

Lancashire Care NHS Foundation Trust

RW5

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5AQ	Longridge Community Hospital	Longridge Ward	PR3 3WQ

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

Overall rating for the service	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Good	●
Are services responsive?	Good	●
Are services well-led?	Good	●

Summary of findings

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Summary of findings

Overall summary

The Longridge ward team were positive and proud of the service they provided for the local community. We saw that multidisciplinary working was in place, the ward had input from therapists and a dedicated pharmacist. Access to dieticians and speech and language therapists were available and staff were positive about their working relationships.

Patient care, including managing patients nutritional needs and pain relief, were well managed.

Staff were observed talking to patients in a kind, sensitive and caring manner. Staff used the Friends and Family test as a formal tool to obtain feedback from patients or their relatives.

Staff were familiar with incident reporting procedures. The majority of staff were up to date with mandatory training. Records and medicines were appropriately audited .

Information was not readily available in different languages, staff stated they could access an interpreter as necessary.

During our inspection we visited the ward over two days as there was only one in patient on our first visit. We spoke with 14 staff, seven patients, eight relatives and we viewed seven patients medical and nursing records.

Summary of findings

Background to the service

Longridge Community Hospital (LCH) Ward is a 15 bedded inpatient facility, operational over 24 hours. It is managed by registered nurses. During normal surgery hours medical responsibility is provided by GPs based at either of the two Longridge surgeries. Preston Primary Care Centre provides out of hours medical cover.

Non acute patients are admitted to the ward according to agreed access criteria. Patients must be registered with a Longridge GP and require either post-surgical care, medical care, rehabilitation or palliative care.

Longridge Community Hospital is also home to many Community Services providing clinic rooms for service users for example; speech & language, cancer help charity meetings, alcohol awareness and leg ulcer care.

Referrals require approval by the patient's GP. Nursing staff co-ordinate assessment and planning of care with patients, relatives and carers to provide a safe and timely discharge. Discharges can involve complex packages that require multi agency input to ensure all needs, both health and social, are addressed. Signposting to other care providers is included in this planning.

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux, Chief Executive Officer, South West London and St George's Mental Health NHS Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Lorraine Bolam, Care Quality Commission

The team included three CQC inspectors.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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 visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an announced visit to the service on 13 and a further visit on the 18 May 2015 so were able to speak with more patients.

During the inspection visit, we visited the ward and looked at the quality of the environment and observed how staff were caring for patients. We spoke with seven patients who were using the service and eight patients' relatives who shared their views and experiences of the service we visited. We spoke with the ward manager and ward sister. We spoke with twelve other staff members, including, a visiting general practitioner, physiotherapist, occupational therapist, pharmacist, qualified nurses and healthcare support workers. We attended and observed two hand-over meetings, and a MDT (Multi-disciplinary) meeting.

We also carried out a specific check of the medication management on Longridge Community Ward and looked

Summary of findings

at a range of policies, procedures and other documents relating to the running of the service. We looked at seven patients' records, including clinical and management records and five prescription records.

What people who use the provider say

We spoke to seven patients and eight relatives on the ward who all expressed their satisfaction with the service provided and made positive comments about the care they received.

Patients told us that the staff were all very kind and sympathetic and that the service provided to them was 'wonderful' and could not be faulted.

Patients said that the staff helped them with eating and drinking needs.

All of the people we spoke to said that staff were efficient, kind and very helpful. Many of the people we spoke to said that there was nothing that could be done to improve the services they received, and that they felt well looked after.

Compliment letters and thank you cards were displayed in the ward area, comments included, "Thank you for your kind, sensitive care over the last few weeks of her life. Your understanding and sympathy has been a great help at this difficult time" and "You showed our family extreme compassion. Thank you for going the extra mile". One patient told us this hospital is, "The Longridge Hilton".

Good practice

Areas for improvement

Action the provider **COULD** take to improve

Consider making medicine administration a protected activity to ensure staff do not get distracted as this is a recognised cause of medication errors.

Lancashire Care NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Following a recruitment plan the staffing levels had recently been increased and nurse staffing levels were found to be appropriate to meet the needs of patients at the time of our inspection.

Staff recorded and reported incidents, completed risk assessment and risk management plans. No serious incidents had been reported which were attributed to Longridge in the last twelve months. Performance information was displayed on the ward to monitor the quality of care provided which were within acceptable ranges. Staff confirmed this was discussed at team meetings.

The ward was visibly clean, in a good state of repair and staff were observed following appropriate infection prevention practices

Pain relief and nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. However, medicine administration was not a protected activity and staff often got distracted which could increase rates of medication errors.

Records relating to patient care were detailed to identify their individual needs. Patients reported they felt safe and confident in the skills of staff.

Medical cover for the community ward was provided by the patients General Practitioners (GP's) or out of hours provider if required.

Reviews of patients progress including multidisciplinary reviews which monitored their progress and ensured planned care was still relevant.

Safety performance

- The service used a dashboard to monitor safety information. Staff used the Safety Thermometer to

record and analyse data about patient safety. This is a recognised tool used nationally by NHS organisations to measure the frequency of falls, catheter and urinary tract infections, thrombosis and pressure ulcers.

- An overview of the safety thermometer showed there had been two patients falls recorded in October/November 2014 with no harm. Staff had taken action by requesting a specialist team to risk assess the ward. Equipment was installed which alerted staff when patients moved from beds or chairs.
- All other parameters of the safety thermometer were within acceptable ranges.

Incident reporting, learning and improvement

- Staff were awareness of what was required to be reported as per the Policy.
- Incidents were reported using a Trust wide system called Datix. We viewed a list of recently reported incidents. Staff gave us an example of an incident involving a fire which was recorded on Datix within the same day.
- Computer systems were available on the ward for the relevant staff to access details on Datix.
- Health care assistants told us they would report to nursing staff any incidents that required reporting.
- We saw that incidents were investigated fully and lessons learnt were shared with staff to improve safety.

Duty of Candour

- Staff were aware of the Duty of Candour regulations.

Safeguarding

- Members of the multidisciplinary team and ward staff had a good understanding of the need to ensure vulnerable people were safeguarded and knew how to respond to allegations or signs of abuse.
- There had been no safeguarding reported to CQC in the last 12 months.
- A link nurse had been appointed at ward level to share any new or relevant adult protection information with staff. The trust lead for safeguarding was displayed on the team information board.
- Safeguarding and mental capacity training was mandatory for staff and we saw from training records that the majority of staff had completed safeguarding adults and children training. Plans were in place for those who were unable to attend the recent training.

- Staff confirmed the combination of face to face and on line training which involved the ward manager was beneficial.
- Trust safeguarding adults training was reported as at 82.48%.

Medicines

- Staff followed the trust medicines management policy which was available on the intranet. Staff were aware of this including the procedure for self medication.
- There was no on site pharmacy. Patients brought in their own medicines and the community stock would be used in order to prevent delays in discharge. Whilst at LCH medications were ordered from Lancashire Teaching Hospitals trust pharmacy along with discharge medications. If blister packs or controlled drugs were required, these were ordered from local pharmacies via the patient's GP.
- Medicines were securely stored, and administered by qualified nurses.
- We observed medicines being given to four patients which were administered correctly and appropriately.
- Systems were in place to monitor and record fridge temperatures daily to ensure storage was appropriate. Fridges containing specimens and drugs were at the appropriate temperatures according to the records of checks made.
- Plans were in place to ensure that medicines could be obtained for patients at all times. During the day they were sourced locally from an acute hospital. Out of hours, requests were made to the local primary care centre or there was an option for prescriptions to be faxed directly from the primary care centre.
- We looked at four medicine administration records for individual patients. These were clearly completed.
- A record of all Controlled Drugs (CD) that were stored and given were held in a register. Two members of staff had signed each entry in line with policy. CDs were handled, stored and recorded appropriately. A spot check on the ward demonstrated compliance.
- There was a specimen signature list available of staff who administered medicines.
- We observed the staff member could be disturbed during the medicine round, distractions for staff administering medicines increases the potential risk of errors.

- A pharmacist had, over recent months, started to provide support and guidance to the ward and was working at reducing the volume of medicines stored and reviewing the system for disposing of drugs when they expired.
- The risk register highlighted a minor concern regarding the lack of an audit trail for patients own drugs. This was being addressed.

Environment and equipment

- The ward had undergone a recent refurbishment with changes made following advice during a fire risk assessment. For example new fire doors had been put in place to provide greater protection for people.
- Systems in place for maintenance and equipment checks varied.
- Resuscitation equipment was visibly clean and in good order. Resuscitation equipment included no drugs. There was no documents to show regular checks however staff used tape around the equipment to demonstrate if it had been tampered with. For emergency oxygen the checklist was dated 12 May 2015 and there were no previous checklists available, staff confirmed the check list had just been implemented following advice from the pharmacist in line with national recommendations.
- Staff had taken positive action to request the repair of an ECG (electrocardiogram) machine, a machine used to measure the hearts electrical activity. Staff were confident this would be repaired in a timely way.
- Portable electrical equipment had been tested regularly to check equipment was safe to use and included dates when the next test dates.

Quality of Records

- Paper held patient records were in place which were securely stored in locked cabinets. Some patient information charts were kept at the end of the patient's bed so they could be readily accessible to the staff, for example food and fluid charts, observation charts. The trust had systems in place to ensure patient records remained confidential.
- An audit of records was carried out annually. We looked at the audit from December 2014 and saw actions had been addressed.

- Staff stated the main computer system was slow, they did not use hand held tablets but hoped this would be introduced in the future as they felt this would assist in record keeping.
- During our inspection we looked at the medical and nursing records for seven patients. Most of the records were fully complete, legible and included a range of documents assessing and identifying risks to patients such as the potential for falls, pressure ulcers, and thrombosis. The service advised us they would raise the one handwritten record which proved difficult to read with the staff member involved.
- Records were up to date and contained information from the multi-disciplinary team. Patients cultural and religious beliefs were also noted and acted upon were appropriate as well as referrals to other professionals.

Cleanliness, infection control and hygiene

- The ward was visibly clean and tidy.
- We viewed records indicating that most staff (excluding GP's) were up to date with training in infection prevention and control.
- Cleaning schedules and checklists were in place to assist cleaning staff with required tasks.
- A quarterly cleaning audit (Essential Steps to Safe Clean Care) were in place. The audit completed on 22 April 2015 showed the ward achieved 100% compliance with hand hygiene, personal protective clothing and sharps management.
- In addition to the cleaning staff, the ward manager also completed a weekly 'walkabout' and the results were recorded. We saw the previous records for these which were dated with required and completed actions noted.
- Steps were in place to prevent Legionnaire's Disease. We reviewed this record and saw that the checklists for it were completed on a regular basis.
- We saw evidence of regular completion of schedules for deep cleaning for the previous 6 months. These were complete, signed and dated. We saw that deep cleaning was completed after patients with MRSA (Methicillin-resistant Staphylococcus Aureus) or Clostridium Difficile had been cared for on the ward. Staff told us that weekly figures of patients with MRSA were provided to a central point in the Trust.
- Any cleaning equipment with expiry dates was within date which showed staff monitored this.

Mandatory training

- A training policy was in place which outlined the training staff were expected to complete. Training was carried out either via e-learning modules or face-to-face sessions.
- Training included : moving & handling, basic life support, fire safety, mental capacity act, and infection, prevention and control. Recent additional training attended by staff was dementia training which staff told us had given them good insight.
- Managers had identified gaps in training and took the opportunity to ensure this was completed in April and May 2015 whilst the ward was closed for refurbishment.
- For some specific training releasing staff to attend had proved difficult , for example to complete training in conflict resolution.
- We were told that a number of GP's were contracted to the trust however their training record showed low compliance on the trust figures. Senior staff told us the GP's would have received training in the organisations they predominantly worked for such as local GP practices, but we did not request this information during this inspection.

Assessing and responding to patient risk

- Admission procedures included appropriate risk assessments of key areas of health and personal care needs including; tissue viability, nutrition screening, moving and handling, infection, continence and risk assessments for falls and venous thromboembolism. We saw that the risk assessments were regularly reviewed according to the level of risk and appropriate action was taken in response to the risks identified.
- We reviewed the risk register with the ward manager. One risk included increased admissions relating to patients living with dementia. In response changes had been made to make the ward 'dementia friendly'. Flooring and signage had been changed to reflect their needs and new beds have been purchased with alarms fitted to alert staff when patients got out of bed. Plans were in place to introduce wrist bands and coloured trays to identify patients who required support.
- The manager gathered and displayed information at ward level to show performance. This included the incidence of falls and pressure ulcers. We saw patients were monitored throughout their stay through the use

of a range of tools, such as the early warning score. Patients who were identified as being at risk of falls were in more observable rooms close to the nurses' stations so they could receive additional monitoring.

- Two hourly intentional rounding was in place to improve patient observation and reduce the risk of incidents occurring for example patient falls. Staff reported this was a positive step for patient care.
- There were daily handover meetings where any changes in a patients condition were discussed. In addition, there were weekly multidisciplinary reviews of patient risks and their progress, to make sure that planned care was still relevant and that patients were making suitable progress.

Staffing levels and caseload

- Staff on the ward felt the staffing levels were safe to meet the needs of patients. We were told recruitment had recently occurred to fill vacant nursing and health care assistant posts. Staff told us they did not use acuity tools to calculate appropriate staffing levels. Instead they used historical staffing numbers. Staffing levels had increased to two registered nurses to 8 patients. If there were difficulties meeting these numbers, bank staff were employed.
- Since staffing levels were on the risk register plans were in place to follow the RCN (Royal College of Nursing) safer staffing levels. The staffing levels had been increased for each shift despite the staffing levels not yet being approved by the trust board, this demonstrates that the trust were monitoring and taking action to resolve the challenges with staffing levels.
- Staff sickness rates and causes of sickness were monitored. For example, senior staff identified a frequent cause of sickness as diarrhoea and vomiting. Checks were done to confirm these staff had received training in infection, prevention and control and the situation was being monitored in line with the trust's sickness policy.
- On admission patients had timely access to physiotherapy and occupational therapy however the amount of people requiring physiotherapy care had increased after the local acute hospital stopped providing rehabilitation services. This had been highlighted at meetings but no feedback had been given. Staff raised that if the ward was full the demand on the physiotherapists would be excessive.

- Nursing staff would be called upon to assist when only one physiotherapist was working, which happened frequently. This removed them from their nursing duties.

Managing anticipated risks

- Nursing staff told us that plans were implemented during winter to cope with seasonal pressures. For example patients were admitted from outside the local area during this time.
- Lessons had been learnt following the fire on the ward. It was identified that action plans were only available on-line and there was no telephone at the assembly point. Action had been taken to ensure that phones and paper plans were accessible.
- Following a fire risk assessment it was also identified that increased staffing levels were required to safely care for patients during incidents such as a fire. Staff told us they were ensuring staffing levels reflected this requirement, which had led to a budget overspend. This issue was on the risk register and had been addressed.

Are services effective?

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

Summary

The staff were clearly patient focused and worked towards achieving good outcomes for the people they cared for. There was some measurement of patient outcomes; the ward was involved in the Patient-Led Assessment of the Care Environment (PLACE) to measure the patients environment. We saw evidence that audits were carried out and any issues identified were actioned as necessary or appropriately escalated. Assessments for patients were completed and outcomes were recorded.

Staff worked well as a multidisciplinary team with timely access to physiotherapy and occupational therapy on admission. Staff had the opportunity to lead on areas of interest such as dementia, consent and safeguarding. Staff had received appraisals with managers. Pain relief was well managed and patients nutrition and hydration needs were appropriately assessed. Clear management structures were in place and staff were familiar with this.

Evidence based care and treatment

- Staff had access to the trust's policies and procedures in both paper form and electronically using the intranet.
- Recently introduced assessments and care plans for patients were comprehensive and included patients health and social care needs. Care plans were regularly reviewed and updated. Care and treatment was planned and delivered in line with evidence based guidelines. Patients and/or their relatives were able to tell us about their care and how it was being delivered to meet their needs.
- Therapists assessed new patients within a timeframe and set goals, for example for mobility, with the aim of promoting patient's independence for them to return home within a reasonable time.
- The ward manager carried out regular audits including, hand hygiene, records and falls. We saw action had been taken where any issues were identified, for example introducing a number of link roles.
- We saw two patients who had been assessed of being at risk of developing pressure sores and required special mattresses and chair cushions, this equipment had been readily provided.

Pain relief

- Medication for pain relief was prescribed by the patients GP. Patients indicated that they received pain relief medication when they required it.
- After consultation with 'The Harbour', a mental health hospital, staff had introduced a pain assessment tool. We observed nurses administering pain relief as required in accordance with patients' pain assessments. The pain assessment tool was developed for patients with communication difficulties and specifically for patients with dementia.
- Staff observed and monitored the condition of all patients and nurses offered prescribed pain relief in line with the GP's instructions.
- Patients were reviewed as required by GPs by an appointment system. GP's were contacted daily by ward staff with a list of patients requiring a visit or review. GPs from each surgery visited each day to see listed patients and they were contactable during surgery hours for any queries if required.
- Nurses confirmed anticipatory prescribing was always put in place for patients who were assessed as being at the end of life.

Nutrition and hydration

- Staff were made aware of up dated information. The staff notice board included a copy of the 'Procedure for identifying nutritional risk in adult community teams' April 2015.
- Patients were screened for malnutrition and the risk of malnutrition on admission to hospital using a recognised assessment tool. We found that MUST (Malnutrition Universal Screening Tool) scores had been completed regularly and referrals to dietician made when required.
- Patients were weighed according to their assessed need.
- Nutrition and fluid intake charts had been completed. Mealtimes were protected and staff were observed supporting and encouraging patients sensitively. We

Are services effective?

saw a patient who required increased calorific intake was having nutritional supplements. These had been prescribed and were being given to the patient in line with the prescriber's instructions.

- Patients had choice where to eat their meals. Seven patients we spoke with said the food was good and they always had a choice. One patient's relative told us the kitchen staff had spoken with them on admission to discuss their relative's preferences.
- The ward manager talked of the move from auditing MUST scores to a more reflective practice approach to managing quality. Staff confirmed 'live' examples of how they could have done things differently for patients was a good way of learning.

Patient outcomes

- The average length of stay on this 15 bed ward was 21 days in 2014.
- 21 patients had died on the ward in 2014 and 24 the previous year. This highlighted more local people were recognising the ward could be used for end of life care and offered local people increased choice of place to die.
- Physiotherapists and occupational therapists told us their response times to assessing new patients was monitored. The ward used a safety thermometer. Outcomes that the unit measured were for harm free care, for example, the number days since the last fall on the ward, which was November 2014 on the day of our inspection.
- Patient-Led Assessment of the Care Environment (PLACE) programme was used and focused on the environment in which care was provided, as well as supporting non-clinical services in areas such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The 2014 PLACE results showed that although Longridge ward was one of the poorest performing wards in the trust, there were no scores under 95% and all were above the national average.

Competent staff

- Staff confirmed they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The manager kept a training plan which confirmed staff had attended mandatory training.

- Informal support from managers and senior staff was effective and staff told us this was provided when they required it.
- New nurses had supernumerary time as part of their induction programme. Two recently recruited staff confirmed this and said their trust induction had been comprehensive.
- Systems were in place for regular staff supervision. Therapists confirmed they received regular clinical supervision.
- Arrangements for managing and supporting staff were in place. During the recent ward closure staff reported their annual appraisals had been completed which included discussions around their learning and development needs. Staff commented the on line system was easy to use and readily accessible.
- All staff (34) were trained in the use of the McKinley syringe driver. This is a subcutaneous infusion of medication/s by a syringe driver to provide symptom control, particularly for palliative care patients when oral medication is not possible or appropriate. Staff competencies were tested.
- Staff talked of using reflective practice, recent examples were in response to relatives comments.

Multi-disciplinary working and coordinated care pathways

- We saw evidence of a multi-disciplinary team (MDT) approach to care for patients on this ward. We spoke with a physiotherapist and an occupational therapist who promoted self care as necessary.
- We saw minutes from a MDT meeting which included detailed discussions about discharge arrangements and plans to improve discharges.
- We observed a physiotherapist and occupational therapist providing mobility support and encouragement for a patient who required rehabilitation in a competent and sensitive way.
- Staff reported multi-disciplinary working was good. MDT meetings were held weekly where social work input was discussed.

Referral, transfer, discharge and transition

- Staff followed a new standard admissions procedure issued in May 2015 to ensure the safe and timely admission of patients.
- There were early discussions regarding each patient's progress and discharge arrangements. There was MDT

Are services effective?

working which included regular meetings, individual case reviews and shift handovers. There were arrangements in place to ensure information was shared with patients and relatives in a timely way.

- The senior staff at the Minerva centre, responsible for discharge planning told us Longridge Hospital were good at managing palliative care patients. They contacted them each morning to discuss prospective patients who needed discharge.

Access to information

- The ward had well-established links with local GPs for any results.
- Some patient information was held for each patient, for example mobility, pressure relief and nutrition so information was clear for staff who were providing the care.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Staff were aware of their requirements under the Mental Capacity Act (MCA) and were able to tell us when a Deprivation of Liberty Safeguards (DoLS) application may be required.

- Interviews with staff highlighted they understood patient consent and when it should be obtained.
- Some staff were assigned as leads in areas such as Dementia and Mental Capacity. We saw evidence that staff were trained to assess mental capacity. Documentation was completed ensuring best interests were assessed and recorded. The documentation included clear questions for staff to include in their assessment such as 'does the person understand the information?' and 'what are the benefits of the proposed treatment?'. Further details were recorded such as who had assessed the person, who had been consulted, what decision had been made and the nature of the person's impairment.
- Staff told us that multi-disciplinary meetings ensured the best patient outcomes were achieved.
- We observed staff clearly asking patients for their consent and explaining what they were going to do before carrying out any treatment or personal care.

Are services caring?

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

Summary

Medical, nursing and allied health staff treated people with kindness, dignity and respect. Patients reported they felt involved in their care, and were provided with emotional support. This was supported by the positive patient experience surveys, for example the 'Friends and Family test' for Longridge ward.

However, the named nurse system was not in place which may further contribute to patients and relatives feeling involved in their care and there was no evidence of any planned or organised activities for patients to participate in to promote their independence and mental functioning.

Compassionate care

- People who used the service and those close to them were treated with respect, felt well-cared for and supported. Patients reported the staff were caring, kind and compassionate. From observations made it was evident staff had healthy relationships patients and those close to them. Staff were seen to respond to patients needs in a timely way. We observed a care worker kindly supporting a patient to elevate their legs on a footstool and saw staff replace a patient's identity wrist band to make them more comfortable.
- We spoke with seven patients and eight patients' relatives. Patients and relatives were positive about their experience on the inpatient ward.
- We observed staff supporting patients with their meals and talking with them.
- Curtains were used to respect patients privacy and staff were observed respecting privacy when supporting patients with personal care. Patients told us they were called by their preferred name and encouraged to be as independent as possible. We noted there was no name board above patients beds. This may be useful to identify individual patients, we were told this had been discussed as a future plan.
- Patient experience feedback was recorded in the Friends and Family Test. This test is used nationally to capture how patients felt about the care they received. It covers

elements of care such as courtesy and respect, confidence in the services provided and whether the views and wishes of friends and family were considered when caring for people.

- The results of the Friends and Family test were displayed on the staff noticeboard and all findings were positive. 80% of people responded positively to the question "did staff treat you with courtesy and respect?"

Understanding and involvement of patients and those close to them

- We saw patients case notes confirming that those close to a patient had been involved in the patient's care. Key questions had been asked to help make the care plan person centred. For example, a detailed explanation of the action taken to assist a patient with physiotherapy was evident.
- The ward had not yet introduced a named nurse system whereby patients would know who the lead staff were looking after them. The manager told us due to the recent introduction of new care plans she was cautious to introduce too many changes at once, however they were still looking to introduce this. Relatives we spoke with confirmed they would find it useful to know who had been caring for their relative on that day so they could direct any questions to them.
- Therapists said each care goal was discussed with the patient or their relative so they were aware of the objectives.
- There was no evidence of any planned or organised activities for patients to participate in to promote their independence and mental functioning. However there was a day room which patients could choose to sit in and socialise.

Emotional support

- Staff showed an understanding of patients' needs in terms of well being and emotional support. For example staff noted and passed on information to colleagues that one patient was lonely and in need of company, and had a preference for keeping busy.

Are services caring?

- We heard medical staff taking time to explain to patients and relatives about their medical condition and how this may affect their progress. This helped patients and relatives to be relieved of any anxieties.
- We saw in care plans evidence where staff recorded communication with the patient and their relatives.
- Despite set visiting times, there was the option of some flexibility if required so patients could maintain family contact.
- Patients reported to us how approachable the ward staff were. Patients or relatives did not raise any concerns during our inspection.
- A stand of leaflets were made available to patients and relatives in the day room which included signposting for cancer support agencies.
- Chaplains from the local community were available to patients who wanted them, in order to provide emotional support.

Are services responsive to people's needs?

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

Summary

The service was responsive to people's needs in the Longridge area of Preston and to patients out of the area at times of need. However, nursing care was delivered in a task orientated way rather than taking a person centred approach. Staff showed awareness of people in vulnerable circumstances and gave examples of how to make care more accessible to them.

People had the chance to contribute to the Friends and Family test about the service they received. Complaints were dealt with primarily at local level however these were not recorded. Information was not readily available for people whose first language was not English although there was access to an interpreter if required.

Planning and delivering services which meet people's needs

- Patients were admitted to the inpatient ward from either a nearby acute trust, care home or from their own homes referred by their GP. The reason for the patient's admission would be assessed, using specific referral criteria, namely the patient requiring nursing or medical care.
- The average length of stay at Longridge ward was 21 days in 2014. From July to December 2014 the bed occupancy was 92%, and there were 11 readmissions. Senior staff thought that the readmission rate was average.
- 21 patients died on the ward in 2014 and 24 the previous year which showed local people were considering Longridge Hospital ward as an option for end of life care.
- Bed occupancy was low at the time of this inspection due to the ward having been closed in order to upgrade in relation to health and safety issues.
- Although the ward takes patients registered with Longridge GP's, commissioners had recently used five beds for "out of area" patients in response to winter pressures on local hospitals.
- We listened to a handover of patient details from one shift to another. We saw evidence that staff were aware

of the needs of patients and how to help them both with care and well being. For example, plans for cognitive assessments were discussed and the needs of patients who were going to be discharged.

- Staff told us that care was given to patients on a task basis, rather than assigning patients to a particular staff member. By assigning patients to staff, care can be provided on a more person centred way. When we discussed this with staff they assured us that due to the size of the ward, they are able to maintain a personal approach with each patient.
- Staff had started to make improvements to the environment for people living with dementia however the 'Forget me not' documentation was not yet in place or picture cards to support patients who had difficulty communicating. Staff were aware of the use of hospital passports for patients with learning disabilities.
- We observed an integrated approach to care delivery on the ward which involved nursing staff, occupational and physiotherapists, medical staff and pharmacy. There was evidence of plans to facilitate a timely, safe and person-centred discharge for patients involving social workers as deemed necessary.

Equality and diversity

- Staff told us it was very rare when they would have to meet the needs of people from different cultural backgrounds.
- We looked at the information leaflets available in the dayroom. Staff told us they could access information for patients where English was not their first language however during this inspection, we did not see leaflets in another language on display. Staff were aware of how to access a translator if required available via the trust intranet.

Meeting the needs of people in vulnerable circumstances

- We saw evidence that staff were aware of the needs of patients with disabilities. For example, we saw notes relating to a person who was registered blind which documented that signatures were not obtained for forms relating to property but that the details had been relayed verbally.

Are services responsive to people's needs?

- Staff had received training in how to safeguard children and adults.
- Staff explained how they worked in the 'best interests' of patients and had regular contact with patients next of kin as necessary, particularly if patients were unable to make decisions for themselves. Staff were able to access advocacy services to support patients if required.
- The environment was being improved to aid people living with dementia, bold colours were being used and pictures were being put in place to stimulate interaction. One member of staff had been identified as the dementia lead on the ward to gather and cascade some specialist knowledge and information for staff.
- We saw many examples of compliment letters and thank you cards displayed in the ward area, comments included, "Thank you for your kind, sensitive care over the last few weeks of her life. Your understanding and sympathy has been a great help at this difficult time" and "You showed our family extreme compassion. Thank you for going the extra mile". One patient told us this hospital is, "The Longridge Hilton".

Access to the right care at the right time

- Staff reported they always prioritised patients at the end of life for admission, otherwise admissions would be in date order for being reviewed.
- Sufficient parking was available at the hospital. The ward provided a locally based services for the community and patients and relatives were positive about the location as it was close to home.

Learning from complaints and concerns

- We saw information in the patient information leaflet which signposted people who had any concerns to a staff member or the matron if they felt concerns were not dealt with. Plans to include information about complaining on general leaflets was recorded on the trust's risk register. There was no information on display on the ward about how to raise concerns. Information should be made available for patients and/or relatives to follow the trusts complaints procedure.
- Patients and relatives told us they would raise any concerns with the ward staff if they needed to and they felt the staff were approachable.
- There have been no formal complaints recorded for the ward in the last twelve months.

Are services well-led?

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

Summary

The trust values were clearly displayed and staff were aware of these but there was no local service vision or strategy in place. Staff had not seen members of the board locally but felt supported by their local managers and since the appointment of an Integrated Service manager they felt part of a wider team.

There were local governance procedures in place to monitor and address risks and the ward performance was monitored and areas for improvement highlighted to staff. Managers were conscious not to implement too many changes at once as this makes it difficult for staff to deal with. There were plans underway to improve the experience of people living with dementia.

Service vision and strategy

- The values of the trust were clearly displayed on the ward notice board and in the staff rest room.
- The ward had a newly appointed Integrated service manager and staff reported this had made them feel part of a wider team.
- The ward manager told us there had been a big drive for improvement over the last eighteen months. More change was possible now that staffing levels had increased.

Governance, risk management and quality measurement

- Locally held risk registers had been reviewed and updated to reflect the current situation and had been assigned to a named lead who had responsibility for the risk.
- Risks to the service such as staffing issues, medical cover and training had been identified and actions in place to address them.
- Senior staff on the ward were aware of what was on their risk register.

Leadership of this service

- The ward manager and sister were visible in the clinical area and had a strong focus on the needs of the patients and what the staff team required to do to deliver a good service.

Culture within this service

- Within Longridge Community Hospital ward, team working relationships between nurses, members of the multidisciplinary team and doctors was good and other teams spoke positively about their working relationships with the team, for example the discharge team.
- We observed staff interacting positively with the visiting GP's.
- Staff told us the ward had improved over the past eighteen months and they were proud to work at Longridge Community hospital and provide quality care for the patients.

Public engagement

- Staff were given feedback from the NHS Friends and Family Test during staff meetings and the information was displayed on the noticeboard.
- The trust collected patient feedback using the Friends and Families Test, a single question survey that asks patients "How likely is it that you would recommend this service to friends and family?" Results from the test June 2014- March 2015 showed all areas to be positive.

Staff engagement

- Staff talked of the 'weekly huddle' where they got together to discuss new policies, procedures, improvement to the service and reflective practice. In addition the staff used a 'huddle board' where staff could readily see and readily access any new information. Examples included; a new Controlled drugs policy, identifying nutritional risk procedure and management of dysphagia in palliative care.

Are services well-led?

Innovation, improvement and sustainability

- The ward were considering accessing a blood monitoring machine to improve the service for checking patients blood clotting results.
- Plans were underway to improve the services for people with dementia.
- Staff were conscious that when the ward was running at full capacity the demand for physiotherapists outweighed their capacity.
- NHS reforms may bring additional specialist services, such as chemotherapy to the ward.