

Lancashire Care NHS Foundation Trust

# Wards for older people with mental health problems

## Quality Report

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Date of inspection visit: 12 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)
RW5KM	The Harbour	Wordsworth Ward Dickens Ward Bronte Ward Austen Ward	FY4 4FE
RW5CA	Burnley General Hospital	Hurstwood Ward (formerly Ward 22)	BB10 2PQ

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

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 wards for older people with mental health problems as 'good' because:**

- The ward layout was well planned in the Harbour services: the layout used space to good effect. At Hurstwood ward, space was at a premium but utilised well. Hurstwood ward was due to close in December 2016 and a new location with more space was planned. Any ligature points were assessed and mitigated for, and reflected in the trust risk register. Staffing had been improved by the use of the safecare system, allowing shortfalls to be identified and covered. Wards were clean and well furnished. Patients had comprehensive risk assessments completed. Any incidents on the wards were reported and dealt with effectively.
- Care records were holistic, comprehensive and showed evidence of patient and carer involvement. Patients could access psychological interventions across the service. National guidelines were being followed. Physical health care was given strong consideration, and was monitored on all patients. The Mental Health Act and Mental Capacity Act were implemented and monitored effectively: regular audits and a centralised team ensured detained patients had their rights explained properly and regularly. However, it was noted that mandatory training figures for the wards did not match the figures provided by the trust and the system of core and effective training was confusing. We also saw that supervision and appraisals were being done for staff but all wards agreed that they needed to improve this aspect. Records showed that planning was in place for regular supervision and appraisals.
- Staff were seen to interact in a professional and caring manner with their patients, with time and attention being given to all. We saw activities with patients that showed consideration for mental state and abilities, and staff were able to make the activities meaningful. Patients told us that generally, they were happy with the service, and comment cards from carers were mostly positive.
- Ward staff actively tried to ensure discharge to appropriate locations were completed in a timely manner. Facilities at the Harbour site were excellent, and Wordsworth and Bronte wards used a mock 'pub' and a mock 'café' in the outdoor area for patients to relax. Hurstwood ward did not have a designated outdoor space for patients, but they were regularly taken into the hospital grounds to relax and get fresh air. The planned replacement location had a large outdoor area for patients so they did not have to be taken off the ward. Ward facilities were designed with disabled access, ensuring that wheelchairs could be used freely on the wards, and bathrooms had brightly coloured equipment so patients could easily identify facilities. The service only upheld seven complaints out of 24 complaints in the 12-month period from April 2015 to March 2016.
- Staff knew and upheld the values of the trust: there was lots of evidence on each ward explaining trust values for both staff and patients. Staff knew who their senior managers were, and a non-executive director had recently spent a shift on a ward within the service as a support worker to experience life on a ward. Quality reports compiled by the trust showed that the service was actively monitoring physical health, record keeping, mental health and observations, with good results. Wordsworth and Bronte wards had recently taken part in a human rights project with a university faculty; the results were not known at the time of the inspection.

# Summary of findings

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

### Are services safe?

We rated safe as good because:

- Blind spots were dealt with by the use of mirrors, and closed circuit television cameras were in use at the Harbour site.
- Ligation risk assessments were present on all wards, they were up to date and comprehensive.
- Hurstwood ward was the only ward that admitted both males and females, and it met all the requirements for same sex accommodation.
- The wards were clean and well furnished, and cleaning rosters were maintained.
- Staffing levels across the wards were being managed, the safecare system allowed for any problems with staffing to be identified and revised.
- Risk assessments were completed, and were comprehensive.
- Incidents were reported quickly and were dealt with effectively.
- Mandatory training was being undertaken across the service.

Good



### Are services effective?

We rated effective as good because:

- Care records were comprehensive, holistic, and up to date, showing evidence of patient and carer involvement.
- Psychological input was available across the service, providing relevant interventions for patients.
- National guidance and best practice were being followed, including improving physical healthcare: Hurstwood ward were actively recruiting a registered general nurse specifically to enhance physical health care.
- Mental Health Act documentation and application was being audited by a central team within the trust, and service figures showed full compliance with the Mental Health Act.
- Mental capacity was being assessed when required, and findings were noted on records.

However,

- Mandatory training figures provided by the trust for the service did not match the figures from the wards and the trust decision to have 'core' and 'essential' training led to confusion in what was fully required or not.
- Supervision and appraisals were taking place but all wards across the service said they needed to improve. We saw evidence of planned supervision and appraisals.

Good



# Summary of findings

## Are services caring?

We rated caring as good because:

- Staff were seen to be interacting well with patients, their actions reflecting their relationship with the patients.
- Patients told us that, generally, they were happy with their treatment and the staff on the wards.
- Meal times were protected, ensuring that patients could eat and drink without any intrusion.
- Patient preferences, such as how they wished to be addressed and the gender of their support workers, were considered and included in care plans.
- Patients had regular meetings on the wards to discuss ways to improve their admission and these meetings were reflected in “You said, we did” noticeboards.

Good



## Are services responsive to people's needs?

We rated responsive as good because:

- Wards within the service tried to facilitate discharge of patients in a timely manner, although external pressures relating to few appropriate discharge locations could mean delays.
- Facilities at the Harbour site were excellent, with lots of activities and outdoor space for patients, including a mock ‘pub’ in the garden area of Wordsworth ward for male patients and a mock ‘café’ in the garden area of Bronte ward for female patients.
- Hurstwood ward did not have direct access to an outdoor area for patients, due to location of the ward but staff ensured that each patient had time in the hospital gardens each day. There were also many activities for patient involvement. Hurstwood ward was scheduled to close in December 2016 and move to a new location with an outdoor area specifically for patients.
- Food menus were varied and were in both written and pictorial styles for patients to consider.
- Each ward at the service had considered disabled access and ward layout and door widths were designed for wheelchair access: bathrooms and toilets had brightly coloured equipment for easy identification by patients.

Patients knew how to complain about the service.

Good



## Are services well-led?

We rated well-led as good because:

- Staff knew and adhered to the vision and values of the trust.

Good



# Summary of findings

- Staff knew who senior management were and a non-executive director had recently covered a shift on Bronte ward as a support worker, to experience ward work.
- Patient one to one time with their named nurse was taking place and audit figures confirmed this.
- Quality reports for the service showed that indicators had been identified and were used to monitor the efficiency of the wards in relation to key issues, such as mental health act monitoring, physical health care, and observations.
- Staff had access to leadership training, and this was being undertaken.
- Wordsworth and Bronte ward staff had been involved in a human rights research project with a university faculty.

However:

- Mandatory training was being completed but there was an apparent difference in the figures recorded by the trust and the figures on the wards.

# Summary of findings

## Information about the service

The Harbour is a new 154 bedded mental health hospital situated near Blackpool. The hospital was designed with extensive input from service users and clinicians and was based on good practice guidance and 'safety by design' to ensure that it could provide high quality care.

The Harbour is comprised of the following wards:

- Wordsworth ward, a 15 bed a male dementia ward
- Bronte ward, a 15 bed female dementia ward
- Dickens ward, an 18 bed male advanced care ward
- Austen ward an 18 bed female advanced care ward

The advanced care wards accommodate older patients who are experiencing an acute mental illness, but are also physically frail or experiencing physical disability or illness. The dementia wards accommodate patients diagnosed with dementia who require the relational and physical care and security that an inpatient ward can provide.

Hurstwood ward (formerly Ward 22) located at Burnley General Hospital, was an 18 bed ward for both males and females with acute mental health issues and mild to moderate dementia. The ward is not as well equipped as the wards at the Harbour, but patients are treated to the same standard across the service. Hurstwood ward is scheduled to be closed in December 2016, and relocated to a new site with more facilities than the current location.

There had been 20 previous inspections of sites registered to the trust, the last comprehensive inspection being held in April 2015, and a report published in November 2015. This service was inspected at that time, and a report published in October 2015.

Requirement notices were associated with this service.

- Under regulation 18 of the Health and Social Care Act, Hurstwood ward (then ward 22) was found to be utilising a high number of bank staff to cover shifts, staff were not receiving supervision, and there was only one registered nurse covering night shifts when there should have been two registered nurses. On this inspection, those compliance actions had been met.
- Under regulation 12 of the Health and Social Care Act, Hurstwood ward (then ward 22) had no ligature risk assessment, nor were call alarms in areas to summon assistance. On this inspection, those compliance actions had been met.
- Under regulation 10 of the Health and Social Care Act, Hurstwood ward (then ward 22) was in breach of Department of Health Guidelines regarding same sex accommodation. On this inspection, those compliance actions had been met.

## Our inspection team

Our inspection team was led by:

Chair: Neil Carr, 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 this core service comprised one CQC inspector, two specialist advisors and one expert by experience. An expert by experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

# Summary of findings

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at one related focus group.

During the inspection visit, the inspection team:

- visited all five of the wards at the two hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 27 patients who were using the service

- spoke with two carers
- spoke with the managers for each of the wards
- spoke with 20 other staff members including doctors, nurses and social workers
- attended and observed one hand-over meeting
- attended six activities involving patients
- attended one patient meeting group.

We also:

- collected feedback from six patients using comment cards
- looked at 28 treatment records of patients
- attended one focus group for staff at the Harbour
- carried out a specific check of the medication management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

We had six comment card submitted for the wards for older patients with mental health problems. The comments were generally positive, stating the experience overall for both patients and carers was good. One comment card said that while the carer had 'nothing but praise' for the nursing staff on one ward, they felt that communication with relatives of patients could be 'chaotic'.

Patients told us that their experience of the service was positive overall. Patient led assessments of the care environment figures for the service for 2016 showed that the service at the Harbour site was better than the national average, but the figures for Hurstwood ward were not available.

## Areas for improvement

### Action the provider SHOULD take to improve

- The trust should ensure that compliance with mandatory training is recorded and delivered in line with trust policy.

# Summary of findings

- The trust should ensure that staff receive supervision and appraisals in line with trust policy.

## Lancashire Care NHS Foundation Trust

# Wards for older people with mental health problems

## Detailed findings

### Locations inspected

#### Name of service (e.g. ward/unit/team)

#### Name of CQC registered location

Wordsworth Ward  
Dickens Ward  
Bronte Ward  
Austen Ward

The Harbour

Hurstwood Ward (formerly Ward 22)

Burnley General Hospital

### Mental Health Act responsibilities

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

Mental Health Act training was mandatory for staff across the service. We found that the service was adhering to the Mental Health Act, and that monitoring of all aspects of the Mental Health Act was being carried out by a central administrative team. A daily report relating to requirements

under the Mental Health Act was produced and sent to each team in the service, allowing up to date knowledge relating to when rights were due to be explained, tribunals were to be held, or renewal of section status.

Staff received training in Mental Health Act application, and we saw evidence of staff knowledge and application while inspecting the service.

### Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory for staff across the service. Staff knew the statutory principles of the Act,

and applied them in practice. The trust had a Mental Capacity Act lead who could be approached for information regarding the Act, as well as a policy that could be accessed by staff.

# Detailed findings

Functional capacity was audited by the service, and a report produced by the trust showed that in the three months prior to inspection the service had a 100 percent compliancy rate. Deprivation of Liberty Safeguards were applied for when required.

# 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

The ward layout was well planned in the Harbour services: the layout used space to good effect. At the Hurstwood ward, space was at a premium but utilised well. Blind spots were dealt with by the use of mirrors at vantage points and closed circuit television was fully utilised at the Harbour. This meant that staff were easily able to observe all parts of the ward. Ligature risk assessments were completed on all wards, they were up to date and comprehensive. Any ligature points were assessed and adequately mitigated for, and reflected in the trust risk register. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves.

Hurstwood ward was a mixed sex unit. Single sex accommodation requirements were being met. Male and female accommodation was separated by a newly built wall in the ward, so there were two definitive halves to the ward. The ward was a dormitory configuration, with an extra four side rooms with en suite (toilet and sink). There was one main large bathroom for each of the halves. Curtains surrounded the beds in the dormitories: there was a male and a female lounge, and a split dining room. There was no requirement for males or females to pass bathrooms or bedrooms of the opposite sex. All wards at the Harbour were single-sex.

Clinic rooms at the Harbour were shared, due to the design of the wards: Wordsworth ward shared a clinic room with Bronte ward, and Dickens ward shared a clinic room with Austen ward. The clinic rooms at both the Harbour and Hurstwood ward were clean and tidy. The clinics were well equipped, with seated and standing weight scales, blood pressure monitoring equipment, and defibrillators. Calibrated equipment was checked and scheduled for re-checking in 2017. Resuscitation equipment at both the Harbour and Hurstwood ward was checked regularly, and the equipment within each emergency bag was within use-by date. Emergency drugs were in date. There was a separate medication administration room attached to the clinic room at the Harbour, where patients could sit comfortably while awaiting medication. The rooms each

had information leaflets concerning medication and treatments on wall racks. Drugs cupboards were checked and in order, and fridge and room temperatures were monitored daily at both the Harbour and Hurstwood ward.

Seclusion was not used at any of the wards in this service. There were no ward-based seclusion rooms, although if a patient required seclusion, there was the facility for transfer to a psychiatric intensive care unit. The wards at the Harbour had rooms referred to as extra care rooms, which allowed patients to be led to a low stimulus environment where they could calm down if they became agitated. These rooms were used with staff present and doors were left open while in use, allowing patients to leave.

Ward areas in all wards inspected were clean, well maintained and with good furnishings.

We saw staff using hand gels and ensuring that they wore aprons during meal times and dealing with elderly patients when necessary. Cleaning rosters were in date in all wards, and staff were seen to be cleaning all areas of the wards during the inspection.

Environmental risk assessments were viewed on each ward and found to be up to date and regularly checked. Ligature risk assessments were included on each ward. Hurstwood ward had previously been without a ligature risk assessment, but at the time of inspection had an up to date ligature risk assessment, due for review in December 2016.

All staff at the service had personal alarms issued and on arrival, the inspection team were asked to carry personal alarms. Alarm buttons could be found in all toilets and bathrooms, and call buttons were in each bedroom on the Harbour wards. Call buttons were available in rooms on Hurstwood ward.

### Safe staffing

Staffing levels across the wards in the service were being managed, utilising the safecare system to adjust staffing figures to match acuity when required. Safecare was a nationally recognised evidence based audit tool, a system used to ensure that wards were being staffed adequately in relation to levels of acuity on the ward. The wards also had a daily teleconference between ward managers, allowing staffing issues to be discussed and plans put in place.

# Are services safe?

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

In the October 2015 inspection, Hurstwood ward had problems regarding staffing levels, especially at night. During this inspection, figures for staffing showed that from July to September 2016 the staff coverage for night shifts was only low on one occasion, when the shift compliment was down by one member of staff. Numbers of bank staff being used was seen to be markedly lower than during the previous inspection.

There were vacancies for trained nursing staff on each ward except Wordsworth ward, which reported being without any vacancies in staffing. Hurstwood ward had one nursing staff vacancy, but this was reported as being for a registered general nurse, rather than a mental health nurse: this was to improve physical health care on the ward. Staffing rotas showed that bank staff were used to fill shifts when necessary. Austen ward had reported that, up to April 2016, they had a 40% qualified nursing staff vacancy rate, however three new qualified nurses had been employed just prior to the inspection.

Staff sickness for the service was reported by the trust as ranging between seven percent on Wordsworth ward and 14% on Hurstwood ward for the 12-month period up to April 2016. However, the trust was inspected in September 2016, some six months after the recorded data, and as such was not considered accurate at the time of inspection.

Bank staff were often ward staff who agreed to cover additional shifts. Austen ward were using one bank staff member each night in September until the end of the month, at which point new staff would cover the shortfall in staffing.

Ward managers were allowed to bring in extra staff up to the agreed shift total for staff, and matrons could be approached if more staff were required. During the inspection we saw that there was a qualified nurse in the communal areas of the ward at all times and we saw high levels of interaction with patients.

Ward staff reported that they were able to have regular one to one time with patients. On Hurstwood ward, patients said that they were not getting one to one time, although an audit carried out by the ward showed that one to one sessions were happening.

Escorted leave was not being cancelled due to lack of staff. Due to the design of Hurstwood ward, with no specific garden area available, staff ensured that all patients were regularly taken off the ward and into the hospital grounds

to ensure that they had access to fresh air. The use of wellbeing workers and activity assistants throughout the service allowed ward activities to take place every day of the week. However, at the time of the inspection, both activity assistants on Hurstwood ward were on leave and sick leave respectively, and staff had to try to fill in the gaps in activity times.

Medical cover was available at all wards in the service. An on call system was used to cover the wards during the evening and weekends. At Hurstwood ward, there were three junior doctors working the on call system and they were based on site, so could quickly attend emergencies.

## Assessing and managing risk to patients and staff

We examined 28 care records across the five wards in the service. All 28 records contained a comprehensive, up to date risk assessment. The full risk assessment was entered on to the trust computer system, and included a falls assessment, an environmental risk assessment, a review from the physiotherapist, and a physical health assessment. This meant that any member of staff working with the patient could easily access the information they needed to be able to provide safe care and treatment. On Dickens ward, there was some confusion when we could not find a particular patient physical health check: we found the relevant data had been stored in another section of the assessment.

Pressure sores were managed according to trust policy: a Waterlow score, which gives an estimated risk of development of a pressure sore in any given patient, was completed on each admission. There was access to a tissue viability nurse for advice.

There were no blanket restrictions in place at the service. Blanket restrictions are restrictions on patients' freedom that apply to everyone rather than being based on individual risk assessments. Hurstwood ward liaised with a restrictive practice nurse who gave advice concerning consideration for removing items from a patient. Crisis plans were in effect. For example, the ward manager on Wordsworth ward spoke of an incident where a patient with a history of absconding would set off the fire alarm, thereby triggering the automatic unlocking system on the door from the ward, allowing the patient to abscond. As such, care plans took note of patient history, and plans were in place to offset such incidents.

## Are services safe?

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

Signs were placed near the doors of each ward informing patients of their right to leave the ward if they were an informal patient. There were nine informal patients on Hurstwood ward at the time of inspection and they knew to ask the staff if they wanted to leave the ward. The observation policy at the trust had recently changed, with levels of observation being changed to either intermittent or continuous: intermittent allowed for checks at specific intervals, continuous allowed for line of sight and arms reach observations. We checked observation records and saw that they were up to date for each patient. Patients were not searched as a rule; however, on admission to the wards, property was checked in order to ensure that valuable items were noted or items such as razor blades were dealt with safely.

There was a protocol in place for dealing with violent or aggressive patients. Verbal de-escalation would be attempted, followed by distraction techniques: medication prescribed to calm the patient down would then be offered. Finally, as a last resort, restraint would be used and consideration for the use of rapid tranquilisation given. Staff across the service had received training in violence reduction techniques. Rapid tranquilisation was rarely used in the service, but guidelines issued by the National Institute for Health and Care Excellence were followed.

The service utilised restrictive practice care plans: these were designed to minimise the impact of staff trying to help patients who could not complete tasks such as washing or bathing themselves. The care plans outlined the number of staff that would be required to assist the patient to carry out a specific task, and the measures employed to ensure that neither the patient nor staff would be harmed.

There were no seclusion rooms on the wards inspected. Patients could be transferred to psychiatric intensive care unit if deemed necessary. There were no reports of seclusion from the service during the period December 2015 to June 2016. During the same period, there were 235 incidents of restraint across the service, none of which resulted in the use of rapid tranquilisation. There was no reported use of prone restraint by the service.

Staff were trained in safeguarding and knew how to make a safeguarding alert when appropriate. If an incident report was issued regarding a safeguarding issue, the safeguarding team for the trust would decide if the local

authority safeguarding team was informed or not. None of the wards in the service had issued more than two safeguarding alerts in the three months prior to the inspection.

Mandatory training was split into two categories: core and essential. Core mandatory training included mental capacity act training, safeguarding, mental health act training, basic and immediate life support, and violence reduction training. Essential training included higher levels in the disciplines mentioned in core training. Figures provided by the trust did not match the figures seen on the wards in the service. Bronte ward showed that none of their core mandatory training figures was less than 75%. Wordsworth, Dickens, Austen and Hurstwood wards also showed that none of their core mandatory training figures was less than 75%. We inspected the data held on computers and confirmed the figures.

Medication management was monitored and completed at the Harbour site using the e-prescribing and medicines administration system. This meant that all medication administration was computerised, with no use of medication administration record charts. This allowed very few errors to be made during administration of medication. However, the e-prescribing and medicines administration system was not in use at Hurstwood ward, and medication administration record charts were still in use: the electronic system was scheduled for introduction at Hurstwood ward in October 2016. We checked 16 prescription records, along with accompanying mental health documentation and consent forms, and found the information was up to date and correct. We saw evidence of patient involvement in decisions about medication. Medication reconciliation, completed when a new patient was admitted to the ward, was done by pharmacy staff. There were no nurse prescribers on the wards in the service.

Pressure ulcers were monitored and care was audited by the service. There was a policy in place for the prevention and management of pressure ulceration, the policy was up to date and due for review in November 2016. A clinical audit was published in April 2016 in which the five wards in the service submitted information: the audit showed that the sample from the five wards had all had Waterlow risk assessments completed, pressure ulcer care plans had been completed, and those patients deemed in need of specialist equipment had been so supplied.

# Are services safe?

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

The service audited compliance with their falls policy. It was found to be at 100% across all five wards inspected. This was confirmed in the trust's advanced care and dementia wards quality report. All patients in the service had received a falls assessment on admission, and this was adjusted accordingly.

No children under the age of 18 were allowed on the wards across the service. However, there were family or visiting rooms available at both sites. This meant that children and young people were kept safe when they visited family members.

## Track record on safety

In the period from April 2015 to March 2016, there were five serious incidents specific to this service. Staff on Hurstwood ward reported bone injuries such as fractures that had not been detected at the referring location; these were detected by Hurstwood staff and actions taken. Staff reported that, after escalation, this led to improved physical health monitoring across the service.

The manager of Bronte ward reported the recent incident of a patient who suffered a stroke on the ward; it was agreed that the patient needed end of life care, and that it would be best served on the ward. An external provider brought training, support and advice to the ward staff. This included equipment, paperwork, and contacts to manage the situation. The work in relation to this incident meant that the ward is now fully capable of dealing with such a case in the future.

## Reporting incidents and learning from when things go wrong

Staff knew what to report and how to report incidents if things went wrong. The system used to report incidents

was an electronic system. Staff were encouraged to complete a report if an incident occurred. In the period 1 April 2016 to 1 August 2016, there had been 918 incident reports submitted within the service. Staff reported anything that may be deemed untoward: one patient fell asleep with a hot drink and spilled it on his trousers, and although there was no injury, it was reported.

Staff meetings were used to feed back learning from investigations; the trust used 'huddles', informal gatherings of staff to ensure that any relevant issues were fed to the team as quickly as possible. If patients needed to be informed, they would be informed either personally or in patient meetings. Minutes from a joint governance meeting for Bronte and Wordsworth wards dated 24 August 2016 showed that incident themes were discussed and considered for feedback, as were compliments and other aspects of training that the staff needed to know.

Debriefing after a serious incident was discussed, and we were told that appropriate staff would take the lead in debrief: the violence reduction training lead, or the restrictive practice lead, as well as psychological input if required.

## Duty of Candour

Staff were seen to be open and transparent on the wards when dealing with patients. Duty of candour was discussed with staff, and staff knew of the requirement to be open and honest with patients and families if something went wrong.

The trust had a policy that reflected duty of candour, the 'being open' policy. The policy outlined the formal process for compliance with the duty of candour statute.

# 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 28 care records across the service, and they were found to be holistic, comprehensive, up to date and timely. There was evidence that patients had been involved in the creation of the care plans, although it was also clear that some patients could not be actively involved. Physical examinations had been undertaken, and on going monitoring of physical health was being maintained. Hurstwood ward were actively recruiting a registered general nurse to ensure that best possible physical health care was being given to patients. In the trust's advanced care and dementia wards quality report 2015 to16, all five wards in the service had consistently recorded 100% for the recording of a physical health assessment.

Care plans from the point of referral for patients were available to staff, as was a full history of the patient: the nature of the patient base meant that histories could not often be secured from the patient themselves. Malnutrition universal screening tool assessments were carried out for each patient in the service on a weekly basis, Waterlow scores for possible pressure ulcers, weight loss and gain was recorded, as well as assessments for possible choking risks, with input from a speech and language therapist.

Patients were assessed as to any equipment they may need to assist in their self-care; plate guards were available, as were feeding cups with lids, and specialist knives and forks. Staff were seen to be assisting patients to eat meals during the inspection of the service and this was done in a respectful manner.

Staff were aware of the resuscitation policy for the trust and part of the handover each shift ensured that staff clearly knew which patients had a do not attempt resuscitation form in their files. Each ward also used a colour code on or over the door of each patient room to denote resuscitation or not: these were closely monitored, to ensure that the correct colour code for each patient was correct.

Information was stored on the trust computer system, and was secure and available to staff when needed. Paper notes were also maintained, but mostly the notes were electronic. Information contained in the paper notes was matched with the electronic data.

### Best practice in treatment and care

Injectable medication was audited in compliance of national patient safety guidelines, as outlined in the trust procedure for storage of medicine policy. The trust had a policy for management of all aspects of medication, and a supporting protocol for the management and introduction of National Institute for Care and Health Excellence technology appraisal reviewing medication. We saw medication administration that followed guidance throughout the service.

Psychological input was available within the service. We saw arrangements at the Harbour wards for psychologist interventions. Psychologists were also available at Hurstwood ward. Psychological input was relevant to the needs of the individual patient.

Physical healthcare was closely monitored and audited across the service. Assessments were carried out on admission and then maintained during the length of stay. We saw evidence in care records of ongoing monitoring of physical healthcare, and in the equipment that was used for each patient, such as air profiling beds.

The malnutrition universal screening tool was used to assess the dietary and hydration requirements of patients, the advanced care and dementia wards quality report 2016-17 showed that the use of the tool was audited regularly. The report stated that each of the five wards in the service were 100% in the use of this tool within the service. Care records showed that the tool was being monitored regularly.

Rating scales were used to record and assess severity and outcomes. The Cornell scale for depression in dementia was used, along with the Doloplus-2 pain assessment for the elderly, as well as cognitive rating scales. The commissioning for quality and innovation framework was also used to record outcomes at the service.

Ward managers on the five wards within the service told us that clinical audit was being carried out throughout the service. We viewed files that showed that audits were taking place on each ward within the service; on Bronte ward, we saw audits relating to capacity, care plans, enhanced risk, medication, and hand hygiene. The trust's advanced care and dementia quality report 2016 to17 showed audits relating to multidisciplinary team quality, resuscitation, falls, harm free care, dementia, and malnutrition universal screening tools.

# 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.

## Skilled staff to deliver care

There was a full range of mental health disciplines to provide input to the service, including consultant psychiatrists, mental health nurses, junior doctors, occupational therapists, psychologists, physiotherapists, speech and language therapists, and pharmacists. A pharmacist or pharmacy technician visited wards daily across the service.

Staff were experienced and qualified to work within the service. Specialist training was available to staff, additional to mandatory training, that was relevant to their posts, such as dementia advanced care, appreciative leadership courses for band six and band seven staff, and higher levels of training in safeguarding.

Supervision was being carried out on each of the five wards within the service. The trust protocol was for all staff to receive four periods of supervision each year and an annual appraisal. The trust provided data relating to the period May 2016 to July 2016. On Bronte, Austen and Wordsworth wards, compliance was 100% for the supervision of trained staff, and 97% for health care support workers. On Hurstwood ward, 67% of trained staff had received supervision, while only 35% of health care support workers had. On Dickens ward, 69% of trained staff had received supervision in the three-month period from May 2016 to July 2016, and only 11% of health care support workers had received supervision in the same period.

The trust had introduced a 'supervision passport' for staff to carry with them, and should they request supervision at any time, it could be entered on the passport, to indicate the amount of supervision they were receiving.

Appraisal rates across the service were low; however, we saw evidence that appraisals had been booked for non-medical staff within the service. The highest appraisal rate in the service was on Bronte ward, at 52%. The average appraisal rate for the service was 34%. A staff member on Hurstwood ward told us that an appraisal had been booked for them but they also felt fully supported. The Hurstwood ward governance meeting minutes of 10 August 2016 had appraisals as an agenda item, and the need to improve their figures. Appraisal recording and schedules had been 'reset' in April 2016, and these figures reflect the change in procedure.

Team meetings were held regularly, and minutes of team meetings were inspected. Minutes of meetings showed

consideration of agenda items such as safety, effectiveness/excellence, leadership, physical healthcare. The minutes of a joint team meeting of Austen and Dickens ward staff on 31 August 2016 were viewed and found to be comprehensive, thoughtful, and fair.

Staff performance issues were dealt with efficiently and effectively. We saw evidence of capability reports on staff from two of the wards, indicating the process in which the matters were being dealt with.

## Multi-disciplinary and inter-agency team work

Multidisciplinary team meetings to discuss individual patients' care and treatment were regular and effective across the service. Dickens ward had three regular multidisciplinary team meetings on a weekly basis, due to there being three consultant psychiatrists attached to the ward. Hurstwood ward had one multidisciplinary team meeting each week and all patients were seen at that time. The meeting rooms on the Harbour wards were equipped with a large screen and a computer, allowing patient records to be updated as the meeting was taking place.

Handover formats were comprehensive and well planned. The information contained allowed full and effective hand over for each shift.

Ward managers told us that the working relationships with other teams and organisations were quite good; they did state that they had mixed relationships with some care coordinators, as they needed to keep in contact with them to ensure full updates. The service used discharge coordinators, specifically to ensure that care coordinators and referring agencies kept good contact with the service.

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

Staff received Mental Health Act training as part of their core training, and in discussion with staff it was noted that they had been knowledgeable about the Act, as well as key changes to the 2015 Code of Practice. Consent to treatment forms and capacity requirements were adhered to in place and being followed.

The service received a daily Mental Health Act report from a Mental Health Act administrator. The report was seen to be very informative and up to date, with information regarding dates of section application, rights read, renewal dates, and the section details clearly documented. Staff were able

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to act upon the information in the report quickly, and the report was audited by the Mental Health Act administrator. The report showed that the Mental Health Act was being rigorously followed and adhered to.

The Mental Health Act administrator was a central point of contact for staff concerning all aspects of the Mental Health Act. Detention paperwork was checked daily, with original paperwork being held by the administrator and copies retained on file in each ward of the service.

The trust's advanced care and dementia wards quality report 2016 to 17 showed that the Mental Health Act audit for the service was maintained at a high level of success: all five wards showed that they were 100% compliant with Mental Health Act requirements.

Advocates were available if requested or deemed required. Leaflets were available on each ward that had been prepared by the trust, outlining rights and contact details for the advocacy services that were available.

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

Staff received Mental Capacity Act training as part of their core mandatory training. Figures provided by the trust showed a compliance level of 78% for the service. Staff showed that they had a working knowledge of the Mental Capacity Act, and the five statutory principles of the Act.

The trust had a policy on the Mental Capacity Act, and staff were aware of this and knew how to access the policy. We

saw evidence that capacity to consent was being considered and recorded. An audit of the service concluded in March 2016 showed that capacity recordings fluctuated between 92% and 100%.

We saw evidence of best interest meetings for patients; on Wordsworth ward, we saw evidence, mostly regarding future placements, where a patient had no direct relatives, and the best interest meeting was well documented in care records.

Deprivation of Liberty Safeguard applications were made on behalf of patients, when deemed necessary. However, ward managers reported difficulty getting applications processed once made, due to pressures in the local community. There had been 44 applications in the period February 2015 to February 2016 from the service, with the highest number having been made by staff on Wordsworth ward (20 applications). However, at the time of the inspection, there was only one patient at the service under a Deprivation of Liberty Safeguard.

The trust had a service lead for mental capacity. The lead could be contacted for advice regarding Mental Capacity Act or Deprivation of Liberty Safeguards.

In the trust's advanced care and dementia wards quality report 2016 to 17, functional capacity assessment had been audited and shown to stand at 100% for the three months prior to the inspection.

# 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 observed staff to be caring, responsive, respectful and thoughtful when dealing with patients. Staff across the service knew patients by their names, and appeared to know the best way to approach patients in order to make the most of the interaction. We observed six activity groups across the service: on Dickens ward, we witnessed an art group where patients and staff were very relaxed, lots of laughing and joking, appropriate tactile contact between staff and patients, encouragement given in a positive manner.

At mealtimes, we saw patients being assisted with their food; they were asked if they wanted assistance and it was seen that the staff on the wards tried to promote independence of each patient. Mealtimes were protected, there were no medical staff interruptions and family were only allowed in at meal times if they were actively assisting in helping the patient to eat. Patients could sit and eat where they decided.

Bathrooms were well stocked with continence aids, and these were available in the bedrooms of patients. At medication rounds, patients were invited into a small sitting room off the clinic room, where they were kept company by staff until the medication was ready to be administered. We saw patients who were given their medication in their rooms, as they did not want to attend the clinic; this was done privately, and with dignity for each patient.

Care plans reflected any mention of preference by the patient of the gender of staff they would prefer to treat them. We saw one patient care plan that clearly stated that the patient could only be assisted in washing and bathing by staff of the same sex, and this was monitored on the handover sheets.

Patients were generally positive in their views on the treatment by staff. On Hurstwood ward, we were told by female patients in their lounge that the staff were “lovely”, and they “would not hear a bad word said against them”. However, during a patient meeting on the same ward, one male patient said the staff were only being attentive because there was an inspection going on.

Patients told us there was always plenty of staff who were kind and supportive. None of the patients we spoke with had made complaints to the staff.

Staff we spoke with were aware of patient needs and were able to describe the individual needs of each patient in their care. Staff knew not only the clinical problems with patients but were aware of family histories and carer contact. This was reflected in the care records of patients, where we saw lots of contact with carers by ward staff.

### Patient led assessments of the care environment (PLACE)

PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and 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 2016 PLACE score for Lancashire Care NHS Foundation Trust was 86%, which was on par with the England average of 86%. In the wards for older people with mental health problems, the average PLACE score was 88%, above the national average.

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

The service used welcome packs to help orient patients to the ward and service. There was an orientation checklist that ensured that each patient was shown the ward, the facilities, and introduced to staff, as well as a briefing for families and carers.

We saw lots of information on the wards that gave information regarding the different treatments and the rights of patients. Hurstwood ward had an information board specific to Mental Health Act information, regarding rights of patients and an explanation of the different sections. Wards at the Harbour all had wall racks in the sitting rooms off the medication dispensary, the racks containing information about medication and rights under the Mental Health Act.

We saw evidence in care plans and risk assessments of patient involvement. Patients were asked to be involved, and given the option as to the amount of input into their care. Care plans and risk assessments were seen to promote as much independence as possible for patients. We tracked one care record and noted that the patient was

## Are services caring?

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sometimes consenting to aspects of care, and then the next week would not consent to the same level of care: discussion in the record showed that staff were considerate of the patient's wishes, and consideration given to capacity.

Patients could speak to a pharmacist if they so wanted. If a patient refused a particular treatment regime, then the staff would always try to find an alternative treatment. However, it depended on the level of capacity of the patient to understand the treatment and the necessity to accept it. There was access to advocacy, should a patient request it, or if it was felt that an advocate should be present to represent the patient's views. We saw evidence of carer participation in the treatment of patients; this was reflected in care plans and risk assessments.

Patients were offered copies of care plans, and the decision to accept or refuse was noted in their records. Discharge care plans were created in conjunction with care coordinators, and it was up to the care coordinator to

ensure that the plan was followed through on discharge. We saw small booklets about each patient called "All About Me", and the booklets held information like to how the patient liked to be named, a general working background, hearing and eyesight acuity, communication skills, ability to eat and drink, all things that would enable staff to know patients better and improve care.

Patients had regular meetings on the wards, as well as being provided with questionnaires regarding activities and treatments. Hurstwood ward had a "You Said, We Did" noticeboard, outlining changes made on the behalf of patients. The Harbour wards had electronic devices that linked directly into the friends and family test questionnaire that could be immediately uploaded to the computer system. However, ward managers told us that there was very little involvement of patients into decisions about the service, such as recruitment of staff.

# 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

Ward managers told us that patients were 'rarely' admitted out of area if the ward was full. The wards with the highest average bed occupancies in this core service were Wordsworth Ward, Dickens ward and Austen ward. All of these wards had bed occupancies of 100% or more.

The ward with the lowest average length of stay rate was Wordsworth ward, which had a bed occupancy rate of 72 days. Dickens ward had the highest length of stay for current patients with 131 days.

The ward with the highest number of delayed discharges in the six months prior to the inspection was Wordsworth ward with 32 incidences. At the time of the inspection, Wordsworth ward had 12 delayed discharges. The reasons were not internal service related, but were caused by a lack of future placements and nursing care placements for patients. Delayed discharges on the other wards in the service were fewer in number, but the reasons for the delay were the same.

Overnight leave from the service was rare, due to the nature of the patient base. We were told that if patients were on leave, then they would have a bed to come back to. Discharge of patients took place during office hours, if possible, Monday to Friday.

Patients were moved between wards, but this was dependent on the level of functioning of the patient; we found on Wordsworth ward that if a patient had high functionality, then they could be transferred to Dickens ward, although we were told that this did not happen often across the service.

If a patient required transfer to a psychiatric intensive care unit, ward managers told us they would try to ensure it was in the local area, but could not always assure this would happen.

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

The facilities at the Harbour were excellent. There was a full range of rooms and equipment to support treatment and care on each ward; there was a well-equipped clinic room, a large activities room and a movie picture wall with photographs of film stars from the 1940 and 1950 eras. The ward designs at the Harbour included curved walls that

gave the impression of a circular shape, allowing patients to move around freely and remain under cover even when outside. The garden space on Wordsworth ward was preceded by a wall mural that suggested a walk in a forest, then on to a beach, before arriving at a purpose built "pub", called Iggy's bar. The bar had seating, an area outside to sit, and a proper bar with beer pumps (disconnected) to give an atmosphere of a real bar. Bronte ward had a similar design, with a purpose built "café" in the garden, named Maureen's Café. There were quiet rooms for patients, and multidisciplinary rooms for staff meetings. Assisted bathrooms were available alongside the en suite bathrooms; the assisted bathrooms were fitted with bespoke baths designed to assist less able patients.

Hurstwood ward did not have the same range of facilities and space as the wards on the Harbour. There were male and female lounges, the lounges could act as activity rooms. The ward utilised space to the maximum. There was no garden area for patients to visit, so staff ensured that patients were taken into the hospital grounds on a daily basis, in order to exercise and have outdoor time. There were two nursing offices on the ward, allowing staff to cover both male and female sides of the ward. The assisted bathroom had a bespoke bath with a built in seat/hoist, to ensure safe access and to avoid back strain on staff. The toilets were white, but the toilet seats, safety rails and equipment was coloured blue to distinguish for those with failing sight. Hurstwood ward did have an activity of daily living kitchen that allowed patients to be involved in cookery and baking.

We were shown documentation that stated Hurstwood ward was due to close on 20 December 2016, and new premises had been created for patients. The new premises would still be dormitory style, but it had a large garden area for patients to use.

The wards at the service utilised cordless telephones that patients could use in the privacy of their own rooms if they wanted to make a telephone call. Menus for food were clearly outlined in both written and pictorial manner at the service, allowing patients to make informed choice as to their dietary intake. The patient led assessment led assessments of the care environment figures for 2016 showed that the Harbour service scored better than the trust average across two of the three food categories. The

# Are services responsive to people's needs?

Good 

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

figures for Hurstwood ward were not available; however, patients said that the standard of food provided was “not brilliant” or “poor”. Snacks and hot drinks were available at any time for patients.

Patient bedrooms had been personalised. The dormitory style at Hurstwood ward did not lend itself to personalisation, but we saw family photographs within the bed areas of the ward. Patients could access their bedrooms at any time across the ward. The Harbour had secure areas for patients to store items, but Hurstwood ward was limited on storage space. Signage was placed at a height where it was visible, and most signs were raised, allowing tactile contact to assist in understanding the sign.

We saw activities taking place across the service, and we saw that activity boards listed weekend activities. The service employed wellbeing workers and activity assistants; these workers were on a seven-day rota, and were tasked with ensuring that activities took place all week. At the time of the inspection, the activity assistant for Hurstwood ward was on sick leave, but activities were still available at the weekend.

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

Wards at the Harbour were all situated on the ground floor, and we saw that all the doors leading to the wards and the ward doors themselves were wider than usual, to accommodate wheelchair access. Hurstwood ward required patients to use a lift to reach the ward, but doors allowed easy access. Flooring was smooth, allowing good grip for wheelchairs; bathrooms throughout the service were well equipped for disabled access or assistance if needed. Signage included pictures, to make understanding easier. On Wordsworth wards, the doors that led to rooms off limits to patients were incorporated into a forest mural, so patients did not attempt to access the rooms.

The leaflets we saw during the inspection were all in the English language, but we were told that should another language be required, relevant information could be obtained. Austen ward had recently treated a patient who spoke Gujarati (an Indian dialect), and the ward staff obtained information for the patient via leaflets and an interpreter. Dietary requirements were considered on admission for all patients, and this would include religious or ethnic aspects of diet.

There was lots of information available on treatments, local services, and patient rights, along with other information, across the service. Both at the Harbour sites and Hurstwood ward, notice boards were in abundance, with activities boards, quality SEEL (Safety, Effectiveness, Experience and Leadership) noticeboards with up to date information about the wards, quality feedback boards, and ‘good news’ boards that included compliments and success stories for each ward.

There was a chaplaincy available at the Harbour site, which also considered other faiths and religions. There was a multi-faith room that had copies of the Quran and prayer mats available. We were told that religious leaders such as Imams could be invited on to the wards. Hurstwood ward had a multi-faith room available in the main hospital site, staff arranged for patients to be taken over if they so wished. Hurstwood ward staff also told us that they would arrange for religious leaders to visit if so requested.

## Listening to and learning from concerns and complaints

Patients were given a welcome pack on admission to the ward, and this contained details of how to make complaints, both formally and informally. Complainants were listened to and their complaints considered, including arranging for advocacy if the patient required assistance. Notice boards on each ward also had information on how to complain.

Data provided by the trust showed that the service had received 24 complaints in the period April 2015 to March 2016. One complaint was withdrawn, seven complaints were not upheld, nine complaints were partially upheld and seven complaints were upheld. No complaints were referred to the ombudsman.

Staff displayed knowledge of how to handle complaints appropriately. We discussed duty of candour with staff; they knew that they had to be open and honest with patients and their families.

Staff received feedback from formal complaints via staff meetings, hand overs and supervision. Patients were informed of the result of a complaint personally.

# 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 values of the trust were displayed throughout the wards in the service, the values being teamwork, compassion, integrity, respect, excellence and accountability. Staff were aware of the values and the trust requirement to follow the values.

The ward manager of Wordsworth ward stated that there was a ward ethos based on the trust values, and that the staff of Wordsworth ward agreed with the values. Dickens ward had a wall mural consisting of eight Cs that included compassion, courage, communication, competence and commitment; the ward manager stated that these aims ran alongside the trust values.

Staff knew who the senior managers of the organisation were, and the Bronte ward manager stated that a non-executive director had recently completed a shift as a health care support worker on the ward, to experience how the ward operated. We were told that the chief executive had recently visited the wards in the service.

### Good governance

We saw evidence that staff were completing core mandatory training, but essential mandatory training figures were not as high. The figures provided by the trust did not match those provided by the wards in the service. There was no evidence of impact on the care of the patients across the service. However, the trust should ensure that the mandatory training system of core and essential is revised and simplified for recording purposes.

Qualified staff were being supervised, but appraisals did not appear to be happening regularly. We saw evidence that appraisals had been booked in for staff at dates after the inspection. Staff told us that they felt they were receiving adequate supervision. Staffing was being covered using the safecare system, and the staffing levels on Hurstwood ward that had been a requirement notice at the last inspection had clearly improved.

Patient one to ones were documented as happening regularly and staff felt they had the time to complete one to ones. We saw evidence that clinical audit was taking place, and the figures relating to the audits showed that the service was meeting trust targets.

The number of incidents reported across the service shows that staff were actively reporting anything of an untoward nature. There were 24 complaints made in a 12-month period, of which seven were upheld. Mechanisms were in place to feed back relevant information to staff from these complaints, and any shared learning.

We saw evidence that safeguarding procedures were in place, and that the Mental Health Act and Mental Capacity Act were being followed and audited effectively.

Quality reports prepared by the trust reflected the use of audit and indicators to gauge team performance, and to monitor and act on any failings within those reports. Ward managers told us they had sufficient authority to act in order to improve their wards, and had good administrative support to maintain the ward.

We were told that all staff had the ability to submit items to the risk register but that staff normally used their line management to refer any concerns for consideration.

### Leadership, morale and staff engagement

Sickness rate data provided by the trust was for the 12-month period up to April 2016; the inspection took place in September 2016, and as such, the data was not deemed accurate at the time of inspection.

There were no bullying or harassment cases within the service at the time of the inspection. Staff were aware of the whistle-blowing policy and how to use it. Staff told us that they felt able to raise concerns to management without the fear of victimisation, and generally, staff morale was good at the time of inspection.

There were opportunities for leadership development: staff on Wordsworth ward told us that there was access to leadership courses and that they had attended a leadership course. Staff reported good teamwork across the service. We saw evidence of staff explaining to patients that an error had occurred, and that the patient accepted the explanation. Staff were able to comment on services in meetings, and felt that their points were considered.

We saw evidence that staff performance issues were actively being addressed: on one ward in the service, there were four capability reports in progress in relation to staff performance.

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Good 

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

At the time of the inspection, Wordsworth ward and Bronte ward staff reported recent involvement in a human rights project with a local university that had recently completed. The results were unknown at the time of the inspection.