Review of compliance

Isle of Wight NHS PCT Sevenacres (Inpatient Wards)	
Region:	South East
Location address:	St Mary's Hospital Parkhurst Road Newport Isle of Wight PO30 5TG
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Date of Publication:	September 2011
Overview of the service:	Sevenacres provides inpatient mental health services and is a base for several services provided to people in the community. The separate inpatient wards accommodate older people with mental health needs, adults with acute mental health needs and a psychiatric intensive care unit for people detained

	under the Mental Health Act. All bedrooms are for single occupancy and many have ensuite facilities. Communal lounges, dining rooms and therapy rooms are provided.

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

Our current overall judgement

Sevenacres (Inpatient Wards) was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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

Why we carried out this review

We carried out this review to check whether Sevenacres (Inpatient Wards) had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 11 - Safety, availability and suitability of equipment
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 July 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

Most of the patients we spoke to told us that the care they had received was good, although some said that it varied. In general, people were very positive about their experience in the unit.

Most of the people we spoke to said they had been involved in planning their care, although one person said they had not. This person was not sure whether they had been detained under the Mental Health Act.

Two people told us that they wanted more time to talk to nurses.

All the patients we asked said they felt safe on the ward.

What we found about the standards we reviewed and how well Sevenacres (Inpatient Wards) was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Since our last visit, changes have been made in ensuring people receive safe and appropriate, personalised care. Systems are in place for assessment, planning and review of people's physical and mental health care, and we saw evidence that people had been involved in planning their care.

We have a minor concern that there are still some inconsistencies in the documentation of care in people's notes, and in some cases people may not have received the most effective care because of this. This had also been identified through the unit's quality assurance processes, and action is being taken to address it.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

Since our last visit some action has been taken to ensure that hazardous substances are stored securely at all times, but this is not consistently implemented.

We have a minor concern that people have been placed at risk by substances hazardous to health not being kept secure at all times.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Changes have been made in assessing and monitoring the quality of service provision since our last visit. There is a care plan audit system in place to monitor and make changes to the assessment and planning of a person's care where necessary.

We have a minor concern that this system is not yet embedded, and that it does not always capture the risks or improvements needed and ensure that action is taken to address this.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome.

Actions 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.

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 reports for more information about previous reviews.

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 04:
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 are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke to people on the wards, most of whom told us that the care they had received was good. One person said that the care varied between nurses, and that sometimes they had to wait for medication.

We spoke to one person who felt they had not been involved in planning their care, and who was not sure whether or not they had been detained under the Mental Health Act. This person wanted to be able to spend more time talking to nurses. Another person told us that they wanted nurses to come to patients, rather than patients having to approach staff who might be too busy to talk.

Two people told us they had been involved in planning their care. One person said "I have been involved in planning my care while on this ward, for the first time since I got ill two years ago". This person gave an example of how the core team had worked with them to plan a visit home, and to review how the visit had gone and plan the next visit. This person said they had signed their care plan.

We spoke to one person who was very positive about the care and support they had received. They were clear that they had been fully involved in care planning. They said that initially they had felt staff were not sorting out their problems quickly enough, but they now understood that at the time they were not ready for discharge. They were now very satisfied with the service they had received. This person was positive about staff and had no concerns about their care.

We spoke to four patients on the older people's ward and none raised any concerns about their care. All of them felt that there were enough staff, that staff were helpful and friendly, and that they were being cared for appropriately. All said they felt safe. They told us that the meals were fine, and that drinks were available when they wanted them; staff tend to give drinks at regular intervals.

Other evidence
Our visit was a follow up to a review undertaken in March 2011 which found areas of non-compliance with this outcome relating to inconsistent quality and review of care planning.

We spoke to staff on the wards who told us that physical as well as mental healthcare needs are assessed on admission to the unit during a joint admission undertaken by a nurse and a doctor. Care plans are written to reflect the needs identified; the level of observation is decided based on risk assessments. Staff told us that there is a 72 hour care plan for the first three days, and a longer term care plan is written during this period. Care plans are then reviewed weekly with doctors, and the named nurse for a patient updates the care plan.

One member of nursing staff said that the nursing team are advocates for patient involvement in care planning, and that the multi-disciplinary team takes the lead in planning care. She told us that patients agree what they want to achieve on admission, and that this is reviewed with the doctor. People who are detained under the Mental Health Act have a weekly appointment for discussing their care with a doctor. The member of staff told us that patients who are not detained also regularly review their care with a doctor. However she said that they do not always have a weekly appointment for this, so may not always know when their care will be reviewed.

We spoke to a care assistant on one ward who said that she would discuss people's physical care needs with them when they first met, and also read the care plans. She said that the ward manager ensures that there is always an appropriate balance of male and female staff to meet people's personal care needs. She told us that patients were always involved in their daily care, and that she would always explain what she was planning to do and give the person a choice. They try to promote independence on the ward, but ultimately people can make a choice about what they want to do.

We asked staff on all three wards whether there were enough staff to provide the care people needed. Most staff said that there were enough staff, and one member of staff said that a period of low staffing due to maternity leave and staff sickness had now passed. We observed that there appeared to be enough staff to meet people's needs.

One member of staff told us about a patient who had a serious physical illness which was deteriorating and will be terminal. When this person was admitted to the unit they were not able to make decisions about end of life care planning because of their mental illness. However having had treatment on the ward, they were now able to make these important decisions, and the multi-disciplinary team were working with the patient and specialists from other parts of the hospital and external agencies to review this person's care and agree plans for the management of their physical and mental health needs in the future. This person had been involved in making decisions about their care; for example they had refused invasive interventions. We looked at this person's notes and

confirmed that this had been well-documented.

During our visit to the unit, we observed that people's physical care needs appeared to be met. We saw that people on the older people's ward looked clean and in appropriate clothing. We observed people being given afternoon drinks.

We saw that staff were talking in a quiet and friendly way to patients, and that staff were available to have one to one conversations with patients on the ward. On one ward people were gardening, and there was information on a wide range of ward-based therapy and activity groups on the wall of the ward. A member of staff told us that nursing staff now take responsibility for the timetable of the groups, and that nurses, occupational therapists, and external specialists run the groups. She felt that the groups work well. We spoke to a nurse who told us that all patients now have therapeutic timetables which a doctor is involved in developing. We saw in people's notes that this is checked in the care plan audit.

We asked the Modern Matron of Sevenacres what changes had been made since our last visit in March 2011. He told us that the in-patient care pathway has been amended to include physical risk assessments on the older people's ward, and the admitting doctor decides whether physical risk assessments are required on other wards.
He said that he had undertaken a care plan audit and identified that, although care plans are good and are individual to the person, there is a lack of consistency in the formats used. He has initiated a project across the wards led by nursing volunteers to look at every care plan and develop a standard format which includes a log of review. Templates will be available and accessible on the shared drive, and will be completed by September. We looked at the recent care plan audit undertaken by the Modern Matron. This reviewed 12 individual care plan audits across the three wards, and identified gaps in some patients' care plans, risk assessments and notes, as outlined under outcome 16. When we looked at people's records, we also saw that there were sometimes gaps in risk assessments and care planning. The Modern Matron told us that the issues identified were being addressed by senior ward staff.

We looked at records on the older people's ward and saw that risk assessments for nutrition, pressure injuries and falls had been completed, and there were care plans to address the risks identified. There was good information on how personal care needs should be met. We looked at the notes of one person which stated that they had a history of alcohol misuse and psychotic episodes, and recorded that this person smelt strongly of alcohol on admission. However there was a Drug/Alcohol Use Screening Tool in the records which had not been completed.

We saw that physical assessments and observations were recorded in people's notes. We looked at the notes of one person who had refused consent for any physical assessments or observations, and this was clearly documented. The notes also showed that repeated attempts had been made to address this as part of the person's care plan.

We noted in one patient's records that they had a fall in May resulting in a fractured hip; after surgery they returned to the ward. The falls risk assessment completed at this point stated that falls risk should be reviewed weekly. This person was found on the floor at the end of June, but the falls risk assessment had not been reviewed since the beginning of June, and they had not been assessed as at high risk of falls. We

discussed this with ward staff who said that sometimes this person prefers to be on the floor, and it was not clear whether they had actually suffered a further fall. The Modern Matron told us the day after our visit that he had reviewed this incident and will be working with the Charge Nurse on the ward to review the sensitivity of the falls assessment tool. This is a trust-wide tool which may not be sensitive enough to reflect risks specific to patients receiving psychiatric care, for example medication side effects.

In another file we reviewed, we noted that the patient had lost a significant amount of weight. The Modern Matron later explained that they had gained weight as a result of medication, and since dosage had been reduced, they had returned to their weight on admission. However ward staff had not been able to explain the weight loss and the care plan did not indicate that either nursing or medical staff had considered the reason for the weight loss.

Our judgement
Since our last visit, changes have been made in ensuring people receive safe and appropriate, personalised care. Systems are in place for assessment, planning and review of people's physical and mental health care, and we saw evidence that people had been involved in planning their care.

We have a minor concern that there are still some inconsistencies in the documentation of care in people's notes, and in some cases people may not have received the most effective care because of this. This had also been identified through the unit's quality assurance processes, and action is being taken to address it.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

There are minor concerns with Outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We did not, on this occasion, speak to people about this outcome, so cannot report what the people using the service said.

Other evidence
Our visit was a follow up to a review undertaken in March 2011 which found areas of non-compliance with this outcome relating to storage of substances hazardous to health and use of equipment.

We asked the Modern Matron of Sevenacres what changes had been made since our last visit in March 2011. He told us that lockable trolleys for cleaning equipment were on order. He reported that the Facilities Manager said that cleaners must have trolleys with them or locked away, and they had done a walk around together to reinforce this message. Since our visit, only washing up liquid and cream cleaner should be stored on top of the trolley.

However during our visit we saw an unattended cleaning trolley in a corridor which had accessible chemical cleaning products. The Modern Matron dealt with this issue immediately with the member of staff involved.

The Modern Matron told us that the use of the pressure relieving mattress which was identified as a concern at our last visit had been reviewed, and it was found that this was being correctly used as it has an automatic pressure sensor, although staff did not

know this. Staff are now aware of how this works.

During our visit to the older people's ward, we observed that storage space for equipment was extremely limited, and staff mentioned that this was a problem. Large items of equipment were stored in corridors and in the conservatory. The ward manager told us that there would be storage space included in a redevelopment which is planned for 2012.

Our judgement
Since our last visit some action has been taken to ensure that hazardous substances are stored securely at all times, but this is not consistently implemented.

We have a minor concern that people have been placed at risk by substances hazardous to health not being kept secure at all times.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not, on this occasion, speak to people about this outcome, so cannot report what the people using the service said.

Other evidence
Our visit was a follow up to a review undertaken in March 2011 which found areas of non-compliance with this outcome relating to the effectiveness of quality monitoring systems.

Since our last visit in March 2011, the Modern Matron of Sevenacres has put in place an audit system for care records. We looked at people's records and saw some evidence of this.

There is a weekly care plan audit at the front of all files; this had been completed weekly in most cases. The audit is comprehensive and includes physical observations undertaken, risk assessments and care plans in place, and weight charts, among other checks. In one of the records we looked at the audit had been incorrectly completed, stating that some risk assessments had not been completed on admission when in fact they had. On the back of the page is a section for comments and actions to address issues identified. We saw some records where this had been completed and the issues identified had been addressed. However this was not completed in all cases and we looked at two records where this section was blank. In some cases where it had been filled in, it did not address all of the issues identified in the audit, or did not say who would take action and when. There was no evidence that the identified issues had

been addressed in some cases, and in these cases subsequent audits identified the same concerns.

The Modern Matron told us that night staff are responsible for doing the audits, and that they should write identified actions in the diary to handover to day staff. Action should then be taken by the primary nurse for the patient, and would be followed up by the Ward Manager. However this system does not appear to be resulting in the necessary action being taken – or if action is taken it is not always documented.

We spoke to nursing staff about audits. They told us that they had been doing the care plan audits outlined above for a month. One member of staff told us that they had always done reviews of care, and that they asked people if they were happy with their care. One nurse told us that she felt the audits took time away from caring for people, although they were developing new ways of working to reduce the extra work. She gave the example of taking the care plan with her when talking to a patient, so the care plan could be easily updated at the time of the conversation. She also told us that staff were now in groups of three, with one member of night staff and two day staff linked in a group. They would work together on the audits for the patients they were responsible for. She said this system worked really well.

In addition to the care plan audit of each patient's records, the Modern Matron told us that he had undertaken a random audit of the individual care plan audits. He told us that this had been done the previous week and that he had identified areas for improvement. We looked at a copy of this audit, which was clear and comprehensive. It demonstrated that the individual care plan audits had identified gaps in some patients' care plans, risk assessments and notes. The audit also notes that in over half of the individual care plan audits reviewed, the audit had not been fully or correctly completed. This is also what we found when we looked at the care plan audits. This demonstrates that, although there is now a process in place for care plan auditing, it is not yet functioning effectively across all three wards, and further work is needed to ensure it is embedded.

We spoke to the Chief Nurse, who had also visited the wards recently and looked at care plans, and she said she had identified similar issues. However she felt that there had been an improvement in monitoring the quality of care and that there was an enthusiasm to get this right within the staff team.

The Modern Matron said that he had discussed the areas for improvement which he had identified with ward managers, and that senior ward staff would work with their teams to address the issues identified. The Modern Matron plans to restructure the audit to make it quicker to complete, and was planning to do a re-audit the following week. He will then move to a monthly audit.

We asked the Modern Matron about the system to ensure that all staff complete mandatory training. He showed us the training matrix on one of the wards which demonstrated that mandatory training had been undertaken since our last visit, and the majority of staff were up to date. We asked about gaps on the matrix, and these staff were either on maternity leave or long term sick leave. All of the staff we spoke to said they had had their mandatory training within the last year. All staff we spoke to had had safeguarding training in the last year. The Modern Matron told us that he had addressed the issue of part-time night staff having time for training.

Our judgement
Changes have been made in assessing and monitoring the quality of service provision since our last visit. There is a care plan audit system in place to monitor and make changes to the assessment and planning of a person's care where necessary.

We have a minor concern that this system is not yet embedded, and that it does not always capture the risks or improvements needed and ensure that action is taken to address this.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:
Since our last visit, changes have been made in ensuring people receive safe and appropriate, personalised care. Systems are in place for assessment, planning and review of people's physical and mental health care, and we saw evidence that people had been involved in planning their care.

We have a minor concern that there are still some inconsistencies in the documentation of care in people's notes, and in some cases people may not have received the most effective care because of this. This had also been identified through the unit's quality assurance processes, and action is being taken to address it.

On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome</td></tr>
<tr><td rowspan="2">Accommodation for persons who require treatment for substance misuse</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
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Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
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Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: Changes have been made in assessing and monitoring the quality of service provision since our last visit. There is a care plan audit system in place to monitor and make changes to the assessment and planning of a person's care where necessary.	

	We have a minor concern that this system is not yet embedded, and that it does not always capture the risks or improvements needed and ensure that action is taken to address this. On the basis of the evidence provided and the views of the people using the service, we found the service to be compliant with this outcome.	
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The provider must send CQC a report about how they are going to maintain 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 within 14 days of this report being received.

CQC should be informed in writing when these improvement 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 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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