LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

CARE QUALITY COMMISSION REVIEW OF COMPLIANCE

Ward 3 Newsam Centre

1. INTRODUCTION

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission (CQC) carried out a visit to Ward 3 Newsam Centre on the 5th and 6th December 2011.

The review focused on the following two outcomes:

- Outcome 4 – Care and welfare of people who use services
- Outcome 7 – Safeguarding people who use services from abuse

In undertaking the review the CQC observed how people were being supported and cared for, talked with people using the service, talked with relatives or representatives, talked with members of staff and looked at records of people using the service.

2. FINDINGS FROM THE REVIEW

The final draft report has now been received from the CQC. On receipt of the first draft the Trust raised some concerns with the CQC around the proportionality of the report, the language used and the context of some of the findings within a low secure service. A meeting took place with the CQC on the 8th February to discuss in detail the issues raised by the Trust. The report has been amended to reflect some of the issues raised and to include positive practice that was identified at the inspection. The outcome of the inspection, however, remains the same. The Trust still has continued concerns with the proportionality of the outcomes within the revised report due to the number of positive findings by the inspection. The Trust also has concerns as to the understanding by the CQC of a low secure setting and the necessary balance required between appropriate restrictions to manage risk and safety.

The table below shows a summary of the CQC findings. A moderate concern was identified with Outcome 4, meaning that people who use the service 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 was identified with Outcome 7, meaning that people who use the service are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Outcome	CQC Judgement
Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights	Overall the CQC had moderate concerns and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.
Outcome 7: People should be protected from abuse and staff should respect their human rights	Overall the CQC had major concerns and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.

3. DETAILED FINDINGS FROM THE REVIEW

Outcome 4: Care and Welfare of people who use Services

Overall, the CQC had moderate concerns with Ward 3, Newsam Centre, and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.

The CQC spoke with 4 people using the service who told the CQC that they were satisfied with the care, treatment and support they received. Positive comments included 'I have a care plan and health care plans', 'I have meetings with the doctors and nurses and I've got an advocate' and 'staff explain the risks involved in the choices I make'.

Concerns were raised by patients relating to a lack of privacy during phone calls as the phone was located on a communal corridor. Staff informed the CQC that patients could use the phone in the clinic room for privacy.

The CQC spoke with 2 relatives to gather their views about the care, treatment and support offered to patients. One relative told the CQC that "(patient's name) has a care plan and I think he has a Health Action Plan and an annual health check". The relative said they were invited to review meetings but felt that they were not really listened to and that doctors and staff have had the ultimate say in the decision making. The second relative told the CQC they had very little contact with the staff on the ward and were unhappy about the lack of consultation and involvement with staff. However, the service user had specifically stated during the early stages of his admission that he did not want staff to discuss his care with specific members of his family. At a later date he agreed that the clinical team could contact named relatives, but his relationship with them is such that the team would always ask him first, and this permission was sometimes withdrawn.

During the inspection the CQC observed some staff interactions with patients which were friendly and empowering. However, the CQC also reported that they observed some interactions which they didn't find to be respectful and which didn't protect patient dignity and that in some cases there was limited social interaction between patients and some staff.

Assessing people's needs

Staff explained the referral and admissions procedure and provided the CQC with copies which were found to give clear instructions when assessing and admitting a patient to the service. Patients were found to have discharge plans, which staff began to develop on their admission.

The CQC examined the assessment records of 4 patients which were found to be detailed and clearly showed the patients' assessed needs. Records showed that patients had been detained prior to being admitted, with evidence supporting this.

Overall the CQC found evidence 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.

Care Planning

Four patients care plans were looked at in detail by the CQC. The care plans checked were based on the patients needs assessments made prior to and on admission to the unit. These care plans were found to be detailed and were regularly reviewed on a monthly basis. However, the CQC found the care plans to be written in a clinical and technical way, with little evidence to suggest that these had been devised in conjunction with patients. The care plans checked had not been signed by patients to show their agreement about what was recorded in their care plans. The CQC's view was that the care plans checked did not demonstrate a person-centred approach to planning patient care.

All care plans were found to be kept locked in a staff office in order to protect patient confidentiality. Neither of the 4 patients whose care plans were checked had their own copy. However, staff reported that if people requested their care plan then a copy would be made available to them.

The CQC asked staff whether any person centred care plans were planned with patients. Staff informed the CQC that patients had discharge plans in place called 'My future plan' and that these had been devised using person centred principles. Three of the plans were looked at in detail with one of them being found to be comprehensive, detailing the patient's views and wishes and using pictures and easy read formats to meet the patients' communication needs. The other two plans were found to lack written evidence of any patient involvement, however these plans were still in the process of completion with the patients.

There was evidence that CPA reviews were carried out regularly with pre-CPA checklists being completed. Evidence was found in one patient's record of a CPA self-assessment report which had been completed by the patient prior to their CPA review. This practice involved the patient and protected their rights.

The CQC found that a risk assessment and review system was in place and there was evidence that the risk assessments checked had been regularly reviewed. Staff informed the CQC that risks were explained to patients and one patient told the CQC that risks relating to the medication they had been prescribed had been explained. This supported the patient to understand the effects and side effects of the medication.

Written evidence was found to show that staff had explained patients' rights to them whilst detained under the Mental Health Act. However, there was little written evidence to confirm that patients had received this information. In two patients' records it was recorded that patients rights had been explained to them, however these hadn't been signed by the patients.

Overall, from speaking with patients and some of their relatives, the CQC's view was that patients were not involved in making important decisions about their individual care and that patients did not receive person centred care.

Meeting People's Health Needs

The CQC found that patients did not have health action plans, however care plans relating to health need were in place which demonstrated how patient's needs were being met. Staff informed the CQC that patients had physical health checks on

admission as well as annual health checks. This was evidenced within care records and patients confirmed to the CQC that their health needs were recognised and they were offered appropriate treatment to meet these.

The CQC found 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

The CQC found that the "smoking restrictions" in place on the ward were rigid with little attention given to patients' rights and choice. The Clinical Team Manager advised the CQC that if any of the patients wanted to leave the ward to smoke they could as they all have Section 17 leave granted. The CQC 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 and that there are situations where it will be appropriate to place restrictions on people in order to keep them and others safe. However there was no recorded evidence to demonstrate that before restrictions were placed on patients' specialist need and risk assessments had been taken into account and that patients had agreed or been informed about the restrictions. The CQC viewed this as the Trust taking a 'blanket approach' to restrictions, particularly with regard to smoking, access to the external courtyard area and the ordering of take away meals and therefore could not be satisfied that the restrictions were person centred or the least restrictive options.

Patients were found to have individualised weekly activity programmes which included walking and exercise groups. An Occupational Therapist works on the ward 5 days a week to support patient's activities. The CQC reported that these meaningful activities supported patients and met their social, physical and mental health needs.

With regard to meals on the ward staff informed the CQC that "taster sessions" were being held so that patients favourite food could be included on the menu and there were plans for a "special festivals and event menu" to celebrate occasions. The CQC felt that this recognised patients' diversity.

Healthy eating was encouraged on the ward with information available to patients. Staff informed the CQC that patients could only have takeaway meals on 2 set nights per week to ensure patients were not constantly ordering take away food as this was not consistent with healthy eating. The CQC felt that given Ward 3 was a rehabilitation ward, prior to moving onto more independent living, that this decision restricted patients' level of independence and that their rights to make choices were not protected.

There was evidence that patients had access to independent advocacy agencies which included Independent Mental Capacity Advocate and Independent Mental Health Advocate who attend fortnightly MDT reviews, which the patient and their relatives were also invited to attend. Patients confirmed that meetings were also held daily with them in order to organise activities and Section 17 leave from the ward. This enabled patients to have some involvement in organising how they spent their time.

Evidence was found of patient involvement meetings with patient representatives from each ward having the opportunity to be involved in a patient involvement group. The CQC felt that this demonstrated patients' had some opportunities to be involved in decision making within the service. The CQC asked whether the minutes of the meetings could be made available in accessible formats for patients who may not read, which the ward agreed to look into.

From observations and from visitor records, the CQC found that patients' family, friends and professionals visited at different times of the day and at weekends. The visitors the CQC spoke to felt they could visit during the stated times and said they saw patients in the visitors rooms just outside of the ward. This enabled patients to have privacy and to maintain important relationships.

Managing Behaviour that Challenges:

The CQC found that overall 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 and 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.

For this outcome the judgement by the CQC was that patients' needs were assessed with care plans and risk assessments in place. However, 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. The CQC's view was that 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:

Overall, the CQC had major concerns with Ward 3, Newsam Centre and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.

The CQC spoke with 4 people using the service who told the CQC that they were satisfied with the care, treatment and support they received. Positive comments included 'I love it here' and 'staff are good'. They informed the CQC that they would feel able to discuss any concerns with staff and that staff had recently talked to them about bullying and how to report any concerns they may have.

The CQC spoke with a relative who informed them that they had always been involved in their son's care, that their son was generally happy at the Newsam Centre and that they were happy with the care provided.

A patient told the CQC that when they first moved to the ward they were bullied by other patients and that he had raised concerns with staff. He went on to tell the CQC that he did not have a good relationship with some staff but did not name any individual staff. This concern was fed back to the Clinical Team Manager to address with the patient directly.

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One patient made an allegation to the CQC about how they were treated by staff in another facility outside of the Trust. This allegation was made on the day of the inspection and was not previously known to staff. A safeguarding referral was made on the 5th December by the ward to the Trust Adult Safeguarding Lead. The CQC followed this up with the local safeguarding team responsible and were advised a safeguarding referral was made to this team on the 13th December.

Another patient informed the CQC that they were currently being bullied by another patient on the unit and when the CQC spoke to a relative of the person she identified that this was the reason the patient had absconded from the ward previously. The CQC requested that the ward follow this up with the patient and relative to ensure the patient was adequately safeguarded and a safeguarding referral was made on the 6th December.

Preventing Abuse

The CQC were provided with a copy of the Trust's and the Leeds multi agency adult safeguarding procedures. The Trust policy was due for review on the 1st December 2011 and the CQC were informed that this was currently under review. Three members of staff were spoken to who all knew about and had access to the Trust's policies and procedures relating to safeguarding. Each staff member confirmed they would report all allegations of abuse to their line manager or to the Trust's safeguarding co-ordinators or the Safeguarding Lead. All 3 staff confirmed they had completed safeguarding training and also had access to electronic training sessions on this subject. The Lead Occupational Therapist spoke to the CQC who is one of the Adult Safeguarding Co-ordinators within the Forensic service. She confirmed she had completed the Leeds multi-agency adult protection and investigation training and was clinically involved with all 4 patients on the ward.

Members of staff spoken to were aware of whistle blowing procedures and were able to explain to the CQC what they would do if they needed to raise concerns. The CQC were given a copy of this policy which indicated that systems were in place to advise staff how to address and report any concerns they may have.

Responding to Allegations of Abuse

Staff informed the CQC that there were 3 safeguarding referrals made from the ward over the last year. However, when the CQC checked records it was evident that there had been 2 referrals and when questioned whether the referrals led to strategy meetings or to investigations and case conferences, managers were unclear and the CQC received conflicting information. The CQC were unable to verify whether safeguarding procedures had been effectively followed and did not feel that the systems in place were adequately robust to ensure patients were effectively safeguarded.

The Trust's Safeguarding Lead confirmed that advice given to staff, following safeguarding enquiries was not always recorded by the safeguarding lead or co-ordinators and that it is expected to be recorded at a local level by staff. However, the CQC found evidence that advice from the safeguarding lead had not been recorded in a way that could be easily accessed and checked. The CQC felt that 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 procedure was not found to indicate a clear timescale within which an "alert" or a "referral" should be made to the Trust safeguarding co-ordinators or safeguarding lead. The Leeds multi-agency procedure specified that safeguarding alerts or referrals should be made within the same working day. The CQC saw evidence that safeguarding referrals were not being managed with 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. When the CQC asked managers what action had been taken, information made available to the CQC has been reported to be confusing,

contradictory and incomplete. The CQC raised concerns with the ward that safeguarding procedures were not being followed robustly and requested a report be sent to them within 48 hours to clarify what action had been taken by staff in response to this allegation. The report received by the CQC confirmed that no safeguarding "alert" or "referral" was made to the safeguarding lead or to the local area safeguarding team on the same day. It was sent in over 3 weeks after the initial concerns were raised. The CQC felt that 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 to the CQC that managers were not robust in following the Trusts or the local safeguarding procedures.

This report also explained the reason why 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 inform the CQC that a ward action plan was in place and that the Trust Safeguarding Adults Lead had not deemed it necessary to progress this to a case conference. The Trust's Safeguarding Lead was sufficiently assured that it was appropriate for this to be managed by the clinical team. However, the CQC could find no evidence of a recorded reason for this decision making available on the ward when they visited. The CQC could also not find any evidence that the process, highlighted within the Trust's safeguarding procedure, had been followed.

The CQC had concerns that patient's allegations were not being recognised as allegations of abuse, staff were not responding with an "appropriate level of urgency", and 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. According to the CQC this did not ensure that patients were adequately protected from abuse or the risk of abuse.

Using Restraint

Staff spoken to confirmed that they had received training in order to safely use physical interventions (restraint) as a last resort. Staff were found to use de-escalation techniques mainly, with incident records showing staff very rarely used restraint or physical intervention with patients. The CQC 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. There was evidence of incident records being audited and staff informed the CQC that they would use the information to identify any trends or near misses to ensure patient safety. The CQC were satisfied that this ensured that patients safety was being monitored.

For this outcome the judgement by the CQC was that 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 that patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

4. IMPACT ON PERFORMANCE AND ACTION PLANNING

The Trust still has continued concerns with the proportionality of the outcomes within the revised draft report due to the number of positive findings by the inspection. The Trust

also has concerns as to the understanding by the CQC of a low secure setting and the necessary balance required between appropriate restrictions to manage risk and safety.

Based on the findings from the final draft report our Monitor Governance Risk Rating will remain at an 'amber-red'.

In early January 2012 a review was undertaken into safeguarding incidents and critical Incidents across learning Disability services, specifically with regard to the following:

- A review of trends, themes and frequency of serious untoward incidents (SUIs) within the directorate
- A review of trends, themes and frequency of safeguarding referrals within the directorate, as well as actions from serious case reviews
- A reflection upon the Care Quality Commission (CQC) recommendations and findings as a consequence of their recent visits to 3 Woodland square and Ward 3 Newsam Centre.

There was not found to be any commonalities or trends as a result of the review and there were found to be robust action plans in place which were being actively implemented.

Further work is being undertaken within the Trust in relation to safeguarding to ensure that all systems and processes are robust as follows:

- A full and detailed internal review of safeguarding processes is currently underway within the Trust
- A mechanism is being developed to ensure all safeguarding enquiries are recorded
- A specific safeguarding section has been included within patients' records to ensure that all safeguarding concerns are documented.

An action plan has also been developed, which is set out in Appendix A to address the actions required and has been submitted to the CQC.

The CQC will revisit the service to ensure that all actions have been completed. To ensure that our compliance actions are removed as quickly as possible all actions are due to be completed by the end of April 2012. Work is on track to achieve this timescale.

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
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 and this limited patients' involvement in making decisions	**To ensure all service users planning of care is approached in a person centred way.** - Care plans will be completed in collaboration with service users, and when appropriate, their relatives	Clinical Team Manager	February 2012	**Completed**. Copy of the signed care plan will be found in each service users care records and documented reason why the service user has not signed if refused. Audit to be completed by the Adult Lead Nurse in April 2012.
about their daily routines. 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.	- All Learning Disability service users will have a Health Action Plan (HAP). All other service users will have an Annual Health Check.	Lead Nurses for Adult & Learning Disability Services	January 2012	**Completed**. HAP documentation will be found in Learning Disability service user care records. Annual Health Checks are monitored via the service quarterly as a Key Performance Indicator.
	- All service users will be given the opportunity to sign and have a copy of their own treatment plan.	Clinical Team Manager	February 2012	**Completed**. Audit to be completed by the Adult Lead Nurse in April 2012.
	- All service users will receive information in a format that meets their needs. A selection of materials will be made available to service users.	Lead Nurses for Adult & Learning Disability Services	March 2012	**Completed**. Information Boards have been developed. These include photos and information in different formats. The ward welcome pack/information booklet includes photos and easy to read text.
	- All ward staff will receive training in engaging with service users who have communication difficulties.	Lead Nurses for Adult & Learning Disability Services	April 2012	A list of staff who attended the training will be maintained.
	- The "20 Service User Defined Standards" for CPA will be met.	Modern Matron	January 2012	**Completed**. Reported through Key Performance Indicators quarterly reports.

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
	- A welcome pack/information booklet will be made available for all service users which will include information about the care Service users can expect on the ward, including how they can expect to be treated as an individual and will include information on CPAs, ward rounds and other helpful information. This will be provided in a variety of formats.	Modern Matron	March 2012	**Completed**. Visibility and accessibility of the welcome pack/information booklet is available in service user bedrooms, and sent to service users prior to admission.
	- Carers will receive information about what they can expect from the ward team and how they can get involved. A Carers Leaflet will be developed	Modern Matron & Trust Carer's Lead	April 2012	**Completed**. Carer's information resources are available. A carer's board containing relevant information has been installed in the entrance lobby. Each ward has a carers lead. The Trust's Carers Manager is working with the service to improve carer engagement.
	- Specific work will be undertaken to identify the most appropriate mechanisms for engaging and supporting carers. Specific options will be identified and implemented.	Carers Lead & Modern Matron	March 2012	A number of different mechanisms will be available eg written information and displays, carers service referral numbers will be monitored.
	- Ensure that all staff are completing appropriate documentation when informing service users of their rights under the Mental Health Act 2007.	Lead Nurse Adult Services	January 2012	**Completed**. Service user care notes. Adult Lead Nurse will complete an audit in April 2012 and will feature in the Annual Documentation audit.
	- All service users will receive their rights in a format that they are able to understand.	Lead Nurse Adult & Learning Disability Services	January 2012	**Completed**. Mental Health Act information booklets are now made available on the ward.
	- There will be a review of the Multi Disciplinary Team (MDT) process to ensure that the service user and their carer are at the centre of the planning of their care. An MDT review form will be developed and implemented which will be completed by the	Modern Matron & Lead Consultant Psychiatrist	April 2012	**Completed**. Process completed and communicated to staff. Away day on 14 March focussed on MDT working. Work stream projects will be progressed. Ward 3 is engaging in a pilot project regarding the

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
	primary worker prior to the review meeting. This will be done in partnership with the service user to identify progress, any risks or concerns.			MDT process. Productive Mental Health Wards process module will evidence MDT new ways of working. There will be evidence of standardised documentation in the service user's care records.
	- The ward, in partnership with service users, should ensure that healthy diet options are available and promoted on the ward and that there is an agreement with service users regarding how and when access to take-away meals will be facilitated.	Dining Experience CQUIN Lead	February 2012	**Completed**. New menus are now in use. Information boards about nutrition and healthy eating are installed in the dining area. Evidence is contained in the service user feedback forms, Your Views meetings and the service user involvement leads. This is a CQUIN for the service and quarterly reports are produced. Staff discuss with service users regarding access to take-aways.
Regulation 11, Outcome 7: People should be protected from abuse and staff should respect their human rights	**Action required**	**Lead individual**	**Target Date**	**Progress & Evidence**
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.	**To ensure that the Leeds Adult Safeguarding Procedure is implemented to and adhered to.** - A specific training package will be developed and implemented which will support staff skill development to empower service users in their being involved in their care planning and how to support a service user who has raised a concern.	Lead Nurse Adult & Learning Disability Services	April 2012	Production of a training package and training attendance records. Service User feedback.
	- To include in the ward welcome pack/information pack, information for	Modern Matron	March 2012	**Completed**. The welcome/ information pack is now

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
	service users on how to raise concerns and how they can be expected to be treated by staff.			available on the ward
	- A central Adult Safeguarding referral email inbox is established that is accessible by designated members of the safeguarding team.	Trust Safeguarding Lead	February 2012	**Completed**. A central safeguarding adult mailbox has been developed.
	- The safeguarding team will develop a mechanism by which they can record all enquiries and provide an auditable trail. They will also maintain a central log of concerns raised.	Trust Safeguarding Lead	March 2012	Evidence of the log will be available.
	- All safeguarding concerns will be documented in the service user's records with an indication of what further actions are required. All risk assessment and treatment plans should be updated to reflect these concerns and actions taken. Where there are specific safeguarding concerns an individual safeguarding care plan will be developed.	Clinical Team Manager	February 2012	**Completed**. There is a specific safeguarding section in the service user's care records. Staff are aware of how to record enquiries and referrals in this section of the notes.