Review of compliance

Lincolnshire Partnership NHS Foundation Trust Witham Court	
Region:	East Midlands
Location address:	Fen Lane North Hykeham Lincoln Lincolnshire LN6 8UZ
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Date of Publication:	July 2011
Overview of the service:	Witham Court is one of ten locations that form Lincolnshire Partnership NHS Foundation Trust. This location provides services for up to 41 older people with mental health needs such as dementia, depression and psychotic disorders. Younger people with dementia needs

	can also be provided with a service if appropriate.

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

Our current overall judgement

Witham Court was not meeting one or more essential standards. Improvements are needed.

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 Witham Court had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 08 - Cleanliness and infection control

How we carried out this review

We reviewed all the information we hold about this provider, 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

A patient told us 'I trust the nurses here, they are very good.'

A relative said 'can't fault them (staff), always around for patients, my relative gets everything they need, they've looked after them so well.'

Other patient experiences were captured through records, our observations, and other information received from the trust. This information is recorded in the main part of this report.

What we found about the standards we reviewed and how well Witham Court was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patient's views and opinions about their support are taken into consideration, and their privacy and dignity is maintained.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

There are systems in place to enable patients to make decisions about their care. However the provider must ensure that compliance with this outcome is maintained.

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

Patients currently receive the appropriate levels of care. However there are times when the numbers of appropriately trained staff may not be sufficient to meet patient's needs.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

Patients experience good standards of cleanliness, and there were systems in place to protect them from the risk of infection.

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We did not get patient views directly from them about this outcome, however their experiences were captured through records, our observations, and other information received from the trust. This information is recorded in the other evidence section of this report.

Other evidence
Since our last visit, we saw that the ward staff had been implementing their action plans to address the things we said needed to improve. For example, they had started to hold weekly patient meetings. We saw a meeting taking place, and patients were taking part in discussions with staff. We saw that things the patients wanted were recorded, and the ward managers had made sure that action was taken where necessary. We saw that patients had taken part in discussions about decoration for their bedrooms and quiet rooms, and their choices had been implemented.

We saw that meetings for carers and relatives were also taking place. Again the meetings were recorded, and any actions needed were taken by the ward managers. There were also suggestion boxes at the entrance to the wards to give people more opportunity to voice their views and opinions.

A new ward information pack had been developed and will soon be made available. We saw that it included information about how to get help from the trust and external support networks, and about advocacy services. Specific information about advocacy services was displayed around the wards. A ward manager told us that advocacy services have not held meetings with patients on the ward recently, and that he is working towards restarting this service.

We know that care plans are now being checked on a weekly basis to make sure that patients are being supported to join in with their care planning where they are able. We saw that there was also a new care plan format being developed to make sure that discharge planning is done in a better way.

We saw staff supporting patients in a sensitive way. For example, helping them to make choices about what meals they wanted, and how they wanted them presented; offering patients an informed choice of activities, and helping patients to choose where they spent their time.

Doors that lead to the outside of the wards had been fitted with special glass to increase patients' privacy and dignity. Wards areas had been clearly identified for male or female use, and there was a visitor's room to use when patients wanted to see people in private.

Our judgement
Patient's views and opinions about their support are taken into consideration, and their privacy and dignity is maintained.

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

The provider is compliant with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
We did not get patient views directly from them about this outcome, however their experiences were captured through records, our observations, and other information received from the trust. This information is recorded in the other evidence section.

Other evidence
Since our last visit, we saw that the ward staff had been implementing their action plans to address the things we said needed to improve. For example, we know that care files were now being checked every week to make sure patients and/or their relatives are consulted about the care planning process. We also know that ward managers and staff hold regular meetings together with patients and relatives.

We saw that patients' ability to make decisions and consent to their treatment was assessed and reviewed whenever it was needed throughout their stay, and it was noted in care files when a patient cannot, or refuses to sign their care plan.

We saw one care record that contained an assessment of the patient's ability to understand their rights when they were admitted. The assessment showed that the patient could not understand this information. However the care plan that followed did not make this very clear. Staff took action about this straight away. We asked the trust let us know the outcomes of the weekly checks of care plans that now take place, and

they have agreed to do this.

We saw that records for patients who had been detained under the Mental Health Act 1983 were completed in full, and expiry dates were clearly highlighted. Reports from other professionals were also available in the files to show that the process for detention had been completed in the right way.

Our judgement
There are systems in place to enable patients to make decisions about their care. However the provider must ensure that compliance with this outcome is maintained.

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

Our findings

What people who use the service experienced and told us
A patient told us 'I trust the nurses here, they are very good.'
A relative said 'can't fault them (staff), always around for patients, my relative gets everything they need, they've looked after them so well.'

Other patient experiences were captured through records, our observations, and other information received from the trust. This information is recorded in the other evidence section of this report.

Other evidence
We saw that staff had been implementing their action plans to address the things we said needed to improve. They had completed all of the things they said they would do by April 2011. They have two further actions to complete in relation to improving physical healthcare support for patients. A ward manager has also identified that staff need further training about how manage collaborative care planning, and we know that arrangements are in place for this to take place.

Staff told us that the care planning system has improved and the plans are now more personalised. We saw personalised care plans for things like orientation to the ward environment. We also saw that care plan overviews which include a patient's needs, wishes and views, are now kept in their bedroom area so that they can be easily accessed by staff and the patient.

We saw care plans that include details about a patient's nutrition needs, mobility,

physical health needs, and older adults risk profiles. The plans were up to date, and they were cross referenced with things like assessments of the person's ability to make decisions, and specific behaviour management plans.

We saw patients joining in with a wide range of activities, and an activities programme was displayed in ward areas. We saw staff helping patients to choose the activity they wanted to join in with, and then helping them to participate. Volunteers now attend the ward to help staff provide activities. We saw that the volunteers were supporting patients in a way that allowed staff more individual time with patients. A volunteer told us that they enjoyed being part of the team, and that it was a good place to work. Patient's art work was displayed around the ward environment, and there was a twenty-four hour reality board to help patients keep up to date with everyday issues.

There was a specialist physical healthcare nurse who works within the ward areas. We spoke to this nurse who told us that they carry out things like physical health screening when a patient is admitted, monitoring of nutrition and falls, co-ordinating skin and pressure area care needs, taking blood samples when requested, and regularly checking that physical healthcare equipment is in working order. We know that the trust is developing a new physical health assessment tool to ensure that patients' needs are assessed in a more detailed way.

During the visit, a ward manager told us about some of the issues they are facing due to staffing numbers. Wards were using a high number of bank nurses due to sickness levels and vacancies. This means that regular staff had increased pressure on their time to complete things like care records and carry out individual patient interactions. Staff said 'we keep people safe, but we don't get enough one to one time with them.'

We heard, for example, the telephone ringing a lot during patients protected time, and saw staff having to leave patients to take the calls. A ward manager told us that they have developed a plan to redirect phone calls during these times, and we have asked the manager to let us know when this has been done.

We know from our records that there are increasing levels of patient behavioural needs within the ward areas, which also increases pressure on the staff's time. Since our visit we have been informed of a safeguarding adult issue that relates to numbers and training of staff in one area of the location. This is currently being investigated by the local authority Safeguarding Adults team.

We know that a ward manager has given reports to the trust about the current staffing issues. We have also asked the trust to provide us with a detailed report and action plan to show how they are, and will be maintaining appropriate staffing levels in the ward areas.

Our judgement
Patients currently receive the appropriate levels of care. However there are times when the numbers of appropriately trained staff may not be sufficient to meet patient's needs.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not get patient views directly from them about this outcome. However their experiences were captured through records, our observations, and other information received from the trust. This information is recorded in the other evidence section of this report.

Other evidence
When we visited the wards we saw that they were generally clean and tidy. We saw housekeeping staff carrying out their work during the visit. Information about the role of the infection control link nurse was displayed for people to read.

We know from other information we have that there are policies in place about controlling infection, contracts for waste disposal, and there is a trust wide environmental action team in place.

Disinfectant hand gel and gloves were freely available and we saw staff and visitors using them when they needed to. We saw staff using appropriate equipment such as aprons and gloves to make sure that any cross infection risks were managed in the right way.

We know that the wards have begun to monitor how staff follow hand washing procedures, and this is recorded every two weeks. They have also looked at staff training about controlling infection and have made plans for all staff to be retrained in this subject.

The trust carried out a check of cleanliness on the wards just before we visited, and we

saw in their report that they had scored highly for the outcomes.

Our judgement
Patients experience good standards of cleanliness, and there were systems in place to protect them from the risk of infection.

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.

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	Why we have concerns: There are systems in place to enable patients to make decisions about their care. However the provider must ensure that compliance with this outcome is maintained.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	Why we have concerns: There are systems in place to enable patients to make decisions about their care. However the provider must ensure that compliance with this outcome is maintained.	
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	Why we have concerns: There are systems in place to enable patients to make decisions about their care. However the provider must ensure that compliance with this outcome is maintained.	

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.

Compliance actions

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

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients currently receive the appropriate levels of care. However there are times when the numbers of appropriately trained staff may not be sufficient to meet patient's needs.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients currently receive the appropriate levels of care. However there are times when the numbers of appropriately trained staff may not be sufficient to meet patient's needs.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients currently receive the appropriate levels of care. However there are times when the numbers of appropriately trained staff may not be sufficient to meet patient's needs.	

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 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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