Review of compliance

Leeds Partnership NHS Foundation Trust St Mary's Hospital (3 Woodlands Square)	
Region:	Yorkshire & Humberside
Location address:	St Mary's Hospital Greenhill Road, Armley, LS12 3QE
Type of service:	Hospital services for patients with mental health needs, learning disabilities and problems with substance misuse.
Date the review was completed:	October 2011
Overview of the service:	We inspected 3 Woodland Square, at St Mary's Hospital. This service provides a continuing treatment in-patient service for people with a learning disability who require longer-term treatment in a hospital setting. The unit provides care for people, who have complex needs. The service can accommodate up to eight patients and at the time of our inspection, seven patients were in residence. 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 St. Mary's Hospital 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 inspectors joined by two 'experts by experience' – people who have experience of using services (either first hand or as a carer) and 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 25 and 26 October 2011. We observed how people were being supported and cared for, talked with people who use services, talked with their relatives or representatives, talked with staff, checked the provider's records and looked at records of people who use services.

To help us to understand the experiences people have we can use 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. This tool was not used on this occasion, as it was not appropriate to meet the patients' needs.

What people told us

There were seven patients in 3 Woodlands Square at St Mary's Hospital when we visited. Five of the seven patients were detained under the Mental Health Act. Two patients were voluntary patients. We met and introduced ourselves to six of the patients using the service. One patient was on leave on the first day of our inspection and was discharged from the service on the second day of our inspection. We spoke with five patients to get their views of the service.

Overall, patients and their relatives told us they were satisfied with the care and treatment at the unit. Patients we spoke with said, “I like all the staff”. “I like living here”. One relative told us, “Smashing care”. Patients’ told us they enjoyed the activities on offer from the service and were able to still attend their usual daytime activities whilst staying at the unit. This was positive as it enabled people to have consistency in the support they received.

What we found about the standards we reviewed and how well St. Mary’s Hospital was meeting them.

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

Patients’ needs were assessed; some patient care plans and risk assessments were comprehensive and implemented effectively to ensure the delivery of care met patients’ identified needs. Other care plans and risk assessments were not comprehensive, regularly reviewed and care delivery was not always implemented effectively. This placed patients’ at risk of receiving inappropriate or unsafe care, treatment and support. Patients were not routinely involved in devising their care plans, the care plans were not devised using person centred principles and they were not in accessible formats to meet individual’s communication needs. We found that some decisions to restrict patients’ liberty had been undertaken without consultation with them and in adherence with the Mental Capacity Act 2005. This did not protect their rights.

- Overall, we found that St Mary’s Hospital (3 Woodlands Square) was not meeting this essential standard. Improvements are needed.

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

There were clear policies and procedures in place for staff to follow to safeguard patients from abuse or the risk of abuse. Overall, there was evidence these procedures were implemented effectively. However, the actions taken to address one patient’s allegations against staff, had not been effectively implemented or managed. This meant the patient’s welfare was not fully protected and could leave them vulnerable to the risk of abuse. Incidents of challenging behaviour, where restraints had been used by staff were not always fully recorded or reported via the correct procedures and there was a lack of evidence of review and learning from these the incidents. This could place patients’ at risk of receiving inappropriate care, treatment and support.

- Overall, we found that St Mary’s Hospital (3 Woodlands Square) 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 a safeguarding referral from the hospital managers to the local area, Leeds Safeguarding team had been received and was being assessed.

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.

Other information

Please see previous review reports for more information.

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 meets 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 five patients. Their comments about the care, treatment and support at the unit included:
“I like the staff”. “I like living here”. “I have a care plan but I have not got a copy”.
“I like to go shopping for food and I like cooking”.
“I can attend my review meetings with the staff”.

We spoke with two parents and overall, they were very positive about the support, care and treatment their relatives received. They told us, “We can attend weekly meetings and have attended some”. Another relative told us, “We are always invited to review meetings”. This was positive and demonstrated people’s relatives were actively invited to attend patients’ meetings.

A relative told us, “We keep a very close eye on (*patient’s name*). “They are ready for discharge in November (2011)”. “They are going to live in a supported living unit, and we are very pleased”. They said, “We have not seen (*patient’s name*) care plan yet. Another relative said, “I have a copy of their care plan”. They told us they thought it was comprehensive and covered health needs well. However, they said staff had not asked their views or discussed the care plans with them.

There seemed to be a disparity between the relatives’ perception of being invited to attend meetings but not having seen and or contributed towards the development of

patients care plans.

From our observations, we found that most staff engaged well with patients, staff had informal but professional relationships with people and positive regard for each patient.

Other evidence

Assessing people's needs
The nurses told us about the referral and admissions policies for the service. We were shown a copy of the procedures and we examined this whilst at the service. The procedures were satisfactory and gave staff clear instructions to follow when assessing and admitting a person to the service.

We looked at the `72 hour assessment', records for two patients', to see if their needs were identified. The two we looked at were comprehensive and identified a wide range of needs.

Discharge `pathways planning' was in place. This included comprehensive details of people's history and current needs that would aid a smooth transition when they left the service. The service manager told us and showed us admission and discharge records, which showed the average length of stay was 43 days for most patients. Three patients (excluded from the average stay figures) had been living in the service for between three and fourteen years. This was because historically this service was for patients' with longer-term placement needs. The staff told us they had not found suitable alternative accommodation for two of the three patients. We asked the service manager about this and were told, two patients had recently been referred to local commissioners to find suitable alternative placements. The staff said a third patient was due to move out in November 2011 and we saw recorded evidence of this.

Care planning
We looked at two patient's care plans in detail. We did this to identify what the patient's needs were, how they were to be met and if there was evidence, they had been met. The care plans we looked at were based on the `72 hour assessments'. We asked a nurse how often patient's care plans should be reviewed. We were told this should be, 'as often as required'. They said they had told nurses to review the care plans when they were on night shifts. However, this would mean that patients' and their relatives would not be involved in the process and this would not meet patient's needs.

Overall, there was evidence that patients needs, values and diversity were taken into account when devising care plans. For example a range of specific health, social and cultural needs were identified.

There was evidence the care plans checked had been evaluated and reviewed. In one case, we found the care plan was comprehensive, covered a whole range of needs and there was evidence the care plan guidance was implemented in practice by staff delivering care. These care plans had been regularly, reviewed and evaluated. However, the dates of the reviews of the other patient's care plans were

spasmodic; For example, the records indicated the plans had been reviewed three times in 33 months. This did not provide evidence the patients' needs were regularly reviewed, to identify whether the care and support they received was effective. We saw evidence in this patients' care plan of recordings, which were vague, for example, one care plan stated, "Use common sense in judgements". This was too vague to clearly indicate the approach to be taken by staff. We found evidence in patients `daily general notes' that the care plan had not been consistently followed by staff in the delivery of care to this patient. This placed the patient at risk of receiving inappropriate or unsafe care, treatment and support. This did not protect their rights. (See outcome 7)

Neither of the care plans checked were devised in accessible formats. They were written in a technical way, for the staff to follow as opposed to being `person centred'. The care plans checked did not take in to account the patient's individual communication needs and this meant that the care plans were inaccessible to them, as they did not read. There was evidence that two care plans had been signed by patients' and staff told us they would speak to patients' to inform them of the content of the plans before they were asked to sign them.

A risk assessment and review system was in place. A nurse told us told us, "Risks are always explained to patients in their multi-disciplinary team (MDT) meetings". Risk assessments checked had been devised in an electronic form, there was evidence most were accurate and had been regularly reviewed. We saw evidence that one risk assessment had not included some risks identified in the patient's daily notes and the nurse addressed this, on the day of the inspection.

Overall, we found evidence on the patients care records that some important records were not accurate, up to date, fully completed or adequately detailed. Examples of this included; a risk assessment, which did not contain details of risks identified in a patient's daily notes, a care plan which, had not been regularly reviewed and had not been reviewed after a serious incident had occurred. These examples of poor record keeping at the unit could place patients at risk of receiving inappropriate care, treatment and support.

All the care plans were kept locked in a staff office to protect patient confidentiality. Neither of the patient's whose care plans we checked, had their own copy. Staff said if people requested their care plan, it would be made available.

There was evidence in some of the care plans checked that staff had sought the views and involvement of some carers or relatives in developing plans.

We spoke to the lead nurse about the how they implemented the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) within the service. They told us that staff were trained in MCA and DoLS, and where applicable, they only use DoLS when it is in the best interests of the patient and in accordance with the Mental Capacity Act 2005.

We asked for evidence of whether two voluntary patients were able to leave the ward of their own volition. We were told by a nurse the patients were not able to go out alone, but needed staff support to ensure their safety. We asked whether mental capacity assessments had been undertaken or best interest meetings had

been held and were told this had not happened in either case. This did not protect the patients' rights.

Meeting people's health needs

We found evidence of nursing care plan's that demonstrated people's health needs had been identified and evidence in nursing notes they were being met. For example, patients had regular health and medication reviews and there was evidence that appointments with other health professionals, for example speech therapy and GP appointments had taken place. This meant people's health needs were identified and records guided staff in how they should be met, but there was no evidence of patients' involvement.

Health Action Plans (HAP's) ensure patient's health needs are identified and assessed and include the individuals views of how their health needs should be met and managed. The nurses told us that some, but not all patients had a HAP. One Health Action Plan (HAP), we saw had been completed by a nursing assistant. The HAP seen was devised using an accessible (pictorial) format. However, it was not fully completed. Large sections of the plan were left blank. The date on the plan was March 2011 and no review dates were recorded. There was no evidence that a medical professional had signed the HAP and there was no evidence that the patient had been involved in the process or had a copy. This did not ensure that patients and or their relatives had been involved in identifying their health needs or that their views had been considered.

Delivering care

We saw that patients' had individualised weekly activity plans. Patients' told us and we found recorded evidence of examples of meaningful activities being provided for them. For example, daily walks for a patient to get regular exercise and this also had benefits for their mental health needs. A patient was supported by staff to visit local shops, to buy their own food and then prepare and eat their own meals, as they were being supported to eat a healthy diet. There was evidence that patients had a good mix of social activities for example trips out to go bowling, to the cinema, visits to café's and days out to local parks etc. Staff told us and we saw evidence that people's 'usual day services', were supported and we saw staff from a local care provider, come in to the service to support a patient to meet their social needs. This was positive as it demonstrated patients were offered continuity of care between the hospital care and their permanent care provision.

From our observations and from visitor records we saw that patients' family, friends and professionals visit patients at different times of the day and at weekends. The visitors we spoke to felt they were free to visit when they wanted to and were made welcome when they came.

The team manager told us an independent advocate from Leeds Advocacy service was invited to attend each; multi disciplinary team (MDT) meeting and staff said they attended most weeks. This was positive and ensured patients had an independent person in the meeting to speak up on their behalf.

Managing behaviour that challenges

Plans of how to manage the risks posed by patients', `challenging behaviour' were present in all the records checked. Some of the care plans did this well. For

example, some plans checked had been devised with the support of a psychologist and included very detailed information of how staff should support the patient to prevent challenging incidents. The plan also indicated how to safely manage an incident if it placed patients' or staff at risk of harm.

Judgement
Patients' needs were assessed; some patient care plans and risk assessments were comprehensive and implemented effectively to ensure the delivery of care met patients' identified needs. Other care plans and risk assessments were not comprehensive, regularly reviewed and care delivery was not always implemented effectively. This placed patients' at risk of receiving inappropriate or unsafe care, treatment and support. Patients were not routinely involved in devising their care plans. The care plans were not devised using person centred principles and they were not in accessible formats to meet individual's communication needs. We found that some decisions to restrict patients' liberty had been undertaken without consultation with them and in adherence with the Mental Capacity Act 2005. These practices did not protect patient's 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 moderate concerns with

with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

Overall, patients spoken with told us they were satisfied with the care, treatment and support they received from staff.

We spoke with two patients about safeguarding one patient told us, “I’m not sure who to tell if I was being hurt”, and then said, “Staff”. There was evidence that this patient had spoken to staff about their peer’s behaviour on occasions. We found the staff had listened to their concerns and taken action to address the patient’s concerns.

One patient we spoke with told us sometimes staff used restraint or physical interventions with patients. They told us, “They do (use restraint), but not on me because I am good”. They went on to say, “Staff do not hurt people when they do it” (restrain patients), “they do it by holding them”.

A patient told us, “Staff keep my money in the safe; I ask when I want it”.

We spoke with two relatives who told us they were satisfied with the care, treatment and support their relatives received at the unit. Both parents thought their relative was safe at the unit.

One relative told us, “(Patient’s name) is very well cared for”. They said, “I have a good impression of the care and the attitude (of staff) here”.

Other evidence

Preventing Abuse

The lead nurse provided a copy of the local adult safeguarding policy and procedures that are used by the service (both the trusts and Leeds Safeguarding Partnership Board procedures). We were told these were stored on the intranet and all staff had access to these at all times. The staff we spoke to confirmed this. We spoke to three members of staff who were all aware of the trusts safeguarding procedures. However, there seemed to be some confusion from two staff about how these fitted with the Leeds local area safeguarding procedures, and at what point to refer incidents to the local area safeguarding team.

Training records showed that the majority of the staff team had up to date safeguarding training. The lead nurse told us, and the ward staff confirmed they had recently completed in-house adult safeguarding training. This training was not recorded in the training records checked. Two nurses told us they did not have up to date safeguarding adults training. This will need to be addressed to ensure patients’ are adequately safeguarded.

Members of staff we spoke to 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. A self-assessment form was completed by the trust following our visit. In this, the trust confirmed an up to date whistle-blowing policy and system are in place.

Responding to allegations of abuse

The nurses on the ward told us that systems were in place to both prevent and identify abuse.

Staff were able to tell us the correct procedures to follow if they suspected abuse or if abuse had been disclosed to them. They all told us they would report incidents to their line manager or seek advice from the trusts, Safeguarding Adults’ Enquiry Co-ordinator (SAEC). The lead nurse told us there were, 15 staff who acted as SAEC’s at the trust for staff to call for advice and support.

Over the last year three safeguarding alerts, had been made from this unit, to the local area adult safeguarding team. This demonstrated that the staff had followed correct procedures in these cases.

However, we also found evidence that the safeguarding adults’ procedures had not always implemented effectively. For example, one patient within the service had made an allegation against staff in September 2011. This was recorded on an incident record form. On checking the patient’s care plans we found the patient had previously made allegations against staff and others when unwell. The staff had devised a care plan to support the patient when they made allegations in this context. This was positive and demonstrated the staff had identified the patients vulnerability at these times. When we checked this patients’ care plan we found that the staff had not adequately followed the guidance in the care plan. Nursing staff had recorded the patient’s allegation on an incident form and the line manager had

signed this, but not until several weeks after the incident had occurred. The staff told us this allegation was recognised as a, 'known behaviour', from this patient. This was dealt with as a 'behavioural incident'. There were entries in the daily nursing notes to record the patient's allegation against staff, but there was no recorded evidence to indicate that other aspects of the care plan had been followed. For example, the allegation was not reported to a line manager in a timely way. Staff did not seek advice from a SAEC or report the incident as an 'alert' or 'referral' to the local area safeguarding team, as was the guidance in the care plan. This meant that the patients' welfare was not effectively protected. This could leave them at risk of abuse. We reported this to the lead nurse and a safeguarding referral was made to the local area safeguarding team on the same day. We checked with the local area safeguarding team to ensure this had been received and they confirmed it had. This incident is currently being managed through the safeguarding procedures. The lead nurse and service manager also began an internal investigation in to how this occurred. They will send their findings to us.

Using restraint

Restraint was used within the service. Managers told us and staff we spoke with confirmed they used, `Prevention and Management of Violence and Aggression' (PMVA) techniques to restrain patients, as a last resort. Staff said restraint takes place only as a last resort, and the preferred option was to use de-escalation techniques to prevent challenging behaviours from escalating. We saw evidence of this from our observations and from daily nursing records and incident records. Training records given to us before the end of the inspection showed staff received training to use PMVA techniques. We found staff were knowledgeable about using these physical intervention techniques and they confirmed to us that their training was up to date.

We looked at patient incident records to see if they accurately cross checked with daily records. The majority of the records did. However, the records on incident forms often lacked detail; for example, the level of restraint was not always indicated. Vague terms such as, "*patient* was redirected" was recorded but this did not tell us how. We found evidence that one incident form had not been completed for an incident where physical restraint had been used. We asked for an incident report record of a restraint used with a patient, (which was recorded in daily nursing notes), but staff could not locate this. There was no evidence that the patient's care plans had been reviewed after this incident or that staff were debriefed to learn from what happened. These practices could place patients at risk of receiving inappropriate care, treatment and support from staff.

Overall, we found a number of incident records checked did not contain adequately detailed information of the incident. We brought our concerns to the attention of the service manager to address. The examples of the quality of the record keeping at the unit could place patients at risk of receiving inappropriate care, treatment and support.

Judgement

There were policies and procedures in place for staff to follow to safeguard patients from abuse or the risk of abuse. Overall, there was evidence these procedures were

implemented effectively. However, the actions taken to address one patient's allegations against staff had not been effectively implemented or managed. This meant the patient's welfare was not fully protected and could leave them vulnerable to the risk of abuse. Incidents of challenging behaviour, where restraints had been used by staff were not always fully recorded or reported via the correct procedures and there was a lack of evidence of review and learning from these the incidents. This could place patients' at risk of receiving inappropriate care, treatment and support.

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 of patients detained under the Mental Health Act 1983. Treatment of disease, disorder or injury.	Regulation 9	Outcome 4: Patients 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; some patient care plans and risk assessments were comprehensive and implemented effectively to ensure the delivery of care met patients' identified needs. Other care plans and risk assessments were not comprehensive, regularly reviewed and care delivery was not always implemented effectively. This placed patients' at risk of receiving inappropriate or unsafe care, treatment and support. Patients were not routinely involved in devising their care plans, the care plans were not devised using person centred principles and they were not in accessible formats to meet individual's communication needs. We found that some decisions to restrict patients' liberty had been undertaken without consultation with them and in adherence with the Mental Capacity Act 2005. This did not protect their rights.	
Assessment or medical treatment of patients detained under the Mental	Regulation 11	Outcome 7 Safeguarding people who use services from abuse

Health Act 1983. Treatment of disease, disorder or injury.	**How the regulation is not being met:** There were clear policies and procedures in place for staff to follow to safeguard patients from abuse or the risk of abuse. However, the processes and actions taken to address one patient's allegations against staff had not been adequately implemented or managed. This meant that this patients' welfare was not fully protected and could leave them at risk of abuse. Incidents of challenging behaviour, where restraints had been used by staff were not always fully recorded or reported via the correct procedures. There was a lack of evidence of review and learning from some of these the incidents.

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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