Review of compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

Roseberry Park

Region:	North East
Location address:	Roseberry Park, Marton Rd, Middlesbrough, TS4 3AF
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Date the review was completed:	October 2011
Overview of the service:	On Roseberry Park there are 75 beds that are used for the assessment and treatment of patients with a learning disability in a low secure environment. On the main site, the learning disability beds are on the Ridgeway unit. It is divided into smaller six to eight bed units which were used to meet the different needs of patients. Oakwood unit is a separate eight bed rehabilitation facility. We visited Harrier and Hawk (10 bed male), Kestrel (8 bed male). Kite (8 bed male) , Clover (6 bed female) , Ivy (6 bed female) and Thistle (5 bed female) It is registered to provide the regulated

	activities treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983.

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

What we found overall

We found that Roseberry Park was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

How we carried out this review

The inspection teams are led by Care quality Commission (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 26 and 27 October 2011. We observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records and looked at records of people who use services.

As part of our inspection, telephone discussions were also held with relatives and other professionals who we were not able to meet during our visit. Their comments are included within this report.

The Short Observational Framework for Inspection (SOFI) tool was not used on this inspection as people were able to talk to us about the care and treatment they received.

.

What people told us

Patients told us they knew what was written in their care plans. They had a chance to talk about their care plans at care planning approach (CPA) meetings.

Relatives told us that they were always invited to the CPA meeting and they felt that communication had greatly improved over the last twelve months. Staff always spoke to their relative with respect.

Patients told us their access to activities and home leave had been reduced because of staff shortages.

Patients thought that staff were fair and they felt safe at Roseberry Park.

What we found about the standards we reviewed and how well Roseberry Park was meeting them

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

- Overall Roseberry Park had not met this essential standard.

The delivery of care did not meet the patient's individual needs.

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

- Overall Roseberry Park had not met this essential standard.

  The provider did not have policies and procedures in place to safeguard patients when segregation was used to manage a persons care and treatment.

Outcome 9: People should have their medicines at the times they need them, and in a safe way

- Overall Roseberry Park had met this essential standard.

  Patients had their medicines at the times that they needed them and in a safe way. Wherever possible patients were given information about the medicine being prescribed.

Outcome 13: People should be safe and their health and welfare needs met by sufficient numbers of appropriate staff

- Overall Roseberry Park had not met this essential standard.

The provider did not have sufficient numbers of suitably qualified , skilled and experienced staff employed to meet the needs of patients at all times.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

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 are Moderate concerns with

Outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We spoke to the relatives of one patient. They told us that they were always invited to the care planning approach (CPA) meeting and they felt that communication had greatly improved over the last twelve months. They also said that staff always spoke to their relative with respect.

The expert by experience spoke to two patients at Oakwood. Both patients spoke positively about their care and support. They told us that they got the chance to see their families. Both patients said they knew what was written in their care plans. They had a chance to talk about their care plans at CPA meetings.

A relative said “Staff are flexible about visiting times – her son works weekends and shifts so that’s helpful.”

The expert by experience spoke to two patients at the main Roseberry Park site. One patient was very frustrated and had complaints about the food, the lack of staff (which means activities were cancelled) and about his treatment which he said was not helping him to progress as part of his rehabilitation. He also said there were not enough trained staff to escort patients outside the grounds. He told us his home visits should last three hours, but these are often shortened because of staffing issues.

Both men complained there were not enough activities to do. They told us that there had been no arrangements made to replace the occupational therapist since she left which meant patients were not getting the support they wanted with their independent living skills.

An advocate for a patient on the main Roseberry Park told us “all decisions are related to hospital policy and are not patient centred” and “the way of managing is not to take any risks.”

Other evidence

Assessing people’s needs

The provision of low secure learning disability beds was managed regionally. Patients were referred to the service via the police, probation teams, solicitors or consultants who work in the community. Each patient had a case manager, who was a health professional, whose role was to assess where each patient’s needs could be met.

On admission to Roseberry Park a multi disciplinary team assessed the needs of patients. The team normally included a psychiatrist, psychologist, nurse, and input from the family where appropriate. An assessment and monitoring tool was completed for each patient and a risk assessment tool was used.

We examined three previous admissions to Roseberry Park over the past twelve months. We found that the referral process had been followed consistently. As a result of this, decisions about whether patient’s needs could be met were based on comprehensive information that minimised the risk of patients being admitted whose needs could not be met.

The referrals, admission and assessment processes used Roseberry Park meant that only patients whose needs could be met by the location were admitted for care and treatment.

On Oakwood, in the past twelve months five patients had been discharged, with support into the community. When we visited two more discharges were being organised and one patient was out that day visiting the flat he was due to move in to. Patients that have been identified as suitable for discharge from main Roseberry Park site were often moved to Oakwood in preparation for their return to the community.

All patients at Roseberry Park were detained under the Mental Health Act and for some patients, this meant that their discharges were only allowed if they had been approved by the home office.

Care planning

At Roseberry Park an electronic system was used to record and store intervention

and care plans.

On Oakwood we saw three examples of person centred care planning agreed in conjunction with the patients. We saw evidence of patient involvement and understanding of care planning.

On Ivy and Clover (female assessment and treatment units) a patient we spoke to told us that they had a named nurse and that they took a lot of notice of what they said about their care and what they wanted. They said they had lots of copies of the care plan and took us to their room to show us them. They had a tribunal coming up and the plan was to move into a community residential placement, when one became available. Staff had taken the time previously to explain their rights and the outcome of previous tribunals. They had also always been involved in their care planning approach.

On Kestrel and Kite (male assessment and treatment units) we looked at two care plans. The care plans were signed by the patient they included self harm, physical health, verbal threats, intimidation intervention, absconding, criminal behaviour and racist views. The patient centred plans were written in the first person, included likes ,routines and contained details of future plans to get a flat in the community. The care plan also included tribunal decisions.

Patients on all the units told us that there were unit meetings held every two weeks where they had on opportunity to feedback and discuss issues as a group.
The patient centred plans meant that people received care and treatment that met their needs.

Meeting people's health needs

A full health assessment was part of the admissions procedure at Roseberry Park. We saw that these were reviewed regularly and patients often had appointments with other heath professionals such as dentists. Roseberry Park had an on site health centre which was run by a local GP practice. It did regular health assessments on all patients. The centre also included a dental surgery and optician. This meant that patients always received the physical healthcare that met their needs.

One relative told us their family member had seen a dentist and an optician. They said, "When she was poorly they took her to casualty. The consultant was very good. She lost a lot of weight during her severe catatonic periods – but she is getting better. Her hands are tight and never bothered her before but she is talking about surgery now. There are adapted utensils for her". This showed that the service met the health needs of this patient.

Delivering care

On Oakwood patients told us that they took part in a wide range of activities. For example, preservation of wildlife NVQ levels 1 to 3. The site had a garden, where patients could grow vegetables, which they harvested and cooked for Sunday lunches. Patients also go on escorted and unescorted leave, depending on their risk

assessments and care plans. Each patient had 10 days 'leave', which they can book in and do things such as go to York for the day. Patients were also supported to improve reading and writing skills in the unit and attend college courses. The day services included things such as wood working, the gym, and furniture restoration.

We spoke to an advocate for one of the patients on the main Roseberry Park site. She said, "there is a punitive approach used. He gets a lot of X's which result in him loosing his Section 17 leave. He is on a Section 3 – not a 37 or 41 - so the level of restrictions imposed is too high.

When his leave is cancelled this has an impact on contact with his family. His mum is elderly and disabled and lives in a residential home and his brother is physically disabled. He can only have contact if he is supported to go and visit them. Sometimes his leave is cancelled at short notice due to staff shortages. So between the X's and staff shortages his leave seldom occurs. This means he is at risk of loosing contact with his family."

The provider stated that individualised risk profiles were used for each patient, with episodes of violence and aggression marked with an 'X'. This information was taken into account when the risk assessment prior to commencement of leave was carried out. Risk assessments were individualised for each patient whatever the nature of detention."

On the main Roseberry Park site there was a purpose built activity centre which patients could access to take part in a range of activities. We spoke to four patients who all told us that some of their activities were often cancelled due to staff shortages. The manager confirmed the main unit was short staffed due to staff vacancies and high sickness. The unit was in the process of recruiting new staff.

On Oakwood the manager told us that there was a flexible approach to visitors, with families normally allowed to visit at anytime. There was evidence of a range of visitors on the unit on the day of the inspection and patients confirmed that their families were always made welcome.

Visiting times on the main site was between 4:00-5:00pm and 6:00-7:00pm during weekdays and between 10:00-11:00am, 1:00-4:30 pm and 6:00-7:00 pm at weekends but one relative did tell us this was flexible so that shift patterns could be taken into account.

A patient on the main site told us that he was only allowed to make telephone calls to his family when there was a member of staff present and he did not like this as it made him feel uncomfortable. We spoke to the manager about this who told us that patients could only make private telephone calls after it had been approved by the multi disciplinary team.

Patients had access to an independent advocacy service if they wished; this was a service that was not linked to the provider of the service. From examining patient's records we were able to see regular contact with advocates.

<u>Managing behaviour that challenges</u>

Potential risks to patients living at the location were assessed and minimised through an effective risk assessment and review system. We were able to see a number of examples which clearly identified the potential risk and gave instruction and guidance to staff on how to minimise that risk. All of these examples had been reviewed at regular intervals.

When speaking with the manager we asked about risk assessments, they said that they were reviewed at weekly multi disciplinary team meetings and at care planning meetings. This was confirmed by the records we looked at. The service assessed risk so that the safety of patients was protected.

Judgement

Overall Roseberry Park had not met this essential standard. The delivery of care did not meet the patient's individual needs.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are Moderate concerns with

Outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

We spoke to two patients who said they felt safe at Oakwood. One man said staff were good at calming down situations and making sure no one was hurt when there were arguments. He said the care plan told staff how they should deal with situations on an individual basis to help patients manage their behaviour and any anger they might feel. The other patient said that his care plan says how staff should act when he has difficult thoughts or feelings and that they know how best to support him, when it happens so that no one gets hurt. Both men said they would be confident to tell someone if staff did something that was unfair or abusive.

The men living on the main Roseberry Park site said that staff were fair and they thought things were in place to keep people safe, such as the camera (closed circuit television). Both think staff deal with any incidents in a way that makes sure people are safe and if they needed to restrain someone they do this in a safe way.

One relative told us that their family member feels safe, “she hasn’t said she doesn’t feel safe. Staff keep her safe – they will step in if other patients were going to hurt her. She would tell me if she didn’t feel safe. No concerns about safety.”

Other evidence

Preventing abuse

We spoke to the manager about the local area adult safeguarding policy and procedures in place at the service. They supplied us with a copy of these whilst at the service. They were up to date. The service had made 11 safeguarding referrals since April 2011 and we saw that the correct procedure had been followed.

The staff that we spoke to all confirmed that they had undertaken safeguarding training in the last 12 months. They explained that it was an elearning course.

To prevent abuse and to support patients appropriately, the service had an individual intervention plan for each patient which told staff what to do if a patient showed behaviour that may challenge. We saw detailed patient specific protocols if a person required any medication.

From discussions with the ward manager they told us they had appropriate procedures in place to ensure effective whistleblower systems were available to staff. The staff we spoke with were aware of the whistleblower procedures and were able to tell us the correct procedures to follow if they felt they needed to raise concerns with the provider in this formal way.

We spoke to the manager about the how they implemented the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) within the service. The manager told us the service had not made any DoLS referrals in last 12 months as all patients were detained under the Mental Health Act 1983; therefore DoLS did not apply.

Responding to allegations of abuse

The manager was aware of the local area safeguarding procedures and was able to tell us the correct procedures to follow if they suspected abuse. Two at the services that we spoke to were able to identify different types of abuse and stated that they would report any suspected abuse to their manager, or a senior manager if an allegation referred to their manager. However, they were unaware of who the trust safeguarding lead was, or how to directly alert the local authority if they had any concerns.

From discussions with the ward manager they told us they had appropriate systems in place to prevent and identify abuse and the risk of abuse.

On the main Roseberry Park site there was CCTV in all communal areas of the units and the manager explained that where appropriate, after following the correct local procedure, evidence from it could be used to investigate any allegations of abuse. Evidence from this had recently been used when investigating an allegation against a member of staff, who had subsequently been dismissed.

One patient told us that when he reported concerns about another patients behaviour towards him that his claims were properly investigated. He explained that

CCTV from the ward was looked at and although not conclusive the other patient had been moved to another unit. He was happy with this outcome.

Using restraint

The service supplied us with a copy of the challenging behaviour policy and procedure which we examined whilst at the service. The policy was due to be reviewed in November 2011. The manager told us the trust had started to review the policy but it was not finished yet. The procedures contained details of how the use of de-escalation and restraint should always be appropriate, reasonable, proportionate and justifiable to that individual.

When we visited Thistle, a unit for women with the most challenging behaviour, we saw that a patient was being cared for separately by two staff in the management suite. This patient's care had been managed this way for the previous 24 hours. Whilst it was clear that this patient needed to be cared for in segregation due to the threat she posed to other patients and staff, the service was not managing this as seclusion. The service stated that the patient was in 'therapeutic segregation' but the challenging behaviour policy did not define or describe how or when segregation could be used or the safeguards that should be in place when a patient was managed in segregation. This meant the appropriate safeguards were not in place when segregation was being used to manage patients who had behaviour that challenged

We asked whether staff had completed de-escalation and restraint training. The manager stated that all staff had completed prevention and management of violence training to enable them to carry out these practices. Training records we examined provided evidence of this and staff we spoke with confirmed this.

We asked the staff how they worked with patients whose behaviour challenged the service. They explained that any physical intervention was only used as a last resort by trained staff in accordance with Department of Health guidelines. We checked two sets of care plans which showed restraint had been correctly used and recorded appropriately. We saw that incident forms were submitted when required.

During the inspection we looked at a range of documentation and information relating to the use of restraint within the service. We examined the incident reports of people who used the service. We found evidence that the records were adequate to demonstrate that the local policy and procedures had been followed consistently. These meant that patients were protected from the misuse of restraint.

Judgement
Overall Roseberry Park had not met this essential standard. The provider did not have policies and procedures in place to safeguard patients when segregation was used to manage a persons care and treatment.

Outcome 9:
Management of Medicines

What the outcome says

This is what people who use services should expect.

- Will have their medicines at the times they need them, and in a safe way
- Whenever possible will have information about the medicines being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is Compliant with

Outcome 9 : Management of medicines

Our findings

What people who use the service experienced and told us

On the day of the visit we were unable to speak to anyone using the service about their medicines.

Other evidence

This outcome was looked at because CQC had received information that suggested this was an area of concern.

As part of our review we visited the hospital and looked at medicines on five units. We talked to nurses, unit managers and pharmacists. Patients had their medicines at the times that they needed them and in a safe way. Wherever possible patients were given information about the medicine being prescribed.

Good systems were in place to monitor the safe handling of medicines. The pharmacist or pharmacy technician visit daily to check records, order stock and check prescribing. Regular audits were completed as part of the medicines service provided by Trust pharmacists. Records were kept of medication errors and near

Action
we have asked the provider to take

All medicines were stored securely. For the protection of patients, all units keep records of room and fridge temperature. Resuscitation equipment was checked daily and the trust pharmacist monitored the expiry dates of emergency medicines. Medication administration was observed on two units. We saw that staff followed safe practices and treated people respectively. On both of the units people were given their medication privately.

People detained under the Mental Health Act 1983 had either consented to their treatment or had their medicines authorised by a Second Opinion Appointed Doctor, in line with the Mental Health Act 1983 Code of Practice. We saw that patients were only being given medicines that had been authorised.

Judgement

Overall Roseberry Park had met this essential standard.
Patients had their medicines at the times that they needed them and in a safe way. Wherever possible people were given information about the medicine being prescribed.

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 11	Outcome 7: Safeguarding people who use service from abuse
	How the regulation is not being met: The registered person did not have policies and procedures in place to safeguard patients when segregation was used to manage a persons care and treatment.	
Treatment of disease, disorder or injury.	Regulation 11	Outcome 7: Safeguarding people who use service from abuse
	How the regulation is not being met: The registered person did not have policies and procedures in place to safeguard patients when segregation was used to manage a persons care and treatment.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983.	Regulation 9	Outcome 4: Care and welfare of people who use services
	How the regulation is not being met: The registered person did not ensure that the delivery of care met the patient's individual needs.	
Treatment of disease, disorder or injury.	Regulation 9	Outcome 4: Care and welfare of people who use services

	How the regulation is not being met: The registered person did not ensure that the delivery of care met the patient's individual 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 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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA