Review of compliance

Leeds Partnership NHS Foundation Trust

The Newsam Centre (Ward 3)

Region:	Yorkshire & Humberside
Location address:	Ward 3 The Newsam Centre Seacroft Hospital York Road Leeds LS14 6WB
Type of service:	Hospital services for patients with mental health needs, learning disabilities and problems with substance misuse.
Date the review was completed:	December 2011
Overview of the service:	The Service is a low secure forensic in patient ward for patients with a mental disorder and learning disability who may have been involved with the criminal justice system. Five of the beds offer a service to patients with forensic mental health needs and learning disabilities. On the days of our inspection there were 17

	patients on the ward. Four of the patients had a mild learning disability. Therefore we concentrated our inspection on these four patients. All of the patients were detained under the Mental Health Act 2007, Part 2 Civil Sections and Part 3. Patients have been involved in criminal proceedings, some of whom will be subject to Ministry of Justice restrictions. The regulated activities, which the service is registered to provide are: • Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Treatment of disease, disorder or injury • Diagnostic and Screening

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that The Newsam Centre (Ward 3) was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

This review is part of a targeted inspection programme to services that care for people with learning disabilities to assess how well they experience effective, safe and appropriate care treatment and support that meets their needs and protects their rights; and whether they are protected from abuse.

How we carried out this review

The inspection teams are led by Care Quality Commission (CQC) inspectors who are joined by two 'experts by experience', these are people who have experience of using services (either first hand or as a family carer) who can provide that perspective and a professional advisor.

We reviewed all the information we hold about this provider, then carried out a visit on 5 and 6 December 2011. We observed how people (patients) were being cared for, spoke with the patients and staff, checked the provider's records and looked at patients' care records.

As part of our inspection, telephone discussions were also held with relatives and other professionals who we were not able to meet during our visit. Their comments are included within this report.

To help us to understand the patients' experiences, people have we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences. We did not use this tool on this occasion, as all of the patients were able to communicate their views to us verbally.

What people told us

We spoke with four patients when we visited, Ward 3, Newsam Centre.

Some patients were satisfied with the care, treatment and support they received at the hospital. They said they had care plans and were able to attend review meetings with advocates to support them. They told us:

“I have a care plan and health care plans.”
“I have a care plan and I reckon staff are following it.”
“I have meetings with the doctors and nurses and I’ve got an advocate.”

Patients told us they attended daily community meetings with staff where their daily activities and leave could be organised. Patients said they had access to meaningful activities and said:

“I do art, poetry and ten pin bowling.”
“I have some friends here and I like playing the DS (*computer game*)”.

These patients told us they had developed good relationships with staff, had many meaningful activities to do and felt they were making progress.

Other patients told us they did not get on with or feel adequately supported by some staff. They told us they had been bullied by another patient and did not always feel safe.

“I might have a care plan, but not sure. I don’t know what’s in it.” In addition, “Sometimes I don’t get support from staff; I’m left to do my own thing.” They went on to say, “I don’t like it here, I preferred where I was before.”

A patient said, “When I first moved here I was bullied by other patients, this went on for six months, I was called names, they would `bang’ (*speak disrespectfully about)* my family”.

Some patients complained they did not like the food available on the unit. One patient said, “I eat take-away food or go to my mums.” Another patient told us, “Food is not very tasty.” Patients said staff would only allow them to order take away meals on Friday and Saturday nights.

Patients told us about restrictions placed on them by staff, which included smoking. This was limited to one cigarette per hour. One patient told us, “We have cigarettes on the hour. When it is meal times, we have cigarettes at quarter past the hour. If you are a slow eater and have not finished by quarter past then you have a choice of whether you have your meal or a cigarette.”

What we found about the standards we reviewed and how well, The Newsam Centre (Ward 3) was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

Patients' needs were assessed; care plans and risk assessments were in place. There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the `least restrictive' options or person centred. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.

- Overall, we found that, The Newsam Centre (Ward 3) was not meeting this essential standard. Improvements are needed.

Outcome 7: People should be protected from abuse and staff should respect their human rights

Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an `appropriate urgency' and there was no clear recorded audit trail of the actions taken by staff to safeguard patients. This meant patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

- Overall, we found that, The Newsam Centre (Ward 3) was not meeting this essential standard. Improvements are needed.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We have ensured that two safeguarding referrals were made to the relevant safeguarding teams to make sure any necessary actions can be taken to protect patients from abuse. The two safeguarding concerns were raised by the individual patients during the inspection. One was a new concern regarding an external provider and the second was the re-emergence of a previous concern, which the ward had already taken some actions to address.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meet their needs and protects their rights.

What we found

Our judgement

There were moderate concerns with

Outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We spoke with four patients to gain their views about the care, treatment and support they received on Ward 3, The Newsam Centre.

A patient told us “I have a care plan and health care plans.” Another patient said they had two advocacy workers and they keep themselves busy by taking part in a range of activities. They went on to tell us, “I enjoy attending the gym.”

Other comments included:
“I have a care plan and I reckon staff, are following it.”
“I do art, poetry and ten pin bowling.”
“I have some friends here and I like playing the DS (*computer game*).”
“I have meetings with the doctors and nurses and I’ve got an advocate.”
“My family come and visit me.”
“Staff, explain the risks involved in the choices I make.”

Overall, these patients told us they were satisfied about the care, treatment and support they received from the service.

Other patients told us, “I might have a care plan, but not sure. I don’t know what’s in it.” In addition, “Sometimes I don’t get support from staff; I’m left to do my own thing.” And, “I have an advocate, who I see every two weeks.” They went on to say,

"I don't like it here, I preferred where I was before."

One patient told us, "We have cigarettes on the hour. When it is meal times, we have cigarettes at quarter past the hour. If you are a slow eater and have not finished by quarter past then you have a choice of whether you have your meal or a cigarette." We observed that patients were only allowed out of the ward in to the court yard area once an hour, on the hour for a cigarette. One patient told us they thought the smoking restriction was in place because staff had made the decision to only allow patients to smoke once an hour, they did not think it was fair and did not understand why it was in place. This indicated `restrictions' were placed on patients (see O*ther evidence*, Delivering care, section below).

Other concerns raised by patients related to a lack of privacy during phone calls, from the patients' phone. One patient said, "Patients' ask you questions about what you have been talking about on the phone, there's no privacy." We saw the phone was located on a communal corridor and this did not offer patients adequate privacy. The staff told us patients could use the phone in the clinic room for privacy.

In addition, two of the four patients told us they did not like the food on the ward. One patient said, "I eat take-away food or go to my mums." Another patient told us, "Food is not very tasty." A third patient said, "Meal times are set, you can't choose."

We spoke with two relatives to gather their views about the care, treatment and support offered to patients. These were their comments:

One relative told us, "(*patient's name*) has a care plan and I think he has a Health Action Plan (HAP) and an annual health check." The relative said they were invited to review meetings. They said they felt invites to the meetings were, "Rather tokenistic." And said, "I am not really listened to. All along whether I or (*patient's name*) have been involved or not the doctors and staff have had the ultimate say in the decision making."

The second relative told us they had very little contact with the staff on the ward. They commented, "We were not informed when (patient's name) was moved here." They said, "Staff did not contact me or their dad. We only found out when (patient's name) phoned to tell us." They said they were not happy about the lack of consultation and involvement with the staff. We passed on these concerns to the Clinical Team Manager (CTM) to address, at the time of the visit, as we were unsure of whether the patient had consented to their relative's involvement.

During our inspection, we observed some staff interactions with patients, which were friendly and empowering. However, we also observed staff interactions with patients, which were not respectful and did not protect patient dignity. For example we observed a patient being told by staff, "Do not to swear in front of a lady." (Meaning the inspector). In this case, a patient was having a conversation with a member of staff. They were generally chatting, the patient was not presenting as agitated, angry or shouting. They were having a general conversation and in the context of the conversation the patient swore, this was not out of context, extremely explicit or observed to be offensive to other staff or patients in the vicinity. The member of staff talking with the patient did not stop the conversation to address this or advise him of any concern in relation to this behaviour. However, another

member of staff then walked across to the patient and said, “Don’t swear in front of a lady.” (Pointing to the inspector). When the member of staff intervened in this way, the patient then became angry because of the way the member of staff had intervened, the patient told the staff, he was just having a chat.

Another poor interaction observed was when several patients were approached by a member of staff and were told, “Don’t use this as an excuse to have a cigarette.” (During a fire evacuation from the building, as a result of a fire bell sounding). When we raised concerns about this interaction the Clinical Team Manager (CTM) told us, which member of staff it would be and they were correct. This indicated to us, they were aware of this member of staff’s approaches / attitude prior to our visit. Both the CTM and Service Manager agreed this approach to engaging patients was not appropriate and they advised us, they would take action to address this with the member of staff.

Overall, from our observations we found there was limited social interaction between patients and some staff. The general atmosphere on the ward was quiet.

Other evidence

Assessing people’s needs

The Clinical Team Manager (CTM) told us about the referral and admissions procedures for the service. We were supplied with a copy of these. They gave staff clear instructions to follow when assessing and admitting a patient to the service.

We looked at the assessment records of four patients. These were detailed and clearly showed the patients’ assessed needs. Records showed that patients had been detained prior to being admitted and we saw legal documents, which confirmed this. We were told nurses managed admissions. They then collated information from the Multi-Disciplinary Team (MDT). A primary nurse and care coordinator was then allocated and a health care assistant (HCA) is allocated to be a link worker to all patients.

We saw that on admission patients’ individual needs were considered, for example, bedroom allocation was dependent on the patient’s needs, including physical disability, vulnerability and other individual diversity issues.

Patients had discharge plans, which staff began to develop on the patient’s admission.

Care planning

We looked at four patient’s care plans. The care plans checked were based on the patient’s needs assessments made prior to and on admission to the unit. These were detailed. Those care plans checked, were regularly reviewed on a monthly basis. They were devised in written formats, were written in a technical and clinical way and were therefore not person centred in approach. There was little evidence they had been devised in conjunction with patients and the patients had not signed the care plans to show their agreement about what was recorded in their care plans. Overall, the care plans checked, did not indicate a person centred approach to

planning patient care.

None of the patients we spoke with had a copy of their care plan. Staff said all the care plans were kept in the staff office, to protect patient confidentiality. The CTM said if patients wanted a copy of their plan, they would be made available.

When we asked whether any person centred care plans were planned with patients, staff said patients had discharge plans called, `My future plan'. They said these had been devised using person centred principles. One patient told us they had been involved in devising their `My future plan'. We checked three of these plans, one was comprehensive, it detailed the patient's views and wishes and used pictures and easy read formats to meet the patient's communication needs. However, the two other plans lacked written evidence of any patient involvement and were incomplete. We were told after the inspection that the reason the plans were incomplete was, "The two incomplete plans were as a result of them still being in the process of completion with the service users." This did not demonstrate that person centred approaches to care planning were yet embedded within the service.

There was evidence that Care Programme Approach (CPA) reviews, were carried out regularly. Staff told us, they had a pre-CPA meeting checklist and we saw evidence these were completed; this included asking if the patient would like an advocate present at their meeting to speak up for them. We saw evidence in one patient's records of a CPA self-assessment report. This had been completed by the patient prior to their CPA review. This practice involved the patient and protected their rights.

A risk assessment and review system was in place. The risk assessments checked had been regularly reviewed. Staff told us, risks were explained to patients and one patient told us that risks relating to the medication they had been prescribed had been explained to them. This supported the patient to understand the effects and side effects of the medication.

Whilst there was written evidence (in some cases) to show that staff had explained patients' rights to them whilst detained under the Mental Health Act, there was little written evidence to confirm that patients had received this information. For example, in two patient's records we saw that although staff had recorded, they had ` Read the patient their rights under the Mental Health Act 1983', neither of these had been signed by the patient and only one was signed by a member of staff.

From speaking with patients and some of their relatives, we found that overall patients were not involved in making important decisions about their individual care and the records we checked in relation to patient care confirmed this. Overall, we found that patients did not receive person centred care.

<u>Meeting people's health needs</u>

Patients did not have health action plans. We saw care plans relating to health needs and this demonstrated how patient's needs were being met. Staff told us patients had physical health checks on admission; this was evidenced within care records checked. Staff said patients also had annual health checks, patients confirmed to us their health needs were recognised and they were offered

appropriate treatment to meet their health needs.

Staff told us that a psychologist and two psychotherapists carry out work sessions with patients to provide support with their mental health needs.

We saw evidence that a patient had requested to read their health records with a solicitor present and the ward staff had arranged for this to happen. This protected the patient's rights.

Delivering care

Staff confirmed that smoking restrictions were in place on the ward. We found these `smoking restrictions', were rigid with little attention given to patients' rights and choices. When we asked the senior staff about this restriction, we were told this was not in place for any specific reason other than monitoring patients. The CTM advised us, that if any of the patients wanted to leave the ward to smoke they could, as they all had `Section 17 leave granted' (this is where patients can have the opportunity to leave the ward for a specified amount or time under certain conditions). The next day we were advised that the reason the restriction was in place was because the fence in the court yard posed an `absconding risk' as it was too low to meet the low secure unit standards for security.

We acknowledged that some restrictions placed on patients in the unit may be as a result of the nature of their detention under the Mental Health Act. There are situations where it would be appropriate to place restrictions on patients in order to keep them and other people safe. However, we looked to see whether restrictions, which were placed on patients met the following criteria:

- The restrictions were based on specialist need and risk assessments, or recorded evidence the restriction was required by their treatment programme;
- Whether patients had agreed or been informed about the restrictions during the assessment process;
- Whether the restrictions were proportionate and in line with Human Rights legislation.

We asked for, but were told there was no recorded evidence to demonstrate that before restrictions were placed on patients, that these factors had been considered in relation to individual patients smoking, ordering take away meals and access to the external courtyard area. Therefore, we could not be satisfied that the restrictions were `person centred' and / or were the, `least restrictive options' available to the staff team / service. This did not protect patients' rights.

We found the restrictions were placed on all patients on the ward. This was a `blanket approach' and compromised patients' rights and dignity.

The manager explained that patients were encouraged to limit or stop smoking and there are smoking cessation groups for patients.

We saw an activities board on the ward corridor, with all the weekly activities on display. The activities board included photos and pictures to support patients'

communication needs. Each patient had a weekly activity programme. There was an art room, a laundry (where patients did their own washing and ironing) and a kitchen to enable patients to develop cookery skills. Walking and exercise groups also formed part of the weekly activities programme. An Occupational Therapist (OT) works on the ward five days a week, to support patients' activities. These meaningful activities supported patients and met their social, physical and mental health needs.

Staff explained that mealtimes were flexible. However, this was not supported by some patient comments. Food was provided by an external catering firm. Staff said `taster sessions', were being held, so that patients favourite foods could be included on the menu. The CTM told us there were plans for a `special festivals and events menu' to celebrate occasions. This recognised patients' diversity. After the inspection the trust told us, "Whilst there is some flexibility within mealtimes, hot meals have to be served within a strict time frame in order to adhere to food hygiene laws. Snacks and fruit are also available throughout the day. There are also facilities available for service users to self cater as part of their recovery plan and this is actively encouraged."

Staff told us, `healthy eating', was encouraged and there was information available to patients about this. Staff told us that patients could only have takeaway meals on two set nights per week. The CTM told us, this decision had been made by the staff team to ensure patients were not constantly ordering take away food, as this was not consistent with `healthy eating'. However, given the fact that several patients had told us the food was poor and given that this was a rehabilitation ward prior to patients moving onto more independent living, the philosophy came across as 'staff know what is best for you'. Because of this patients' level of independence was `restricted' and their right to make choices was not protected.

Patients had access to independent advocacy agencies, (a local Leeds Learning Disability and Mental Health advocacy service). This included Independent Mental Capacity Advocate (IMCA) and Independent Mental Health Advocate (IMHA) who attend fortnightly MDT reviews, which the patient and their relatives were also invited to attend.

Staff told us morning meetings were held daily with patients in order to organise activities and individuals, `Section 17 leave', from the ward. The patients we spoke with confirmed this. This enabled patients to have some involvement in organising how they spent their time.

Patients told us, and we saw records of, minutes from patient involvement meetings. The records showed patient representatives from each ward had the opportunity to be involved in a patient involvement group that takes place fortnightly for the in-patient services provided at The Newsam Centre. This demonstrated patients had some opportunities to be involved in decision making within the service. We saw minutes of the meetings and discussed with the occupational therapist whether they were made available in other accessible formats for patients who may not read. They advised this was not done at present, but could be looked into.

We saw visitor records, which showed that family, friends and professionals visited people at the service at different times and at weekends. The visitors we spoke with

felt they could visit during the stated times and said they saw patients in the visitors' rooms, just outside the ward. This enabled patients to have privacy and to maintain important relationships.

Managing behaviour that challenges

Overall, we found there were care plans in place, which indicated how to minimise risks relating to patients who may present behaviour that challenges. There was recorded evidence, in incident records, that staff regularly used de-escalation techniques. There were clear guidelines for staff to follow if physical interventions were used including the importance of monitoring patients both during and after the incident.

Judgement

Patients' needs were assessed; care plans and risk assessments were in place. There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the `least restrictive' options or person centred. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There were major concerns with

Outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

We spoke with four patients to gain their views about the care, treatment and support they received on Ward 3, at the Newsam Centre. One patient was very happy with the support they received at the unit and it was clear staff had formed good relationships with the individual. He told us, “I love it here; it’s a lot better than where I was before.” And “Staff are good.” They went on to tell us they would feel able to discuss any concerns with staff and staff had recently talked to them about `bullying’ and how to report any concerns they may have.

A second patient told us, “Sometimes, I get confused, but I know I want to stay here.”

A relative told us, they had always been involved in their son’s care. Overall, the relative believed the patient was generally happy at the Newsam Centre and the relative was happy with their care.

A third patient told us, “When I first moved here I was bullied by other patients, this went on for six months, I was called names, they would `bang’ (*speak disrespectfully about)* my family”. He said he had told the staff about these concerns. This patient went on to tell us, “There are `anti-bullying’ posters on the ward, been there for two weeks and no one has explained them to people who can’t

read".

The patient went on to tell us they did not have a good relationship with some staff, "Some of the staff are nasty to me, they put fingers up to me. These are male members of staff." They did not name any individual staff. This concern was fed back to the CTM to address with the patient directly.

A fourth patient told us, "Staff pretend to be polite when there are visitors". They told us, another member of staff, "Was very intrusive in personal space, when we complain to the doctor, (N*ame)* gets upset and walks past the patient who has complained and has a cigarette." They went on to tell us, "There are only a handful of staff that are nice and respectful." "(*Name)* is really good with me."

We fed back these patient's concerns about staff, back to the CTM, the service manager and consultant psychiatrist on the first day of the inspection. We asked them to follow up these concerns with the patients. The service manager agreed to follow this up and take appropriate action.

One patient made an allegation to us about how they were treated by staff in another facility (outside the trust) before they moved to Ward 3 at the Newsam Centre. This allegation was made on the day of the inspection and was not previously known to staff. We asked the CTM to follow this up with the patient. The provider told us a safeguarding referral was made on 5 December 2011 and they were allocating this to a trust safeguarding adult enquiry co-ordinator (SAEC). We followed this up with the local safeguarding team responsible and we were advised the trust had made a safeguarding referral to this safeguarding team on 13 December 2011.

Another patient told us they were currently being bullied by a patient on the unit, they said, they were `being asked for money'. When we spoke with the patient's relative, they said the patient had complained to them about being bullied for money by another patient. The relative told us this was the reason the patient had absconded from the ward (three months prior to our visit). We passed this information on to the CTM, the service manager and the associate director and asked them to follow this up with the patient and relative to ensure the patient was adequately safeguarded. The trust notified us on 9 December that a safeguarding referral was made on 6 December 2011, to the trust's Safeguarding Lead. We followed this up by sending a referral to the Leeds safeguarding adults team in order to safeguard the patient.

Other evidence

<u>Preventing abuse</u>

Senior managers provided us with a copy of the trust's and the Leeds multi agency adult safeguarding procedures. They confirmed that the trust works within the multi-agency procedures. We looked at the trust's procedures and found it was due for review on 1 December 2011. A senior manager said the policy was currently under review. Staff told us the safeguarding policy and procedures were stored electronically on the trust's intranet, which was available in the ward office and was available to all staff.

We spoke with three members of staff who told us they knew about and had access to the trust's safeguarding policy and procedures. All three staff told us they would report all allegations of abuse to their line managers or to the trust's safeguarding co-ordinators (SAEC) or the Safeguarding Lead (SL). Three staff interviewed, all confirmed they had completed safeguarding training and also had access to electronic training sessions on this subject.

We also spoke with the Lead Occupational Therapist, who is one of the Adult Safeguarding Co-ordinators within the Forensic Service. She had completed the Leeds multi agency adult protection and investigation training and was clinically involved with all four patients.

Members of staff we spoke with were aware of whistle-blowing procedures. They were able to explain to us what they would do if they needed to use these to raise concerns. We were given a copy of the trust's whistle-blowing policy, this indicated that systems were in place to advise staff how to address and report any concerns they may have.

Responding to allegations of abuse

During the inspection, we asked the CTM and other senior managers for information about the number of safeguarding referrals made from the ward over the last year. We were told initially there were three, then were given a record indicating there had been two referrals and when we asked whether the referrals led to strategy meetings or to investigations and case conferences, managers were unclear and we received conflicting information. They told us this was because they had no central records to check to identify the number of incidents referred to safeguarding. This did not enable us to verify whether safeguarding procedures had been effectively followed; this could place patients at risk. This demonstrated the systems in place were not adequately robust to ensure patients were effectively safeguarded.

We spoke to the trust's SL who confirmed that the records relating to advice they had given staff, following safeguarding enquiries were not always recorded by the SL or SAEC. They would expect it to be recorded at the local level, by staff. In the case of this ward, the advice from the SL had not been recorded in a way that the information could be easily accessed and checked. This demonstrated the system was not effective to ensure a clear, accountable and accessible safeguarding audit trail was maintained by the trust.

The trust's safeguarding procedures checked did not indicate a clear timescale within which an `alert' or a `referral' should be made to the trust SAEC or Safeguarding Lead. The Leeds multi agency procedure states, "Every reported incident of abuse of a vulnerable adult must be treated with appropriate urgency". These procedures stated this should be done, "within the same working day". We saw evidence that safeguarding referrals were not being managed with, an `appropriate urgency', to protect patients from abuse or the risk of abuse.

In mid August 2011, several patients told staff in a community meeting they were being, `bullied', by other patients on the ward. This took the form of , `name calling' and `threats made to beat up a patient', asking patients for their snacks, selling

goods to patients for one price and then demanding further payments for the goods, with threats of violence if they did not agree. We asked what action had been taken to address the patient's allegations.

Information made available to us by managers during the inspection was confused, contradictory and incomplete. We spoke with the service manager, consultant psychiatrist and associate director about of our concerns that safeguarding procedures were not being followed robustly and that this could place patients at risk. We also advised that we had been given conflicting information about whether safeguarding referrals had been made, by whom and their status. Due to this we asked for a report to be sent in to us within 48 hours to clarify what action the staff had taken in the case of the patients alleging bullying in the ward meeting.

The report was sent in by the trust on 9 December 2011. It confirmed that no safeguarding `alert' or `referral' was made to the safeguarding lead at the trust or to the local area safeguarding team on the same day. It was sent in over three weeks after the initial concerns were raised. This did not demonstrate an `appropriate level of urgency', to address patient's allegations of abuse and this may have placed patients at risk of abuse. It also indicated that managers were not robust in following the trusts or the local area safeguarding procedures.

The report explained the reason that the safeguarding referral was not sent immediately. It stated, "This was a general ward safeguarding referral due to a number of issues of inappropriate behaviour being displayed". The trust went on to tell us a ward action plan was in place. They said, "The trust's safeguarding lead has not deemed it necessary to progress this to a case conference and to this end this is not an open case. The trust's safeguarding lead (SL) was sufficiently assured that it was appropriate for this to be managed by the clinical team". The trust told us in their report to us that after the safeguarding referral was made on 15 September 2011 to the SL; that a decision not to proceed with the case was made by the SL. However, there was no recorded reason for this decision making available on the ward when we visited.

The trust's safeguarding procedure stated that, "a decision about how to respond to the concerns will be made following consultation with all relevant individuals and after consideration of the legal and ethical parameters,…This will be made by the SAEC following consultation with all relevant parties… There may be some cases where it is felt appropriate to refer to the Local Authority, this decision will be made after multidisciplinary consultation and after taking advice from Leeds Safeguarding Adults unit". We were not provided with recorded evidence to demonstrate that this process had been followed.

We were told that Leeds safeguarding adults team had not been involved in the case as the seriousness of the allegation was deemed to be `Level 1 – safeguarding', (Lowest level) and this was to be dealt with via the clinical team on the ward. There was no recorded information about how, why and when this decision had been made.

We were concerned that patient's allegations were not being recognised as `allegations of abuse', staff were not responding with an `appropriate level of urgency', records were not being kept in relation to when allegations were made

and the rationale for decision making. This meant that safeguarding procedures were not being effectively implemented and any actions staff had taken were not being appropriately recorded. This did not ensure that patients were adequately protected from abuse or the risk of abuse.

Using restraint

Staff told us they had received training in order to safely use physical interventions (restraint) as a last resort. We found staff mainly used de-escalation techniques and incident records showed staff very rarely used restraint or physical interventions with patients. We saw evidence in incident records that when patients had presented `challenging behaviour', they were supported by staff who used de-escalation techniques and these were effective in supporting patients. Staff told us, the ward does not have a seclusion room but there is the facility available within another unit. We were told that seclusion had not been used at the service for over two years. We saw evidence that incident records had been audited by the trust's risk management team. Staff said they would use the information to identify any trends or near misses to ensure patient safety. This ensured that patients safety was being monitored.

Judgement

Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an `appropriate urgency' and there was no clear recorded audit trail of the actions taken by staff to safeguard patients. This meant patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury.	**Regulation 9**	**Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights**
	How the regulation is not being met: Patients' needs were assessed; care plans and risk assessments were in place. There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the `least restrictive' options or person centred. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury.	**Regulation 11**	**Outcome 7: People should be protected from abuse and staff should respect their human rights**
	How the regulation is not being met: Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an `appropriate urgency' and there was no clear recorded audit trail of the actions taken by staff to	

	safeguard patients. This meant, patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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