching patients. Staff understood the policy. Patients were asked for permission to carry out a search. If the patient refused, staff carried out a risk assessment to determine the need to proceed with a search. Patients belongings were recorded on admission.

The trust had relaunched its observation policy in April 2016. There were three levels of observation; intermittent, continuous with eyesight and continuous within arms reach. Intermittent observations should occur at irregular times between 15 and 30 minutes apart. There should be at least three checks in every hour. We observed staff carrying out observations during the inspection. We reviewed observation records on five wards. We found that on one ward (Ribble ward) there were some gaps in four of the records we reviewed. The longest gap without an observation being recorded was two hours.

Between 1 December 2015 and 3 June 2016 there had been 149 incidents of seclusion on acute admission and psychiatric intensive care units. Four of these were instances of long term segregation (3%). The highest use of seclusion was on Keats psychiatric intensive care unit (39 instances).

We reviewed the use of seclusion on four wards. The use of seclusion had been appropriate. Overall seclusion records were up to date and complete. However, we found that there were gaps in some of the seclusion records. For example, we found instances where there were gaps in nursing observations. We found one instance where there was no recorded evidence that a planned two hour review had taken place.

Between 1 December 2015 and 3 June 2016 there had been 957 incidents of restraint on 230 different patients in acute admission and psychiatric intensive care units. The highest use of restraint was on Byron psychiatric intensive care unit (196 instances). Restraint had been used on 21 people during this time. Of the 957 restraints carried out across the service 35 (4%) were incidents of prone restraint. Fifteen of the prone restraints resulted in the use of rapid tranquilisation (43%). The highest use of prone restraint and rapid tranquilisation was on Stock Beck psychiatric

intensive care unit. There had been seven instances of prone restraint and four instances of rapid tranquilisation during that period. The use of prone restraint was monitored by the trust and reviewed through the governance structure.

Staff were given training on the management of violence and aggression and violence reduction techniques. The service had worked with the trust's violence reduction team on a series of initiatives to reduce violence and aggression on the wards. A policy on the management of violence and aggression was in place to support staff. Restraint was only used when de-escalation had failed. The use of prone restraint or rapid tranquilisation was a last resort. A policy on the use of rapid tranquilisation was in place to support staff. We reviewed the records of 10 patients who had been administered medication for rapid tranquilisation. We found that incidents were recorded in nursing notes and datix entries had been made. This was in line with the trust policy. However, it was not always clear that patients were monitored in line with the policy after the administration of rapid tranquilisation. Staff we spoke to described some confusion about where monitoring should be recorded as the trust policy included a monitoring sheet that was not referred to within the document. Where patients were in seclusion the recording of monitoring formed part of the seclusion record. The trust had completed its own audit against National Institute for Health and Care Excellence guidance NG10 (management of violence and aggression). An action plan had been developed but was not due to be fully implemented until October 2016.

Staff demonstrated a good understanding of safeguarding procedures and reported positive links with local safeguarding services. We saw examples in the case notes we reviewed of safeguarding issues being identified, reported and managed. There was a trust safeguarding policy in place. Staff were able to access advice from a central safeguarding team and lead safeguarding nurses.

Staff received training in safeguarding vulnerable children and adults. The average rate of compliance with safeguarding adult training was 90%. There were no wards where compliance was below 75%. Compliance rates with safeguarding children training were varied. There was full compliance with level one training where it was applicable. Average compliance with level two training was 69%. There were six wards where compliance was below 75%. They were:

Stevenson ward, 71%

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

Churchill ward, 50%

Orwell ward, 56%

Keats psychiatric intensive care unit, 55%

Ribble ward, 64%

Byron psychiatric intensive care unit, 33%

Average compliance with level three safeguarding training was 55%. There were 12 wards where compliance was below 75%. They were:

Shakespeare ward, 55%

Stevenson ward, 23%

Churchill ward, 22%

Orwell ward, 24%

Keats psychiatric intensive care unit, 30%

Ribble ward, 50%

Hyndburn ward, 64%

Stock Beck psychiatric intensive care unit, 62%

Edisford ward, 64%

The Orchard, 45%

Scarbrick inpatient unit, 47%

Lathom Suite psychiatric intensive care unit, 63%

Byron psychiatric intensive care unit, 29%

There was good medicines management practice on the wards. Pharmacists and pharmacist technicians attended each ward daily during the week. They reviewed prescription charts, provided advice and carried out checks on medication including stock levels. There were procedures for the ordering and disposing of medication and a policy around controlled drugs. Pharmacists completed medication reconciliation procedures when a new patient was admitted to the ward.

The trust was rolling out the use of a new electronic prescribing system called the e prescribing and medicines administration system. The system replaced paper records and was designed to help reduce medication errors. Staff we spoke with, including pharmacy staff were positive about the new system.

The trust had introduced a smoke free environment. However, staff told us that this was difficult to enforce. It was evident that patients were smoking within the hospital and the grounds. We smelt smoke on two of the wards we visited. We observed patients smoking in garden areas. Staff we spoke to told us that if patients were smoking, ward staff would discuss this with them. Staff asked patients to hand in their smoking paraphernalia but if patients refused staff felt, they were not able to enforce this.

There was a nicotine management policy and supporting procedures for staff to follow. This included online brief advice training. Some staff had also received level two training as stop smoking champions. Smoking cessation advice and nicotine replacement therapy was offered for patients who wished to give up smoking. We spoke to one patient who had requested nicotine therapy. The patient told us that he had been supported in his efforts to give up smoking.

## Track record on safety

In the period from 2 April 2015 to 27 March 2016 there were 118 serious incidents reported by the adult acute admission and psychiatric intensive care units. Ten incidents were reported to the strategic executive information system. NHS trusts are required to report certain incident types to the strategic executive information system. These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported:

Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public, five incidents.

Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation, four incidents.

A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially, one incident.

We reviewed five strategic executive information system reports. They were comprehensive and used root cause analysis to identify contributory factors and root causes of the incident. Reports contained evidence of family involvement. Each report had recommendations, an action

# Are services safe?

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plan and arrangements for shared learning in place. Reports had been signed off by the network director and clinical director and discussed in network governance meetings.

## Reporting incidents and learning from when things go wrong

In the period between the 1 March 2016 and the 3 August 2016, the service reported 3634 adverse incidents. Incidents were reported using the electronic DATIX system. Staff we spoke with knew what type of incidents to report and how to report them.

Adverse incident data and trends were discussed within the locality governance meetings. Learning from adverse incidents was circulated via email in the form of blue light and green light bulletins. Datix reports and lessons learnt were a standing agenda item at ward governance meetings. However, not every ward was having regular meetings and not all wards were following the standard agenda. We saw evidence of lessons learnt being shared in team meetings but this was not universal across all 17 wards.

There was a process to debrief staff and patients following an adverse incident. Debriefs were led by the team manager and staff on each ward had trained as psychological first aiders. Psychologists also carried out reflective practise sessions with staff. Staff could also be referred to occupational health and staff support services.

## Duty of candour

Duty of candour is a statutory requirement that ensures services are open and transparent with patients and carers. This includes informing patients about adverse incidents related to their care and treatment, providing support and offering an apology.

There was a trust policy on duty of candour to support staff. However not all staff that we spoke with were aware of duty of candour. However staff displayed an open and honest culture. Staff showed a good understanding of their responsibilities to be open and transparent with people in relation to care and treatment.



# 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.

## Our findings

### Assessment of needs and planning of care

We reviewed 78 care records across the 17 wards. In all of the records, a comprehensive assessment had been carried out. Assessments had been reviewed and were reflected in care plans.

All of the records had a care plan in place. However, the format in which this was captured varied. The quality of care plans we reviewed varied but overall was good. In general, care plans were personalised, holistic and recovery orientated. Of the records we reviewed we found that 75% were personalised, 81% were holistic and 87% were recovery orientated.

Staff carried out a physical health examination of patients. We found that physical health assessments were in place in 81% of the records we looked at. Some of these assessments were in paper form and not recorded on the electronic system. There was ongoing monitoring of physical health although this was sometimes difficult to evidence, as it was not always captured on care plans. Where blood testing and therapeutic drug monitoring had been completed doctors signed off the results on paper rather than authorising them on the electronic system.

We saw evidence of good practice. For example on one ward, a patient with epilepsy had been linked in with a specialist nurse who attended weekly. We saw that patients had been linked in with physiotherapy services and dietary services. We saw one patient with an eating disorder who had a specialist assessment and care plan developed by a dietician. There were procedures to access electrocardiograms and other physical health procedures. However, on one ward we found a patient who was diabetic. They had been admitted 24 hours previously. The need to administer appropriate medication for the patient's diabetes had been identified. This was recorded by the junior doctor on the patient's records. However, this had not been actioned during the patient's admission. The patient was vomiting and refusing food. The patient was transferred to accident and emergency due to concerns regarding blood sugar levels. The incident had been reported using datix and was under review.

The service used Liverpool university neuroleptic side effect rating scale. The Liverpool university neuroleptic side effect rating scale is used to monitor side effects to medication.

Records were stored in paper and electronic form. Paper based records were stored securely

in lockable cabinets. Electronic records were password protected. This meant that records were stored securely and that information and data was protected.

### Best practice in treatment and care

We reviewed 130 prescription charts across the 17 wards. Prescribing was in line with National Institute for Health and Care Excellence guidance. The e-prescribing and medicines administration system included a function that highlighted any prescribing above British national formulary levels. The pharmacy department circulated updates on changes in guidance via green light bulletins.

The service offered psychological therapies in line with National Institute for Health and Care Excellence. Psychologists inputted into each ward and along with staff offered a range of therapies. These included anxiety management, cognitive behavioural therapy, mindfulness, motivational interviewing and well-being groups.

The service had an annual audit programme. Audits carried out in the last 12 months included audits against guidance from the National Institute for Health and Care excellence. Audits had been completed against standards for the management of violence and aggression (NG10) and post-traumatic stress syndrome (CG26). In addition, the service had carried out quality spot check audits on wards as well as a review of bank, agency and local staffing. Completed audits included action plans. The audit programme included repeat audits to evidence that improvements had been made.

Wards used a range of rating scales to assess and record severity and outcomes. These included the health of the nation outcome scales and mental health clustering. Mental health clustering groups patients together based on their diagnosis and severity of symptoms. Patients were reviewed on a regular basis and could move between clusters as their condition improves or worsens.

### Skilled staff to deliver care

A range of professionals inputted into wards. These included nurses, nursing assistants, occupational

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therapists, health and well-being practitioners, psychologists and consultant psychiatrists. Pharmacy staff visited the wards each day. There were recovery and restart teams that inputted into each ward. Restart and recovery teams worked alongside occupational therapists to provide ward based and off-ward activities.

Staff were appropriately skilled for their role. The trust had a corporate induction, which new staff attended. Staff also received a local induction within their teams. We spoke to two new staff members. Both told us they had received an appropriate induction and had been supported to settle in on their ward. They had been given copies of key policies and procedures and signed to confirm that they had read them.

In addition to mandatory training staff were able to access additional specialist training to support the delivery of care. The trust had a service level agreement with two local universities for staff to undertake degree modules. These included courses on personality disorder, dual diagnosis and mentorship. Some staff had been trained in cognitive behavioural therapy, psychosocial interventions and mindfulness. In addition, we spoke with staff who had received additional training around physical health care.

The trust provided data that showed compliance with clinical supervision across the 17 wards was 51%. Compliance levels for each ward were:

Dunsop ward, 50%

Edisford ward, 40%

Hodder ward, 80%

Stock Beck psychiatric intensive care unit, 40%

Scarisbrick inpatient unit, 80%

Lathom suite psychiatric intensive care unit, 80%

Calder psychiatric intensive care unit, 29%

Darwen ward, 60%

Hyndburn ward, 50%

Ribble ward, 35%

The Orchard, 75%

Byron psychiatric intensive care unit, 40%

Churchill ward, 35%

Keats ward, 40%

Orwell ward, 50%

Shakespeare ward, 45%

Stevenson ward, 40%

Despite supervision levels being low, staff we spoke with told us they felt supported in their role. Clinical supervision was also occurring informally in conversations with senior staff and within team meetings, care reviews and multidisciplinary meetings. The trust had introduced a supervision passport for staff to capture details of this supervision.

The trust provided data on appraisal levels, which showed that compliance with the policy across the service was 26%. However, the trust had introduced a new appraisal system in April 2016. The introduction of the new system meant that compliance rates were reset to zero. As a result, the figure provided by the trust only showed staff that had an annual appraisal since April. Figures for compliance against annual appraisal for the previous year were not available. We saw evidence of completed appraisals during our inspection. Staff we spoke with who had been involved in appraisals under the new system were positive about the new approach.

There was a trust policy in place to manage poor staff performance and disciplinary issues. Team managers were able to access support from the trust's human resources team when required. We spoke to two ward managers who had managed poor performance. They told us the process was effective and that they had received good support from the trust human resources team.

## Multi-disciplinary and inter-agency team work

There were regular multidisciplinary ward rounds and care programme approach reviews. However not every ward held regular team governance or operational meetings. This was attributed to staff capacity. Handovers occurred at the beginning of each shift.

We observed 12 multidisciplinary reviews of care. Meetings were well structured and well attended. Patient involvement was facilitated. There was input from a range of professionals including doctors, nursing staff, psychologists, occupational therapists and pharmacists. There was a comprehensive review of patients. Discussions were holistic and actions were agreed collaboratively. We observed three ward handover meetings. The meetings

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were well managed and demonstrated effective communication between staff on the two shifts. Staff gave an overview of activity on the ward and provided detailed accounts of each patient.

Staff told us that there were good working relationships with other teams and services. This included community mental health teams, forensic services, services for older people and crisis teams. In general, staff felt that care coordinators maintained good contact with wards but this varied. Care coordinators attended care programme approach review meetings. Where patients did not have a care coordinator in place crisis teams facilitated 48 hour follow up checks on patients. There were good links with local authority safeguarding teams and acute hospitals.

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

Staff received Mental Health Act training as part of their essential training programme. However, compliance was varied. Average compliance across the 17 wards was 43%. However, staff we spoke with demonstrated a good understanding of the Mental Health Act and the code of practice and were aware of their responsibilities under it. Staff we spoke to told us they had also attended adhoc awareness sessions held by Mental Health Act administrators.

Care records we reviewed detailed patients detention under the Mental Health Act. Patients we spoke with were aware of their legal status and their rights under the Act. Staff regularly reminded patients of their rights during their detention. T2 and T3 forms were attached to medication cards. Patients with capacity use a T2 form to consent to the medication they have been prescribed. Where a patient lacks capacity a T3 form is used to confirm that a second opinion appointed doctor has reviewed the patients medication and is in agreement with it.

Staff could access support and advice from a central Mental Health Act team. Each ward also had input from a Mental Health Act administrator. The administrators scrutinised Mental Health Act documentation and provided a daily email with updates on compliance. This included information on the patients legal status, renewal dates for sections and when their rights were due to be read again. We reviewed the daily emails sent by the administrators for each of the wards. They were comprehensive and provided staff with the relevant information to ensure adherence to the Mental Health Act. However, we found examples were

the Mental Health Act and code of practice had not been followed. On Hyndburn ward, we found one patients whose rights were out of date. On Edisford ward, we spoke with one informal patient who had been told they could not have leave until a doctor had assessed them. The patient had waited 24 hours before the assessment was completed. Detention papers were held centrally and copies were kept in the patients' files.

There were three wards, which were located on the first floor of their building. These were Hyndburn ward at the Royal Blackburn hospital and Edisford and Hodder ward at Burnley General hospital. This meant that there was no direct access to fresh air or an outdoor space. Patients were granted section17 leave to enable them to leave the ward and access outdoor space in the hospital grounds. Where risk assessments had indicated the need for the patient to be escorted staff would facilitate this. However, both staff and patients told us there could be a delay in this depending upon staffing levels and ward activity.

Patients had access to Independent Mental Health Act advocacy services. These were advertised on wards. Staff knew how to refer patients to the service. Patients we spoke with were aware of the advocacy services available. We spoke with four patients who had accessed advocacy services. Patients had been supported by staff to do so.

## **Good practice in applying the Mental Capacity Act**

Staff received Mental Capacity Act training as part of their essential training programme. However, compliance was varied. Average compliance with level one training was 78%. Compliance with level two training was 41%. Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act and the five statutory principles. The trust had a policy on the Mental Capacity Act. Staff were aware of the policy and how to access it. Support and advice could be sought from a central team.

Between 16 January 2015 and 11 February 2016, the service made six Deprivation of Liberty safeguards applications. Staff we spoke with demonstrated a good knowledge of Deprivation of Liberty safeguards and were able to explain when they would be made. Advice and support around making applications was available from a central team.

We saw evidence that capacity to consent was being considered. However, it was not always easy to identify in care records. We reviewed 81 care records and were unable



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to locate clear evidence of capacity assessments in 12 of them. However, we saw evidence of patients being supported to make decisions for themselves. This was on a decision specific basis and in line with the principles of the Act.

Restraint was carried out in line with the definition of restraint in the Mental Capacity Act. The trust violence reduction procedure for mental health inpatient units' policy laid out the procedure for use of restraint. The policy referenced the Mental Capacity Act around the use of restraint and restraint techniques.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

We spoke with 42 patients who were using the service and gathered feedback from 29 comment cards. Overall, patient feedback was positive. Patients considered staff caring, compassionate and interested in their wellbeing. Patients reported incidents where staff had supported and reassured them. However, not all feedback was positive. Eight of the comment cards we received were negative. They raised concern about staff capacity and attitude.

We observed caring and positive interactions between staff and patients. Staff treated patients with respect and demonstrated an awareness of their individual circumstances. We observed 14 meetings where patients were either present or discussed. Within these meetings, staff showed a good understanding of patient history and need. Patients and their cases were discussed professionally.

The trust provided the results of the most recent patient led assessment of the environment. Patient led assessments of the environment are self-assessments undertaken by NHS and other health care providers. They include at least 50 members of the public known as patient assessors. They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy, dignity and wellbeing the service provided figures for:

The Royal Blackburn Hospital, 80%

Ormskirk Hospital, 85%

The Harbour, 88%

The Orchard, 88%

The average patient led assessment of the environment score for privacy, dignity and wellbeing in services across England is 86%.

### The involvement of people in the care that they receive

Patients were orientated to the ward and the service on admission. Patients were shown around the ward and introduced to other patients and staff as part of the admission process. Wards had information and welcome leaflets available for patients.

Patients were involved in their care. We saw evidence of patient involvement in care planning. However, this was not clear in all of the records we looked at. Patients we spoke with knew what was in their care plan. However, not all patients had been given a copy. Some patients told us they did not want a copy. We observed 12 meetings in which care was reviewed with patients. These included care programme approach reviews and ward rounds. Patients were active participants in discussions. Staff listened to patient views and responded to patient concerns.

Patients were able to access advocacy services. Information on advocacy services and how to access them was available on the ward. This was in both poster and leaflet form. Advocacy services attended the wards on a weekly basis to talk to patients. Staff we spoke with knew how to refer patients to advocacy services if they requested it. We spoke with five patients who had engaged with advocacy. They told us staff had supported them to do so.

Family members and carers of patients were involved in care and treatment where this was appropriate and agreed with the patient. We spoke with four family members and carers. Three of the carers that we spoke with told us they had been involved in decisions about their family members care. They had been invited to care review meetings and confirmed they received copies of correspondence relating to the care of their family members. Carers told us they could contact the ward to speak to staff if they had questions. However, they stated they often had to wait for a call back if staff were busy. The fourth carer had only just become involved with their family member's care and was not able to comment.

Patients were able to give feedback on the quality of the service they received. Patient surveys were in place including the friends and family test. There were comments and suggestion boxes available on wards. Most wards had regular patient meetings. At the Orchard the patient meeting was run by an ex-patient who now volunteered for the trust. On other wards, occupational therapy or members of the restart and recovery team ran patient meetings. However, not all wards were holding regular patient meetings; for example, there was no regular meeting on Hyndburn ward. Some of the wards we visited had 'you said, we did' boards on display. These detailed issues raised by patients and the actions taken by the service in response.

## Are services caring?

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

Patients were able to get involved in decisions about the service. At the Orchard, patients had been involved in choosing a colour scheme and decor for the patient café.

On Dunsop ward, a patient had been involved in completing environmental checks on the ward. Patients were able to sit on interview panels for new staff. However, not all patients or staff were aware of this opportunity.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

The service operated a bed management hub. All requests for beds across the service went through the bed management hub. This meant that there was central oversight of bed occupancy and a system to ensure effective use of available beds. Some ward managers expressed concern that previously the process had been driven from an administrative rather than clinical perspective. The bed management hub had recently had its staffing model reviewed. This meant that there was now a capacity and flow service manager, a band seven team leader, three band six clinical practitioners and six band four bed management assistants. The hub operated 24 hours a day seven days a week.

The bed management hub held daily phone calls with the service's modern matrons to discuss current bed occupancy and projected discharges. The phone call also allowed modern matrons to discuss the current level of acuity and activity on each ward. The bed management hub used a matrix to prioritise admissions based on risk. This considered each patient's current risks, circumstances and level of need. Where a patient was identified as needing a priority admission this was actioned.

We observed a weekly bed management hub meeting. The meeting was well managed and structured. Information was submitted from each ward and reviewed. Actions from previous meetings were followed up and new actions identified. The meeting incorporated a discharge pathway meeting. The discharge pathway meeting looked at the throughput of patients. Patients on unescorted leave were reviewed to see if they were suitable for community based treatment. Patient length of stay and complex discharges were discussed. Where there had been delayed discharges the reason for these were reviewed. There was input from a local housing team to help facilitate discharge.

Wherever possible patients would be admitted to a ward within their own locality. However, if this were not possible they would be admitted to a ward within another part of the trust. The bed management hub reviewed the placement of patients. Patients were only moved if a risk assessment or individual circumstances prompted the change. We saw instances where patients had been moved to different wards during their admission as this had brought them closer to family members and helped

facilitate visits. Some staff we spoke with told us that there were constant pressures around bed availability. Patients were able to access psychiatric intensive care units within the trust. Staff we spoke with described a pathway for the referral and transfer of patients to these units. However, there had been occasions when beds within the trust's psychiatric intensive care units were not available. In these instances, the bed management hub had worked with staff on the units to assess if patients could be transferred to other wards. When this was not possible placements in out of area psychiatric intensive care units were secured.

The trust provided data on bed occupancy rates between 1 November 2015 and 30 April 2016. Average bed occupancy was 97%. This is above the national target for bed occupancy of 85%. There were five wards with a bed occupancy of 100% or higher. They were Scarisbrick inpatient unit (100%); the Orchard (102%); Keats psychiatric intensive care unit (104%); Orwell ward (105%) and Darwen ward (111%).

In the six months prior to the inspection, the trust reported that there had been 332 out of area placements. The longest placement had been for 74 days. Forty-seven of the out of area placements were for psychiatric intensive care units. Staff maintained contact with patients and the service provider when they were out of area. Out of area placements were reviewed as part of the bed management hub meeting.

Patient length of stay varied across the wards. The trust provided average length of stay data as of 18 May 2016. The average length of stay for the psychiatric intensive care units was 155 days. The average length of stay for the acute wards was 75 days.

Between 1 January 2016 and 30 June 2016 there had been 124 delayed discharges across the 17 wards. The ward with the highest number of delayed discharges was Orwell ward (21). There were four wards that had not had any delayed discharges in this period (Ribble ward, Latham suite psychiatric intensive care unit, and Byron psychiatric intensive care unit and Calder psychiatric intensive care unit). We discussed delayed discharges with staff. Discharge planning was in place. The main reason for delayed discharges was around waiting for placement to become available and issues with accommodation. Delayed discharges were reviewed by the discharge pathway meeting. A local housing authority attended the meeting weekly to help address any issues.

# Are services responsive to people's needs?

Good 

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

Between 1 January 2016 and 30 June 2016 there had been 191 readmissions to the wards within 90 days of discharge. The ward with the highest number of readmissions was Ribble ward with 50.

## **The facilities promote recovery, comfort, dignity and confidentiality**

At Burnley General hospital three wards (Dunsop, Edisford and Hodder) had shared dormitory bays. Partitions separated the sleeping bays. We spoke with patients who were sleeping in the shared dormitories. The majority of patients told us that they were happy with the arrangement. However, one patient told us that they had requested to be moved to a single room as they found the shared dormitory to be noisy at night time. Staff regularly reviewed patients in shared dormitories and looked to transfer patients into single rooms based on need and risk. From 1 May 2015 to 30 April 2016, the average length of stay on each of the wards was; Dunsop ward 23 days, Edisford ward 56 days and Hodder 46 days. The remaining 14 wards across the service all had single bedrooms. The trust was aware of the issues that the building at Burnley General hospital posed. There was a long term plan to relocate the wards.

There was a range of rooms to support treatment and care on each ward. However, on some wards there were rooms used for dual purposes. For example there were rooms on some wards that were used for multidisciplinary meetings and also used as a quiet room or for visiting. There were activity rooms off the wards that were run by the restart and recovery teams. Patients at the Harbour had access to an onsite gym. Patients at the Harbour and the Orchard had access to a patient cafe.

Each ward had a space that could be used for visiting. There were family visiting rooms available to each ward. However, at Burnley General hospital the room used for family visits was also used as a staff room and not designed for purpose.

Patients were able to make phone calls in private. This was either by using their mobile phone in their bedrooms or by accessing the ward phone. Patients were able to personalise their bedrooms with pictures and posters. Patients had secure storage facilities within their bedrooms. There was access to hot drinks and snacks.

There were three wards, which were located on the first floor of their building. These were Hyndburn ward at the

Royal Blackburn hospital and Edisford and Hodder ward at Burnley General hospital. This meant that there was no direct access to fresh air or an outdoor space for patients. Patients were granted section 17 leave to enable them to leave the ward and access outdoor space in the hospital grounds. Where risk assessments had indicated the need for the patient to be escorted staff would facilitate this. However, both staff and patients told us there could be a delay in this depending upon staffing levels and ward activity. The other 14 wards all had garden areas or an outside space that was directly accessible to patients.

Patients we spoke with gave a mixed view on the quality of the food provided to them. Some patients were happy with the amount, quality and variety of food available. However, some patients told us that the quality of the food was poor. Quality of food is considered as part of the patient led assessments of the environment. The trust provided scores for the quality of food for wards at the Royal Blackburn hospital (96%), the Scarisbrick unit (74%), the Harbour (90%) and the Orchard (73%). The average score was 83%. The average score for services across England was 92%. Patient led assessments of the environment are undertaken by health care providers. At least 50% of the assessment panel are members of the public who are known as patient assessors.

Activity schedules were on display on each ward. Nursing staff, occupational therapists, restart and recovery teams and health and wellbeing workers provided activities. Activities were scheduled for seven days a week. We observed activities taking place during our inspection. Staff and patients we spoke with told us that activities took place in line with the schedule. However, they confirmed that activities were occasionally cancelled due to staffing capacity or ward acuity.

## **Meeting the needs of all people who use the service**

The majority of wards were able to make adjustments for patients who required disabled access. However, on Calder ward there was no assisted bathroom available. At the Harbour, there was an assisted bathroom that was shared between Stevenson and Shakespeare wards. However, the bathroom was out of commission and staff were waiting for the issue to be addressed. Three wards were located on the first floor of their building. There was a lift to enable access.

There was a range of information leaflets available on wards. These included information on mental health and

# Are services responsive to people's needs?

Good 

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

mental illness, local support services, physical health, advocacy and how to make a complaint. Wards had dedicated notice boards for some topics, for example the Mental Health Act and patients' rights. Ward staffing levels were displayed on each ward.

Staff had access to translation services. This included face to face and telephone translation. Information leaflets were not routinely displayed in other languages. However, staff were able to access translation services to have documents translated where required. Language needs were identified through referral and assessment information. Staff told us translation services were generally responsive and of a good quality. On one ward, we saw information leaflets that had been translated into the patients preferred language. The patient's care record showed the involvement of translators during their admission.

Patient's dietary requirements were met. Staff were able to order food that met the needs of different religious and ethnic groups, for example meals made with halal meat. Patients had access to spiritual support. There was a trust inter faith team that supported staff and patients. There was a chaplaincy and multi-faith room available at The Harbour.

## Listening to and learning from concerns and complaints

During the period 1 April 2015 to 31 March 2016, the service received 149 complaints. In total 21 of the complaints were upheld and 65 partially upheld. There were 13 complaints that were withdrawn and five complaints were recorded with an unknown outcome. None of the complaints were referred to the Parliamentary and Health Service Ombudsman. Keats psychiatric intensive care unit was the ward with the highest number of complaints during this period with 20.

Information about how to complain was displayed on wards and available in leaflet form. However, not all of the patients that we spoke to knew how to complain. Those that did not told us they would speak to a staff member. We spoke to two patients who had made complaints. One patient told us they were happy with how the complaint had managed. The second complaint was ongoing.

Staff we spoke with knew how to access the complaints department and were aware of the complaints policy. However, there was some variation in how locally resolved complaints were recorded. Locally resolved complaints are complaints that ward based staff are able to resolve without becoming a formal complaint made to the complaints department. Some wards were recording these on the electronic datix system. Other wards held local files with details of local resolutions.

Complaint investigations included actions to address identified issues. Complaint data and trends were discussed within the locality governance meetings. Learning from complaints was circulated via email in the form of blue light and green light bulletins. The outcome of complaints and associated learning was also discussed within team meetings. However, not every ward was having regular team meetings.

The trust provided data on the three most prevalent complaint outcomes. They were complaints related to communication with a patient or carer requiring improvement (31 complaints); complaints relating to the need to improve internal communications (21 complaints) and complaints related to a patient being unwell or symptomatic (21 complaints).



# 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.

## Our findings

### Vision and values

The trust had a vision and a set of values that had been developed with staff. The trust's vision was to provide 'high quality care, in the right place, at the right time, every time.' The trust's values were:

- teamwork
- compassion
- integrity
- respect
- excellence
- accountability

Staff we spoke with were generally aware of the trust's vision and values. We saw that staff delivered care in line with the values. New appraisal paperwork that had been introduced was based around the trust's values.

Staff we spoke with told us ward managers, modern matrons and senior management within their localities supported them. Modern matrons were a visible presence on wards. The majority of staff we spoke with were aware of senior members of staff within the service and the wider trust.

### Good governance

There was a good governance structure to support the delivery of care. Governance meetings were held at both locality and service levels. There was regular ongoing monitoring of performance and action plans in place to address concerns. There were monthly quality audits carried out on each ward.

Ward managers had access to performance dashboards. These provided live performance data and were discussed in team meetings. There was a centralised bed management hub, daily reviews of staffing levels and monitoring of delayed discharges.

There was a monitoring system in place to ensure that staff received mandatory training and supervision. However, compliance rates were low. There were systems in place to review and learn from adverse incidents. Root cause analysis was used to investigate serious incidents. Safeguarding procedures were in place and followed by staff.

There was a programme of audit in place, which covered both local priorities and compliance against National Institute for Health and Care Excellence guidance. Pharmacists reviewed prescribing practice and a new electronic prescribing system was being introduced.

Ward managers told us they had sufficient authority to run their wards and were well supported by management. Ward managers had access to leadership courses.

There were risk registers in place at locality and service level. Staff were able to submit items to the risk registers. Risk registers were reviewed and updated in governance meetings. Items on the risk register that were scored as a high risk could be escalated to the trust risk register.

### Leadership, morale and staff engagement

The trust provided data on sickness rates for each ward between 30 April 2015 and 30 April 2016. Sickness rates varied between wards. The average sickness rate across the 17 wards was 9%. The ward with the highest level of sickness was Orwell ward (17%). The average sickness rate for the trust was 5%.

There were no bullying or harassment cases in the service at the time of our inspection. Staff morale was generally good. However, this varied from ward to ward. Some staff we spoke with raised concerns over capacity and staffing numbers. However, staff felt they were providing a good service. Some of the staff we spoke with told us they felt that the trust was trying to address issues that had been identified. Staff were supported within their teams. Staff we spoke with described supportive colleagues and managers. Ward managers told us they were supported by modern matrons and senior management within the service and wider trust.

The trust offered an appreciative leadership course for ward managers and deputy ward managers. We spoke with managers who had attended the training. They considered the course to have been a valuable experience. However, not all managers had attended the course.

Staff were aware of the trust whistle blowing policy and process. Staff we spoke with told us that they would raise concerns without fear of victimisation.

Between April 2015 and March 2016 there had been 12 staff that had been suspended by the service. At the time of our inspection, four of these suspensions had been lifted or ceased.

# 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.

Staff were able to give feedback on the service and input into service development, There was an annual staff survey that was completed by the trust. Staff were also able to give feedback in team and governance meetings as well as in supervision. Staff could also send comments and suggestions to senior management within the trust using the intranet.

## **Commitment to quality improvement and innovation**

The service was engaged with research activities. Wards had been involved in a research project with the University of Liverpool around the reduction of self-harm. This had resulted in a new policy, which was at the point of ratification at the time of our inspection.



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  
**How the regulation was not being met:**

Compliance with basic life support and immediate life support was low. Average compliance with basic life support was 59%. Average compliance with immediate life support was 41%.

This was in breach of Regulation 18 2 (a)

#### 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

**How the regulation was not being met:**

The trust should ensure that buildings are safe for their intended use.

This was in breach of Regulation 12 2 (d)