Review of compliance

Leicestershire Partnership NHS Trust The Agnes Unit	
Region:	East Midlands
Location address:	Gorse Hill Anstey Leicester Leicestershire LE7 7GX
Type of service:	The Agnes Unit is one of 14 locations registered to Leicestershire Partnership NHS Trust. Situated in Leicester, it is a NHS organisation.
Date the review was completed:	December 2011
Overview of the service:	The Agnes Unit has 20 beds. Of these beds, 12 are for assessment and treatment and eight are for intensive support and rehabilitation. The Agnes Unit provides inpatient care for adults with moderate to profound learning

	disabilities and associated mental health problems. Admissions were both under the Mental Health Act 1983 and through voluntary admissions. There are five small units, which are known as pods, each with their own communal living area and garden. There are also specialist therapy areas to help patients with day-to-day living, including kitchen and laundry areas and a horticultural courtyard garden. The Agnes Unit is registered to provide the following regulated activities: • Treatment of disease, disorder or injury • Diagnostic and screening procedures • Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Accommodation for persons who require nursing or personal care • Accommodation for persons who require treatment for substance misuse

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

What we found overall

We found that The Agnes Unit was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we have suggested that some improvements are made.

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

Why we carried out this review

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

How we carried out this review

The inspection teams are led by Care Quality Commission (CQC) inspectors joined by two 'experts by experience', people who have experience of using services (either first hand or as a family 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 6 and 7 December 2011. We observed how people were being cared for, talked with patients, talked with staff, checked the provider's records and looked at patients records

As part of our inspection a telephone discussion was held with an independent advocate that supported three patients. We were unable to speak with any relatives over the telephone as none were available but we did speak with two patient's relatives who were visiting during our inspection. Their comments are included within this report.

At this inspection our Short Observational Framework for Inspection (SOFI) tool was not used. This was because the layout of the environment and the individual activities being undertaken was not appropriate for this method of observation. Therefore general observations were made throughout our two day visit.

What people told us

Patients using the service were positive about the support they received from staff at The Agnes Unit. One patient said they felt safe, and told us that staff treated them with respect. They told us about staff helping them to prepare for leaving to live by themselves by introducing them to cooking. This person's aunt and uncle said they were coming home for Christmas and cooking the Christmas meal.

Two patients talked about their care plans. One said "In my care plan it covers what I eat and what medication I take. Staff give me good care and support." The other patient told us, "Staff will ask me if I need anything changing in my plan. A meeting is held every time the social worker comes to see me. I have not got anything written down on the health action plan although I do have annual health checks."

Some of the patients spoken with had an understanding of abuse and what it meant for them. For example one person said, "Abuse is when someone is hit in the face or pulling my shirt. I would ring the police or tell a member of staff if I was being abused."

What we found about the standards we reviewed and how well The Agnes Unit was meeting them

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

People's needs were assessed, and care plans and risk assessments were in place to meet people's identified needs but these did not demonstrate if people agreed to and understood their plan of care. Disorganised records made it difficult to access information, which could potentially compromise patient care, if staff were unable to locate information. Detailed guidance was in place to safely manage behaviours described as challenging. Activities were available to patients to maintain and develop their skills. This means that patients on The Agnes Unit experienced effective, safe and appropriate support but disordered record keeping, compromised this.

- Overall, we found that The Agnes Unit was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

Systems to prevent and identify abuse were in place. People's concerns were listened to and appropriately reported to the local safeguarding team. Incident reports were completed appropriately with evidence of review and learning from incidents.

- Overall, we found that The Agnes unit was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 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.

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 minor concerns with

Outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

One patient told us their family had arranged that they should move to The Agnes Unit they said “It did take a long time to decide if this was the right place for me. In my care plan it covers what I eat and what medication I take. Staff give me good care and support.”

Another patient told us, “Staff will ask me if I need anything changing in my plan. A meeting is held every time the social worker comes to see me. I have not got anything written down on the health action plan although I do have annual health checks. I like to play football and do kickboxing training in my room. My uncle is my advocate”.

From observations of staff and patients’ interactions. Staff appeared calm and caring in their approach. Staff were knowledgeable about individual patients and understood their needs well.

Other evidence

<u>Assessing people’s needs</u>

We were supplied with a copy of the referral and admissions policy. The policy was

satisfactory and gave staff clear instructions to follow when assessing and admitting a person to the service.

There was an in patient pathway from admission to discharge for the patients in the assessment and treatment pods where the average length of stay was four to five months. The other two pods were for longer stays of up to two years although there was one person that had been there since 2009. This was due to their needs and the fact that there was no suitable provision within the community for this person. Plans were in place to provide suitable accommodation within the grounds of The Agnes Unit for this person.

We looked at the records in place for two patients to see if their needs were identified and met. Although we saw evidence to demonstrate that plans were followed this information was not easily accessible because patients' files contained lots of information that was not organised correctly. An assessment record was on file for one of these patients. This was detailed and recorded the person's needs and showed us that assessments were undertaken by the multi disciplinary team. These assessments were undertaken over a period of time prior to and on admission. Within the other patients' files no admission assessment record was in place.

Care planning

We looked at two patient's care plans. We did this to identify what their needs were, how they were to be met and if there was evidence they had been met. One patient's care plan we looked at was based on the assessments made prior to and on admission to the unit. We were unable to determine if this was the case for the other patient as no admission assessment was available.

Care plans focused on individual's strengths and personal preferences and promoted choices. This provided a clear plan of action for staff to support patients. Preferred communication styles were recorded within the care plans seen. Staff spoken with were knowledgeable about patients' specific needs and told us of the methods that were used to effectively communicate with patients.

There was no written evidence that patients were involved in the development of their care plans or understood their care plans, as they were not provided in alternative formats such as easy read documents. However comments made by some of patients spoken with demonstrated that they did understand their care plans.

There was evidence that some care plans were reviewed on a regular basis, however this was not the case in all care plans seen and not all care plans seen were dated.

Meeting people's health needs

Health action plans were not developed at The Agnes Unit other than for the patients on the long stay pods. All other patients brought their health action plans with them from their community placements as all had lived within community or supported living facilities prior to admission.

The health action plans seen demonstrated people's health needs were being met. There was evidence that people received regular health reviews and appointments with other health professionals, such as psychologists, speech and language therapists, GP's and dentists.

Evidence was seen that annual health checks were offered and records were in place to show if patients accepted or declined.

Delivering care

The service provided varied opportunities to patients with the support of the therapy team between 9am to 4.30pm on weekdays. One relative told us they would like to see more stimulating activities provided off site that met their family members changing needs, choices and wishes. They felt that on site activities were also limited. This relative was concerned regarding the progress their family member was making and had some issues regarding missing laundry despite clothing being labelled and the meals available to their family member if they missed their main meal. We fed these concerns back to the managers at the unit and asked them to contact this relative to discuss and address their concerns.

Another relative was very positive about the support their family member received at The Agnes Unit. They told us that they felt their family member was safe and that staff treated them with respect and told us they were meaningfully occupied. They gave us examples of this by saying that staff helped their family member to prepare for leaving to live by themselves by introducing cooking. This relative told us that staff were very good and felt their family member was steadily improving and was moving in the right direction, thanks to staff. They told us that they were involved in the discharge plans and felt it took a long time, but said this was due to forces outside The Agnes Unit.

Each person had their own activity rota and there was a range of therapies from 9am to 5pm in the week but activities weren't specific for 'pod' activities. These activities were leisure activities. We were told this was because people chose on the day what they preferred to do. We did observe people accessing the community with staff during our visit.

There was limited easy read information seen in the pods. Some information was seen in the reception area regarding the local independent advocacy group.

Ten people had active advocate support and we were informed that a peer advocacy service had just started both by phone and at the unit from 1-3pm each Monday. Newsletters were available and we looked at the Winter 2011 newsletter, which included the role of the Care Quality Commission (CQC) with our contact details for people.

We spoke to an independent advocate who supported three people at the unit. The advocate confirmed that they had supported people since the unit opened three years ago and confirmed that their role was to support people by putting their views forward. The advocate confirmed that they supported people at their Care Programme Approach meetings and gave us recent examples of the support they

had provided. The advocate was confident that the staff team supported people's needs in an individualised way and treated them with respect.

We looked at information regarding meetings held for people that used the service. The minutes of these meetings showed us that people took part in the food group meetings and the patients' forum. This enabled them to express their views and choices. The advocate we spoke with told us that they had not been invited to take part in nor heard about monthly meetings between the people using the service and staff.

All of the people staying at The Agnes Unit were from the local area. All received visitors but the degree of visits varied. One person had visits from their family daily.

Managing behaviour that challenges

A risk assessment and review system was in place. A range of written guidance was available for staff on how to support people with their behaviours; this included triggers and warning signs of deterioration. The Recovery Star Model was used, this was a tool for supporting and modelling change and devising person centred therapeutic goals.

Risk assessments and guidance from professionals was available to qualified staff. In addition practice development nurses were available and regularly briefed staff.

The practice development nurse spoke of her trust wide responsibilities for monitoring restraint and seclusion incidents and monitoring safeguarding on the pods. The practice development nurse specialised in supporting people with extreme challenging behaviour and restraint.

Care plans gave clear guidance on how to manage and divert behaviour. Daily records were up to date and detailed incidents where restraint and seclusion was used. Staff confirmed these incidents were monitored with a view to reducing these with improved diversions. Staff knew people well and knew how to respond to triggers to challenging behaviour.

On call arrangements were in place within the unit. This included procedures and protocols for on call doctors, and requesting additional staff in emergencies.

All staff were trained in the prevention and management of challenging behaviour, including de-escalation and physical intervention. Staff received training in emergency response. They were given information about both physical and mental health as part of their training.

Judgement

People's needs were assessed, and care plans and risk assessments were in place to meet people's identified needs but these did not demonstrate if people agreed to and understood their plan of care. Disorganised records made it difficult to access information, which could potentially compromise patient care, if staff were unable to locate information. Detailed guidance was in place to safely manage behaviours described as challenging. Activities were available to patients to maintain and

develop their skills. This means that patients on The Agnes Unit experienced effective, safe and appropriate support but disordered record keeping, compromised this.

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

The provider is Compliant with

Outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

This is what patients told us which demonstrated that they understood what abuse meant and if they felt safe at The Agnes Unit:

“Abuse is when someone is hit in the face or pulling my shirt. I would ring the police or tell a member of staff if I was being abused.

“I do feel safe here”. “Staff tell me to keep my distance from people that might harm me”.

“I can manage my own money and would tell the manager if staff ever asked to borrow money off me.”

Other evidence

Preventing abuse

Staff had received safeguarding training in their induction and refresher training and knew what was expected of them.

There was a clear system to report concerns about colleagues and managers,

which ensured that concerns were investigated in line with whistle blowing policies and procedures.

Qualified and unqualified staff told us that electronic and paper safeguarding versions of the safeguarding policies and procedures were available on the pods in the nurse's station. A safeguarding adults 'keeping you safe' leaflet was available from Leicestershire Partnership NHS Trust in conjunction with Coventry City Council. All documents were available in an easy read version. The complaints leaflet was also available in an easy read version; however these were not seen on display within any of the pods.

One person using the service had specific needs that related to safeguarding and staff had received special training in order to meet this person's specific need. This person's care plan was very prescriptive to ensure their individual needs were met.

Both of the people whose records were looked at had information in place to demonstrate that their capacity had been assessed. Deprivation of Liberty Safeguards (DoLS) were in place within the service. One person whose records were seen had a DoLS assessment in place. Qualified staff reported a working knowledge as they received regular training and updates and were able to seek guidance at any time from the Practice Development Nurse who had responsibilities for DoLS and safeguarding adults.

Three qualified staff confirmed they had been involved in assessing a person's capacity. Staff demonstrated a firm commitment to engagement and moving people along to meet their best interests, needs, wishes and aspirations.

<u>Responding to allegations of abuse</u>

Staff spoken with, were aware of their responsibilities to safeguarding adults. They were unsure of the new safeguarding lead's name but told us they would go to their line manager if they had any concerns. Staff did have access to the contact details via the safeguarding procedure. Staff knew there was a clear system to report concerns about colleagues and managers, which ensured that concerns are investigated in line with whistle blowing policies and procedures.
All information was held on the pods in the nurses' station both in electronic and paper versions.

Qualified staff told us other agencies were involved in safeguarding investigations and welcomed working collaboratively with them. One qualified staff member told us safeguarding activities helped to raise standards and highlight where more resources were needed. The practice development nurse was a member of the safeguarding committee, and provided safeguarding training to staff and supported people through the safeguarding processes. They also provided clinical supervision including safeguarding to nurses. The practice development nurse told us they have good qualified staff, that work to high standards and was confident there was no abuse on The Agnes Unit. Other qualified staff reported the same and felt very confident that abuse was not happening. This was because there was more governance and therefore more accountability.

Records of incidents and accidents were in place, this included safeguarding

referrals made. Three safeguarding referrals had been made in the last nine months. The records showed us that the correct procedures had been followed. All actions taken were recorded and audited.

Using restraint

All incidents were audited. Incidents were discussed at the Trust Violence Reduction Group and also in the Division's governance assurance meetings. The prevention and management of aggression team, who also delivered training to staff, looked at restraint incidents and gave feedback on an advice form. Observations of staff and care records confirmed that staff responded in a person-centred way.

Staff were provided with a five day mandatory training course in restraint and de-escalation. This was updated annually with a two day refresher course. Staff told us about using observation skills. They were aware of people's triggers and their likes and dislikes, and were aware of the impact of new people and visitors, and the effect this could have on the people using the service.

Detailed records were in place regarding restraint including actions and learning from incidents. The records seen demonstrated that restraint was used for less than fifty percent of incidents. This was when other methods such as verbal de-escalation and distraction were not effective and when the patients or others were at risk from their behaviour. Staff confirmed that the extra care suite and seclusion room was used as a last resort. Records of seclusion were held and a policy was in place. In general the seclusion room had low usage. There were two people that took themselves to the seclusion room and were only able to calm down when staff locked the door. From detailed discussions with the manager, it was evident that these two people were, from their actions requesting this level of support. The manager confirmed that alternative methods were being looked at that did not pose as an ethical dilemma in supporting these two people.

Judgement

Systems to prevent and identify abuse were in place. People's concerns were listened to and appropriately reported to the local safeguarding team. Incident reports were completed appropriately with evidence of review and learning from incidents.

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">Treatment of disease, disorder or injury.

Assessment or medical treatment for persons detained under the Mental Health Act 1983.

Accommodation for persons who require nursing or personal care</td><td>9</td><td>Outcome 4:
Care and welfare of people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:

People’s needs were assessed, and care plans and risk assessments were in place to meet people’s identified needs but these did not demonstrate if people agreed to and understood their plan of care. Disorganised records made it difficult to access information, which could potentially compromise patient care, if staff were unable to locate information. Detailed guidance was in place to safely manage behaviours described as challenging. Activities were available to patients to maintain and develop their skills. This means that patients on The Agnes Unit experienced effective, safe and appropriate support but disordered record keeping, compromised this.</td></tr>
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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 28 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 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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