Care Quality Commission

Review of compliance

Sussex Partnership NHS Foundation Trust Millview Hospital	
Region:	South East
Location address:	Nevill Avenue Hove East Sussex BN3 7HZ
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Date of Publication:	February 2012
Overview of the service:	Mill View Hospital is a psychiatric inpatient unit caring for people with acute mental health problems. The service is situated on the outskirts of the town of Hove and is a location of Sussex Partnership NHS Foundation Trust. The unit is divided into four wards; Pavilion Ward, which is a psychiatric

	intensive care facility, Regency, Meridian and Caburn Wards. Each ward has a ward manager and there is a matron with overall responsibility for inpatient care.

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

Our current overall judgement

Millview Hospital 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 Millview Hospital had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 10 - Safety and suitability of premises
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records, observed how people were being cared for and talked to staff.

What people told us

We conducted this compliance review to monitor the home's progress in addressing concerns raised at a previous review of the service undertaken in August 2011.

We did not, on this occasion speak to people so cannot report what the people using the service said.

What we found about the standards we reviewed and how well Millview Hospital was meeting them

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

We found that Mill View Hospital offered people safe, appropriate care which was tailored to their individual needs. Processes were in place to assess and manage individual risks.

However although we found the care records contained much information, it was not easy to locate relevant documents. The care plans did not always reflect the therapeutic care and nursing interventions undertaken. There was a risk that staff would not be able to provide appropriate care based on the information in the care plan.

We have minor concerns that the hospital may not be able to sustain compliance in this area and have set an improvement action upon the provider for these areas.

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 10: People should be cared for in safe and accessible surroundings that support their health and welfare

We found that the hospital had a redecoration and refurbishment programme in place to provide a more therapeutic environment for people receiving treatment.

Although people who use the service were generally kept safe through staff intervention and risk management there remained risks to vulnerable people of unprotected high risk ligature points.

We have minor concerns that Mill View Hospital may not be able to sustain compliance in this area and have set a compliance action upon the provider for these areas.

Overall therefore we found that Mill View Hospital had areas of non-compliance with this outcome.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

We found that the staff were appropriately managed, trained, supported and supervised in order that they could meet the needs of people treated at Mill View Hospital. Training opportunities were available and staff had been encouraged to undertake further training and development.

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 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. When we propose to take enforcement action, our decision 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

In a previous review, we suggested that some improvements were made for the following essential standards:

- 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

- Outcome 05: Food and drink should meet people's individual dietary needs

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 did not, on this occasion speak to people so cannot report what the people using the service said.

However the hospital forwarded the results of questionnaires completed by people who had recently used the service. The overall results were positive but noted that the hospital had received some negative feedback in relation to people not being included in decisions about their care and treatment, lack of involvement in the care planning process, the quality of food and the range of activities.

Other evidence
At our last visit to Mill View Hospital in August 2011 we found the service compliant with this outcome standard. However we had minor concerns that the delivery of care was not always safe, effective and flexible enough to meet individual needs. We also had concerns that people were receiving care and treatment in an environment which did not meet their specialist needs. This outcome standard was reviewed in order to assess how the service maintained safety for the vulnerable people using the service.

During this visit we spoke with the matron and ward managers responsible for the service. We spoke to clinicians and staff on the wards, attended a ward round and reviewed the documentation the hospital used. On the day of our visit Meridian Ward was closed for refurbishment and we did not visit Pavilion Ward as our previous concerns did not relate to this ward.

We were told that since our last visit a process for auditing people's experience on the ward had started. This involved the manager and other people such as occupational therapists visiting each ward, talking to staff and patients and checking the general environment. Improvements following this programme of audits included the replacement of notice boards, updated menus and more art work throughout the building. The audit also focussed on how staff responded to people and visitors. The findings from these checks were fed back immediately to staff. The matron told us that staff were also undertaking customer care training.

Each ward also held weekly meetings where people could raise concerns and discuss their experiences on the ward. The issues were then fed back to staff at the weekly ward business meetings.

The matron told us that since the last inspection the hospital had reassessed the general environment for ligature points and was taking remedial action where possible. This included reviewing the documentation and ensuring all staff had received the appropriate training in suicide prevention.

We asked staff how they safely managed people who were assessed as a high risk. They explained the risk assessment process which included intermittent observations to keep people within eyesight or at arms length. They demonstrated how these observations were recorded. A charge nurse told us that the staff "manage a lot of risk on the ward" and that "they are good at it". However we were told that they were aware that the "management of the risk may need to be recorded more" especially by care assistants.

Staff told us about the improvements to the environment and described the Applied Suicide Intervention Skills Training (ASIST) they had recently completed. We looked at the training matrix for the unit and saw that the majority of staff had received this training. The training was induction training related to suicide prevention and minimising potential risks.

During our visit we sat in on a ward round with the permission of individual people. We noted that this was a regular arrangement where each person could have a private meeting with the consultant psychiatrist, junior doctor and the charge nurse. The meeting was undertaken in an informal setting where people had the choice about where they wished the meeting to take place. We saw that future plans and discharge arrangements were discussed in an open manner that encouraged people to answer in their own time and to ask questions in a calm and unhurried atmosphere.

A record of the meeting was made and we were told that a copy was later given to the each person. We saw that records of the meetings included any issues of concern that were raised and discussed, the plan of care for psychological, physical and social care needs and any barriers to meeting those needs.

We looked particularly at the care and treatment of vulnerable people. We saw that one person was being monitored by "eye sight" observations for their own safety. This involved staff spending an hour at a time, observing the person day and night. We noted that the person was given privacy to access their en-suite facility but the design of the building meant staff could continue to monitor them as needed.

We noted that one person who was detained under the Mental Health Act was wearing an outdoor coat and looked particularly unkempt. The nurse in charge explained that people in an acute phase of their illness were less likely to respond well to suggestions of maintaining their hygiene and changing clothes. However staff worked on this area with the person as their wellbeing improved.

We looked at a sample of care records for people who were particularly vulnerable. We saw that the care records contained a detailed initial assessment, risk assessments, a daily record of care given, clinical interventions and a care plan. We noted that the care plans did not always reflect the assessed risks or provide information on therapeutic interventions. For example one person was admitted after becoming acutely unwell and was assessed as being at high risk of self neglect with poor personal hygiene. This was noted on admission, in the risk assessments and in the daily report; however it was not included in the care plan.

Another person had been assessed as being particularly vulnerable following recent suicide attempts. We saw that a risk assessment had been completed however this was a tick box exercise with no narrative. The daily record documented that the person's wrists had been redressed and included a detailed record of the care given. However the care plan only documented that the person was on 15 minute observations and the restrictions that were in place. The care plan did not give any therapeutic interventions; describe a plan of care or any treatment that was to be given.

On Caburn Ward the group activities for the ward were displayed on a notice board and this included; library and internet access, art therapy, a drop in police surgery, baking, knitting and various therapy groups. During our visit we observed people engaging in various activities. We saw people making their own drinks in a kitchen area on the ward. There was also the opportunity to participle in cake making on the morning of our visit and one person we spoke with spoke positively of this activity.

On Regency Ward there was a quiet atmosphere on the ward whilst we were there. People were either sitting quietly in the communal areas or socialising in the dining area. Several people were in their own rooms. Staff were seen to speak politely to people and offer them the opportunity to speak with us, which they declined. A staff member was observed with a clip board checking on the whereabouts of people.

Our judgement

We found that Mill View Hospital offered people safe, appropriate care which was tailored to their individual needs. Processes were in place to assess and manage individual risks.

However although we found the care records contained much information, it was not easy to locate relevant documents. The care plans did not always reflect the therapeutic care and nursing interventions undertaken. There was a risk that staff would not be able to provide appropriate care based on the information in the care plan.

We have minor concerns that the hospital may not be able to sustain compliance in this area and have set an improvement action upon the provider for these areas.

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 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

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

Other evidence
At our last visit to Mill View Hospital in August 2011, we found that the refurbished areas of the hospital provided a therapeutic environment for people. However the rest of the premises were generally tired and in need of refurbishment to maintain a suitable, safe and comfortable environment for the people who stay there. We found that although ligature points had been risk assessed, vulnerable people had unaccompanied access to the environment where ligature points still existed placing them at risk of harm.

During this visit we spoke with the matron, ward managers and staff to ask what changes had taken place since our last visit. We reviewed environmental risk assessments and undertook a tour of the building. We saw that ligature risk assessment had been reviewed and updated by the matron and the estates department in 2011.

During our tour of the building we saw that the number of ligature anchor points throughout the building had been reduced. On the day of our visit Meridian Ward was closed for refurbishment. The matron showed us the improvements to the ward, which included removal of high risk ligature points such as taps and shower fittings. We were told that Regency Ward was the next area scheduled for such refurbishment and a reduction in the number of high risk ligature points. We were told that a programme of

replacing the windows would start in March 2012. Although not all high risk ligature anchor points had been removed, the hospital had an action plan in place to substantially reduce the risks within a set time frame.

On Regency and Caburn Wards each person had a swipe card to access their own room. This gave them privacy and meant that other people could not enter uninvited. The doors to each room had viewing panels that could be closed if needed. We saw a viewing panel covered on one room in Regency Ward to increase privacy for that person. We noticed that on Regency Ward the bathrooms were kept locked and checked hourly for people's safety.

We spoke with senior staff on the wards who told us they were aware of the ligature points on the wards but felt their risk management systems ensured people's safety.

We saw that the general environments had improved with the introduction of more art work, improved signage and notices boards on both wards. We noticed the outside space looked more inviting despite the weather, with the grass cut and shrubs pruned. The hospital was in the process of negotiating with a private company a programme for volunteers to paint the wards. This was part of the company's helping in the community project. The hospital was ensuring that all volunteers had undertaken relevant checks and appropriate training.

We noticed that on Regency Ward there was a strong smell of cigarettes. We were told that although people were supported to smoke outside the ward this was difficult to enforce in poor weather. The Mental Health Act data base informed us that the availability of a smoking cessation programme was generally much worse that expected for Regency Ward.

Our judgement
We found that the hospital had a redecoration and refurbishment programme in place to provide a more therapeutic environment for people receiving treatment.

Although people who use the service were generally kept safe through staff intervention and risk management there remained risks to vulnerable people of unprotected high risk ligature points.

We have minor concerns that Mill View Hospital may not be able to sustain compliance in this area and have set a compliance action upon the provider for these areas.

Overall therefore we found that Mill View Hospital had areas of non-compliance with this outcome.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

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

Other evidence
At our last visit to Mill View Hospital in August 2011 we found that on each of the wards staff worked well as a team and helped and supported each other. Staff were knowledgeable about their patient group, knew the actions to take in an emergency and how to report adverse incidents, errors and near misses. However we found that although training opportunities were available, the majority of staff had not undertaken mandatory training and further development. Staff told us that due to staffing pressures formal supervision and appraisals had not taken place. We found that the quality of leadership and management on the wards was variable.

During this visit we spoke with the matron, ward managers and staff to ask what changes had taken place since our last visit. We reviewed staff training, appraisal and supervision documentation and looked at staffing levels. We were told that a new matron and general manager had been appointed and a ward manager had returned from a long period of absence.

We were told that since our last visit the Trust had undertaken a review of leadership within the hospital. A leadership development programme had been developed and all ward managers had received appraisals and personal development plans. This had been followed by all staff receiving appraisals.

The new matron told us that there had been changes to ensure ward managers had more control and understood their responsibilities for monitoring quality and upholding standards. We were given examples where ward managers were now closely monitoring staff sickness and following up absences according to the Trust's policies. Annual leave was now being planned for appropriately and staff contributions were being recognised by choosing an employee of the month.

We spoke with ward managers who spoke very enthusiastically about staff development and the plans to redecorate the wards. We were told that although staffing numbers had remained the same, since our last visit a support worker was now designated supernumerary for four days a week. It was felt a positive step which had improved peoples' experience particularly with regard to supporting them returning home.

We spoke with staff who explained that if they felt staffing levels were a risk, they could ask for additional staff. They gave the example of the day before our visit where a request had been made to the matron for more staff. This was because two new people had been admitted to the ward and one highly vulnerable person required within "eye sight" level of support. The need for an increase in the staffing level was immediately agreed. Additional staff were brought in from another ward that was closing and agency staff were used to cover the night shift. As this was a known agency person there were no problems identified.

On the day of our visit the regular and bank staff were on duty and we saw that arrangements for the afternoon staffing level was discussed with the nurse in charge. We were told that there was always a senior member of nursing staff available who could be contacted out of hours if needed.

We looked at the records of staff training and supervision and found that this was now being closely monitored for both day and night staff. Staff told us that they were also supported through reflective practice meetings, and regular supervision.

Our judgement
We found that the staff were appropriately managed, trained, supported and supervised in order that they could meet the needs of people treated at Mill View Hospital. Training opportunities were available and staff had been encouraged to undertake further training and development.

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.

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
	Why we have concerns: We found that Millview Hospital offered people safe, appropriate care which was tailored to their individual needs. Processes were in place to assess and manage individual risks. However although we found the care records contained much information, it was not easy to locate relevant documents. The care plans did not always reflect the therapeutic care and nursing interventions undertaken. There was a risk that staff would not be able to provide appropriate care based on the information in the care plan. We have minor concerns that the hospital may not be able to sustain compliance in this area and have set an improvement action upon the provider for these areas. 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.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: We found that Millview Hospital offered people safe, appropriate care which was tailored to their individual needs. Processes were in place to assess and manage individual risks.	

	However although we found the care records contained much information, it was not easy to locate relevant documents. The care plans did not always reflect the therapeutic care and nursing interventions undertaken. There was a risk that staff would not be able to provide appropriate care based on the information in the care plan. We have minor concerns that the hospital may not be able to sustain compliance in this area and have set an improvement action upon the provider for these areas. 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.

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 to us within 28 days of the date that the final review of compliance report is sent to them.

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.

<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 15 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 10: Safety and suitability of premises</td></tr>
<tr><td colspan="2">How the regulation is not being met:
We found that the hospital had a redecoration and refurbishment programme in place to provide a more therapeutic environment for people receiving treatment.

Although people who use the service were generally kept safe through staff intervention and risk management there remained risks to vulnerable people of unprotected high risk ligature points.

We have minor concerns that Millview Hospital may not be able to sustain compliance in this area and have set a compliance action upon the provider for these areas.

Overall therefore we found that Millview Hospital had areas of non-compliance with this outcome.</td></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury</td><td>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 10: Safety and suitability of premises</td></tr>
<tr><td colspan="2">How the regulation is not being met:
We found that the hospital had a redecoration and refurbishment programme in place to provide a more therapeutic environment for people receiving treatment.

Although people who use the service were</td></tr>
</table>

	generally kept safe through staff intervention and risk management there remained risks to vulnerable people of unprotected high risk ligature points. We have minor concerns that Millview Hospital may not be able to sustain compliance in this area and have set a compliance action upon the provider for these areas. Overall therefore we found that Millview Hospital had areas of non-compliance with this outcome.

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 28 days of the date that the final review of compliance report is sent to them.

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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