# Review of compliance

| Sheffield Health and Social Care NHS Foundation Trust<br>The Longley Centre | |
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| **Region:** | Yorkshire and the Humber |
| **Location address:** | Longley Centre<br>Norwood Grange Drive<br>Sheffield<br>South Yorkshire<br>S5 7JT |
| **Type of service:** | Hospital services for people with mental health needs and/or learning disabilities and/or problems with substance misuse. |
| **Date the review was completed:** | January 2011 |
| **Overview of the service:** | The Longley Centre provides in-patient and day care and for persons with acute mental health problems. The centre includes the Rowan and Maple wards (acute mental health under age 65) along with the Intensive Treatment Service. There is the Pinecroft recovery ward and the Hawthorn ward for persons aged over 65. Additional facilities include the Thornlea Day Centre and the Redwood Day Hospital. |

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

## What we found overall

**We found that the Longley Centre 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

We carried out this review as part of our routine schedule of planned reviews.

## How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 11 January 2011, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

## What people told us

A range of information was obtained that demonstrated how the provider ensures people who use services are involved in decisions about services and how their views are obtained. Submissions from the Sheffield LiNK (local involvement network) demonstrated how the provider has worked with and involved LiNK participants in influencing the city wide strategy for improving mental health services in Sheffield. For example, the LiNK participants work on recovery wards had been fed back to managers and staff, leading to changes in care in respect of service users' sexuality, spirituality and problems with social interaction.The LiNK has been involved in the quality reporting process with the provider and stated "we are pleased with how we have been engaged in this and we will possibly be doing some joint enter and view visits." The provider included some views of people who use services who had fed back comments as part of its last complainants survey, for example, one comment

stated, “I like the face to face contact. I felt they understood our concerns and did their best to address them”.

A large number of comments were provided by people who use services on the site visit conducted 11 January 2011. A small selection include:

“I feel safe here now, calm environment, relaxed”.

“No problems with staff, great they are”.

“Definitely had 100% good care on this ward since I’ve been here, staff been more than helpful…They come and tell us when they come on duty who has been assigned to me for the shift”.

“Some [staff]  very approachable some sit in office too much”

“I like this ward but when I go on leave I get anxious because we are told our bed may have to be given up, this is always on my mind when I am on leave”

“Lots of activities to keep me busy. Enjoy going to OT pottery, baking.2 staff in OT and an activities coordinator”.

“do not feel we have enough time with medical staff seen doctor 4 times in 5 months”.

“I have been in this ward before maybe a year ago. Things are better now. It’s the staff; they are much more approachable and have more time for us”.

## What we found about the standards we reviewed and how well the Longley Centre was meeting them

### Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found the people who use services have their views and experiences taken into account in the way the service is provided and have their privacy and dignity respected. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

### Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

We found that the location is not meeting this outcome in full. We are concerned that there was no systematic and clear recording of assessments of a person's capacity to make decisions for people who was either detained or informally admitted. We were concerned that medical staff did not always record explanations of the risks, benefits and alternative options of treatment in patient records.

- Overall, we found that improvements are needed for this essential standard.

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

We found that the location is not meeting this outcome on the acute mental health wards. We were concerned that there was no robust systematic process of individualised risk assessment which is based on a nationally recognised evidence based tool for mental health. We found that the patient's risk assessment process was subjective, not supported by any policy or guidance and not evidenced based, which places patients and others at potential risk of harm. We were not confident that patients are adequately involved in developing their care plans in partnership with their named nurse and consultant and we found they are not involved in multi-disciplinary meetings. Though we found Maple ward generally meets same sex guidelines we were concerned that one cubicle in the female area of Rowan ward was occupied by a male patient. The provider should work with its partners, South Yorkshire Police, and NHS Sheffield to try to see if it is possible to identify a more suitable location for the section 136 suite or find ways of managing these detentions that may have a lesser negative impact on the ward. We recognise the provider has put in place various measures to lessen the impact of high bed occupancy levels but we continue to have some concerns that bed occupancy may be occasionally having some negative impact on people who use services.

- Overall, we found that improvements are needed for this essential standard.

**Outcome 5: Food and drink should meet people's individual dietary needs**

We found evidence that people who use the services were supported to have adequate nutrition and hydration. No areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

**Outcome 6: People should get safe and coordinated care when they move between different services**

We found systems and processes in place to ensure people who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or where they are moved between services. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

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

We found systems and processes in place to help ensure people who use services are protected from abuse, or the risk of abuse, and their human rights upheld. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

**Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**

We found most of the location was generally meeting this outcome. However during the site visit performed 11 January 2011 we found that the seclusion room on Maple ward had not been cleaned following use, did not include a recommended soap dispenser secured to the wall and did not include a toilet roll holder.

- Overall, we found that improvements are needed for this essential standard.

**Outcome 9: People should be given the medicines they need when they need them, and in a safe way**

We found systems and processes in place to ensure people who use services had received their medicines when they needed them and received had information about the medicines being prescribed. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

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

We found not all areas of this outcome were being met, though we found the building had a positive atmosphere on the day of our visit, and was generally clean and tidy. We are concerned that clear glazing to the link corridor doors and fire exit door may be affecting the privacy and dignity of patients who are residing in the female area of Rowan ward. We are concerned that inadequate heating is being provided in various areas of the Longley Centre and in a number of patient bedrooms.

- Overall, we found that improvements are needed for this essential standard.

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

We found no gaps in assurance that may suggest people who use services would be put at risk from unsafe or unsuitable equipment and we generally found that they would benefit from equipment available to meet their needs.

- Overall, we found that the Longley Centre was meeting this essential standard.

**Outcome 12: People should be cared for by staff who are properly qualified and able to do their job**

We found no evidence that recruitment and selection procedures for workers were not effective. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

We found people who use services should be safe and have their health and welfare needs met by sufficient numbers of appropriate staff. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

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

We found evidence to demonstrate that people who use services would have their health and welfare needs met by competent staff. The provider had declared at registration prior to April 2010 that it was not meeting this outcome because insufficient numbers of staff across several locations had received a recent appraisal. For this location we found evidence to demonstrate all appraisals had been completed for available staff and we no longer have a minor concern regarding this outcome at The Longley Centre.

- Overall, we found that the Longley Centre was meeting this essential standard.

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

We found effective systems were in place to assess and monitor the quality of service provision so that people who use services will benefit from safe quality care, treatment and support due to effective decision making and the management of risks to their health, welfare and safety. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

**Outcome 17: People should have their complaints listened to and acted on properly**

We found evidence that comments and complaints were listened to and acted on effectively. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

- Overall, we found that the Longley Centre was meeting this essential standard.

**Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential**

We found that the location is not fully complying with this outcome. We found that the ongoing use of paper based and electronic records carries some risks; including there may be potential failure to consistently document clear, factual and accurate records for individual patients. We also found the current systems limit the accessibility of records because it was difficult to find specific items of information, such as the current status of a person's capacity.

- Overall, we found that improvements are needed for 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.

**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 1:
# Respecting and involving people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**The provider is compliant** with outcome 1: Respecting and involving people who use services

**Our findings**

**What people who use the service experienced and told us**
Positive comments were included in the CQC Quality and Risk Profile (QRP) for outcome 16 from the Sheffield LiNK which was also applicable to this outcome. LiNK participant's work on the recovery wards has been fed back to managers and staff which lead to changes in care respect of people who use services sexuality, spirituality and problems with social interaction. The LiNK reported that the trust has cooperated with ongoing research involving members of LiNK which has lead to real care quality improvements in long term wards.

A detailed submission from the Sheffield LiNK at registration demonstrates how the provider has worked with and involved LiNK participants in influencing the city wide strategy for improving mental health in Sheffield. An additional positive comment noted that people who use services, carers and foundation trust governors will be involved in visiting service areas, to talk to people who use services and staff about the quality and safety of care as part of the new quality checks process described in the 'quality accounts'. People who use services have also carried out surveys of

privacy and dignity on the wards during 2009/10 and “this will continue”.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. We found the report to be a detailed and informative document containing a large range of information applicable to a number of outcomes for the location. The report contained a number of examples providing evidence of involvement and how feedback from people who use services and carers is obtained. Community meetings are held on a weekly basis which has allowed people who use services to discuss any issues or concerns and make suggestions. The ward had received positive feedback regarding the activity room and the report also explained how the activity coordinator role has remained popular with people who use services. Other examples of groups include a music group along with a health and wellbeing group.

A range of social inclusion partnership work has been continued, for example, a pedal ready cycle touring club. People who use services cultivate an ornamental vegetable garden within Hillsborough park walled garden and the group won a gold medal in the Sheffield in bloom awards. Other groups include a creative potters group which is a partnership between an independent potter, occupational therapy staff and people who use services from this location.

The governance report explained an initiative named “Star Wards”, which was started by a service user. The concept is that of providing people who use services with meaningful activities whilst on the wards. The meetings take place on the ward to allow staff members and people who use services to develop ideas and access them and have been found to be very positive. The report explained that morning planning meetings was one of the activities inspired by Star Wards. People who use services and staff members jointly share and plan the ward routine and activities for the day ahead and these are captured in a book to allow audit.

**Other evidence**
The provider declared compliance with this standard at this location at registration with CQC in April 2010. A provider level submission provided detailed explanatory notes regarding 'respecting and involving people who use services' , ‘how service users views are obtained and used to influence services’ and regarding the ‘promotion of equality, diversity and human rights’.

The current provider level Quality and Risk Profile (QRP) risk rating for this provider contained no negative individual information for this outcome or location. Overall the information contained showed the trust to be positively rated when compared with other NHS trusts nationally. The last MHA Commissioner reports were obtained for Pinecroft ward (visited 27/10/2009), Intensive Treatment Centre (visited 27/10/2009), Maple ward and Rowan Ward (visited 19/07/2010) that contained no negative feedback in relation to this outcome.

As part of the initial assessment of all outcomes a number of external stakeholders were contacted including, Sheffield LiNK (local involvement network), Sheffield OSC (overview and scrutiny committee), Health and Safety Executive, Yorkshire and the Humber SHA (strategic health authority), NHS Sheffield and Monitor (Foundation Trust regulatory body). None of these bodies raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a provider compliance assessment for this outcome. (This tool allows to the trust to perform a self assessment and explain how it is currently meeting each part of the outcome). A comprehensive amount of information was set out that explained in detail, with references to supporting evidence, how this outcome was being met. Examples are given below.

The provider stated that involving and respecting people who use services is fundamental to its approach and this is reflected in the “Service User Involvement Strategic Framework”, which was developed with people who use services. The provider reviews equal access to services through action planning linked to the “Single Equality Scheme” and application of equality impact assessment process to policy development and implementation. The Care Programme Approach (CPA) is used for people receiving mental health care and treatment. Older people have been treated under the CPA approach if their needs are complex, or the Single Assessment Process (SAP) is utilised if their needs are less complex. Training has been provided to staff across the organisation on CPA, which includes promoting the involvement of people in decision making.

The provider had systems and underpinning policy and procedures for accessing interpreting and translation services to ensure that people are able to engage fully in decision making irrespective of language or hearing barriers.

The provider had reviewed information that suggested some black and minority ethnic (BME) groups were either under or over-represented in different services, and so needed additional support or advocacy to make sure their needs were addressed and their voices heard. The provider holds a contract with the Pakistan Muslim Centre (PMC) which employs a link worker for inpatient areas across adult and older people inpatient mental health services. The role of this worker is to support communication and ensure that people are able to access appropriate services relevant to their cultural needs internally and on discharge. The Enhancing Pathways Link Worker post works primarily with south Asian people who use services. African and Caribbean people who use services have access to a similar service through an advocacy worker who is employed by the Sheffield African Caribbean Mental Health Association (SACHMA). Emotional wellbeing workers fulfil a community development role and support individuals, especially people from the Yemeni community and Pakistani women to have their care and treatment needs met.

People who use services have been able to access independent advice through the Mental Health Citizens Advice Bureau (MHCAB) which is hosted within the provider at the Michael Carlisle location. Advocacy is provided by independent mental capacity act advocates. People who use services have been provided with information about this service and directed towards the advocates. Independent Mental Health Advocacy services were found available. The provider maintains an active spirituality group which oversees policy and practical developments in this aspect of choice for people who use services.

A range of measures were found to exist to ensure that people have their care, treatment and support needs met including, audit of the care programme approach,

audits of records, service user feedback via compliments, complaints and PALS (patient, advice and liaison services). The provider reported that it received more than eighteen times as many complements as formal complaints during the period April 2009 to March 2010. Review and action planning arising out of national surveys such the CQC community mental health surveys have also been completed. Evidence that treatment options and choices have been explained to service users can also be found in audits of NICE guideline implementation.

People who use services and carers have been involved in developing processes that assure that people who use services are involved in assessing, planning and carrying out their care, treatment and support, for example, projects that introduced self directed support. Audits and evaluations are available to demonstrate people who use services were included in NICE guideline implementation groups. The provider has collated feedback from people who use services that showed 92% said they had enough 'one to one' time with staff and 84% said they had enough information about their care and treatment. We found the provider had a range of strategies in place that promote choice, examples including, social inclusion strategy and an employment strategy.

The provider was able to demonstrate that people who use services received care, treatment and support was provided in a way that ensures their human rights and diversity is respected. The Single Equality Scheme action plan has been reported on annually and describes the action that has been taken in the previous year to promote equality and human rights in the organisation. Information was available in easy read formats (large fonts etc) and there is access to interpreters and translators and information is provided in a variety of languages, for example, medicines advice leaflets. The organisation also maintains a dedicated trans-cultural team, which has previously organised various events. The provider held an Improving Quality event specifically aimed at engagement with black and minority ethnic communities which was reported as well received and evaluated. The provider has also held bespoke events in inpatient services for diverse cultural celebrations and has been undertaking a review of managing violence and aggression alongside an African Caribbean group.

The provider has encouraged service users and carers to be involved at all levels of decision making in the organisation at local and strategic level. For example, people who use services and carers have been involved in local service forums where decisions have been made. Across the organisation people who use services have received training alongside staff in recruitment and are actively involved in decisions relating to staff recruitment. The provider reported that plans are underway for service user volunteers to be involved in staff induction days. Specific places are available for people who use services as foundation trust governors who have been actively involved in decision making. 'Improving Quality' events have been held regularly, these are predominantly attended by people who use services and carers and have included decision making about improving quality in the organisation and particularly how people would like to be involved, for example, improving services for BME communities (April 2010).

The provider was able to demonstrate in a number of ways how it ensures that people who use services are able to participate in activities of the local community so that they can exercise their right to be a citizen as independently as able.

**Our judgement**

We found the people who use services have their views and experiences taken into account in the way the service is provided and have their privacy and dignity respected. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# Outcome 2:
# Consent to care and treatment

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**There are minor concerns** with outcome 2: Consent to care and treatment

**Our findings**

**What people who use the service experienced and told us**
The provider gave an example of how a person using the service had not agreed with taking prescribed medication and would not consent to receiving medical treatment in the community. The patient, advice and liaison service (PALS) liaised with the person's doctor to arrange a meeting to ensure they had clear and relevant information. Once the person using the service was better informed, consent was given to care and treatment and they were able to be discharged into the community.

Though not relating directly to the consent process itself explanations about medications and involvements in decision making are key parts of the overall consent processes. In the mental health acute inpatient survey 2009 the trust was rated in the best performing 20% of NHS trusts nationally regarding two questions relating to the explanation of the purpose and possible side effects of medications. Also , in relation to the question 'were you involved as you wanted to be in decisions about care and treatment' the provider scored just below the threshold for the highest 20% of NHS trusts nationally.

As part of our site visit conducted 11 January 2011 we sought the views of patients who were admitted about this outcome in relation to side effects and benefits of medication, which is part of the consent to treatment processes for persons detained under the MHA. Of the seven patients we spoke to three did say that the doctor had explained the side effects of treatments.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. The current provider level QRP was not currently risk rated as it contained insufficient information. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

The last MHA Commissioner reports were obtained for Pinecroft ward (27/10/2009), Intensive Treatment Centre (27/10/2009), Maple ward and Rowan Ward (19/07/2010). Both the Maple and Rowan wards received positive commentary concerning statutory (MHA) documentation from the commissioner. However the commissioner feedback reports also found some areas where there was gaps in assurance. On Rowan ward found one patient without a valid consent to treatment form as required by the Mental Health Act. On Maple ward the commissioner was not able to find clear entries in patient notes in respect of discussions regarding capacity with their clinician. Action plans were included by the respective managers.

As part of the assessment of this location the provider submitted a provider compliance assessment for this outcome. We found the provider had a range of policies, procedures and guidance relating to consent to treatment. The consent policy and mental capacity act guidance set out the processes whereby staff members enable people who use services to make informed decisions. Where individuals lack capacity the provider has best interest guidance to inform staff on the most appropriate methods in supporting the person using the service. Informed decision making in relation to treatments are supported by a range of information leaflets relating to the treatment itself. The CPA process requires documentation that shows consent has been given by people who use services. The deprivation of liberty safeguards guidance complimented the Mental Capacity Act in its requirements for consent and is supported by a range of “useful and well used prompt cards” (provider compliance assessment outcome 2).

A specific section on consent and capacity for people aged 16 and 17 years was found in the policy Admission of 16 – 17 year old young people to an adult mental health ward. Guidance in relation to advance decisions/statements made using the provisions of the Mental Capacity Act 2005 was included in the CPA process. The Resuscitation policy was found to include procedure and form for do not resuscitate decisions.

We found that the provider had processes and measures in place to monitor the effectiveness of its various policies relating to consent. These measures were found to include groups such as the provider ‘consent and confidentiality group’, which had identified where improvements could be made in relation to the annual care records audit. The application of the Mental Health Act (MHA) requires staff to ensure recording of consent is documented and audited through a quarterly “MHA Audit” this was conducted through the “clinical effectiveness” department. The use of

relevant forms of persons who are non-consenting are monitored by the 'mental health act group'.

Clinical staff members were found to have access to traditional and electronic training in the implementation of the Mental Capacity Act which included guidance on consent. Through a completed training needs analysis the provider has piloted plans to widen training to include consent in the induction and mandatory training.

We found gaps in assurance that this location may not be fully meeting this outcome based on the findings of the MHA commissioner visits to Rowan and Maple wards which gave an assessment of a minor concern. As we had identified areas of concern in relation to outcome four that required a site visit to gain additional evidence we decided to include this outcome to review consent to treatment practices made via the Mental Health Act along with practices relating to assessing and recording a persons capacity to make an informed decision. On the site visit we reviewed a sample of people who use services records. As part of a semi-structured interview we also asked people who use services if they had had their consent to treatment reviewed and if the doctor had explained the risks and benefits of treatment and if they understood.

On the site visit performed 11 January 2011 we reviewed focused areas of this outcome on Maple and Rowan wards. In our previous visit on 6 January 2011 to the providers acute mental health wards at the Michael Carlisle Centre we had found that there was no systematic and clear recording of assessments of a person's capacity to make decisions for people who was either detained or informally admitted.

On Maple ward we discussed the recording of capacity with the ward manager. We reviewed two sets of patient notes to identify if recording of capacity took place. We found on this ward the patient notes generally contained more detail when compared with previous assessments in other areas, for example, a detailed hand written account was given regarding a persons treatment review under the MHA including information that demonstrated how the patient felt about the change of treatment. In this record, though there was no specific reference to an assessment of the person's capacity it was clear from the detail that it had been considered. The second record for a person who was informally admitted did not include, specific detail regarding discussion of medications or an assessment of capacity.

On Rowan ward we discussed the recording of capacity assessments with the consultant psychiatrist. It was explained why it may not be recorded generally on admission, though it was explained that it may be captured during a treatment review for persons detained under the MHA. The consultant admitted that capacity is not usually captured in the record for persons who are informally admitted. The ward manager confirmed what the consultant explained so we did not review records on Rowan ward.

We are concerned that there was no systematic and clear recording of assessments of a person's capacity to make decisions for people who was either detained or informally admitted. Guidance for the recording of capacity by professionals is outlined in the "Mental Capacity Act 2005 Code of Practice" (2007). We were concerned that medical staff did not always record explanations of the benefits and

side-effects of medication or treatment in patient records.

**Our judgement**

We found that the location is not meeting this outcome in full. We are concerned that there was no systematic and clear recording of assessments of a person's capacity to make decisions for people who was either detained or informally admitted. We were concerned that medical staff did not always record explanations of the risks, benefits and alternative options of treatment in patient records.

# 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**
The last mental health acute inpatient survey was performed in 2009 of which the majority of responses fell within the 'as expected' level in comparision nationally with similar trusts with a smaller number also falling in the best performing 20% of trusts. The 2010 NHS patient survey of people who use community mental health services found that the provider performed well in comparison with other NHS trusts nationally with the clusters of questions relating to medications, talking therapies, care plans and care reviews.

There was two positive comments from Sheffield LiNK included within the QRP relevent to this outcome. The LiNK participants work on recovery wards had been fed back to managers and staff, leading to changes in care respect of service users' sexuality, spirituality and problems with social interaction. The LiNK also reported that the trust had cooperated with ongoing research involving members of LiNK which has lead to real care quality improvements in long term wards. It was noted with both these comments that further work is planned involving the acute wards. The LiNK also contributed the following relevant to this outcome on 29 October 2010 as part of the request for information from external stakeholders.The LiNK has been involved in the quality reporting process with the provider and "we are pleased with how we have been engaged in this and we will possibly be doing some joint

enter and view visits."

The LiNK contributed the following relevant to this outcome on 29 October 2010: The Sheffield Mental Health Citizens Advice Bureau Limited and Advocacy Service at the Michael Carlisle Centre referred us to the 'Innovations in Compassionate Care: Quality and Dignity Volunteer Project report. The work was a joint project between Sheffield Mental Health Advocacy Service, who provided people who use services volunteers to complete the interviews, and the provider who analysed data. The project was carried out on Burbage and Stanage wards (Michael Carlisle location) along with Rowan, Maple and Intensive treatment service wards (The Longley Centre location). Three people who use services volunteers interviewed a total of 101 in-patients over a period of approximately 12 months. The Questionnaire contained 48 questions relating to the quality of care provided on the wards and a report was published in June 2010. It was explained that overall the wards performed reasonably to well on clinical issues, family/carer involvement, catering for cultural/religious needs/food, patients knowing why they were admitted and having clear answers from staff to their questions, gender appropriate facilities, privacy, and information about activities on the wards. Some areas of weakness appeared to be not being given a recovery folder, ward handbooks, information about advice or daily opportunities to discuss care plans.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report gave a number of examples of how people who use services are involved in various social inclusion partnerships that provide therapeutic benefit along with "Star Wards" and a morning planning meeting which allow people who use services and staff members jointly share and plan the ward routine and activities for the day ahead and these are captured in a book to allow audit. (These examples are explained within outcome one).

The provider offered additional evidence which was the Complaints and Complements Quarterly Report for the period 1 July to 30 September 2010. The report was a detailed and informative document containing a number of direct quotes regarding complements received from people who used services. Some views recorded from the Longley Centre included:
"I would just like to say how lovely all the staff are…I'd like to say thank you all for looking after me so well" (Hawthorn ward)
"Thank you to all the staff that have cared for me – the stay has been great" (Rowan ward).

On our site visit to this location on 11 January 2011 we sought the views of patients who were admitted to Rowan and Maple wards about their care on these wards. Some of the views we captured were:

"I feel safe here now, calm environment, relaxed".

"No problems with staff, great they are".

"Feel safe and staff do a good job".

"Been here 2 months, yes seen care plan. Sometimes get upset and aggressive, I write it down makes me feel better, staff helped me a lot."

"Definitely had 100% good care on this ward since I've been here, staff been more than helpful…They come and tell us when they come on duty who has been assigned to me for the shift".

"Do not go into MDT.[Consultant] see's us sometimes but I would like opportunity to go into meeting if I feel like it".

"Came here with alcohol and suicidal problems. Never been in a psychiatric unit. Felt intimidating at first, when you see people more ill than you. But staff have been superb, very friendly, helpful, did not judge me".

"Some [staff] very approachable some sit in office too much"

"Some agency staff poor don't seem to understand. Prefer to have permanent staff. Bank staff are generally o.k"

[Bed occupancy levels] "I like this ward but when I go on leave I get anxious because we are told our bed may have to be given up, this is always on my mind when I am on leave"

"Lots of activities to keep me busy. Enjoy going to OT pottery, baking.2 staff in OT and an activities coordinator".

"can speak to staff although feel they do not always have enough time but they will come back to you and speak later"
"Found that staff attitude has been excellent when I was under section and [close observation] staff were not too intrusive but offered me safety /security whilst maintaining my privacy".

"do not feel we have enough time with medical staff seen doctor 4 times in 5 months".

"I have been in this ward before maybe a year ago. Things are better now. It's the staff; they are much more approachable and have more time for us".

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained mostly positive information. Two negative commentaries from an external source related to issues surrounding bed occupancy levels at the acute mental health locations and have therefore not been applied to this location.

The last MHA Commissioner reports were obtained for Pinecroft ward (27/10/2009), Intensive Treatment Centre (27/10/2009), Maple ward and Rowan Ward (19/07/2010) which contained positive commentary was made. On Maple ward the commissioner observed good interaction between staff and patients and the therapy department was commended on their commitment and wide range of activities available. Similarly Rowan ward was observed as having good interaction between

staff and patients. It was noted that Pinecroft ward runs a 'well-being group focusing on the physical health needs of patients including side effects of medication such as weight gain. The ward has won a service excellence award from the provider. The intensive treatment service had developed "Glyn's Café" which the commissioner noted was very popular with patients and staff. It provides an area where patients can relax, do cooking and other activities in an informal way. The commissioner did make some recommendations relating to care plans and some other areas relating to this outcome.

In key finding one of the 2009 staff survey, 'staff feeling satisfied with the quality of work and patient care they are able to deliver' the trust was found to be better than average when compared to other trusts with this finding and key finding 36, 'staff recommendation of the trust as a place to work or receive treatment' the provider was found to be in the highest 20% when compared with other trusts nationally.

The Sheffield LiNK provided detailed commentary for this outcome and this is set out 'what people who use the service experienced and told us' section above. They also commented, "One user says that the Longley Centre/Michael Carlisle Centre do not have enough acute beds. This leads to restrictions on admissions and patients returning from leave may not have a bed available for them."

NHS Sheffield contributed the following commentary relevant to this outcome regarding serious untoward incidents (SUI's). The provider had reported SUI's timely and appropriately. High numbers of SUI's had been reported, however though was in line with other mental health trusts. There was previously a backlog of open SUI's and during the last 6 months the provider has worked closely with NHS Sheffield to deliver action plans and a significant number have now been closed. Regarding physical health NHS Sheffield explained there has been targeted actions to increase the physical health care of clients. Approximately 60 staff have been trained and updated in assessment and management of people who use services.

There was one positive comment in the QRP. This is a response letter from the trust to the Sheffield Adult Mental Health Association (dated 8/3/2010) who's concerns are outlined below. This contained some explanations that are relevant to services at the Longley centre including positive information in relation to serious incident statistics, the introduction of discharge coordinator roles on inpatient wards to lessen the number of delayed discharges and improve use of beds and the acute care pathway launched in December 2009. NHS Sheffield in it's submission to us explained that acute ward occupancy rates had risen over the last two years and over the same period there have been increases in the numbers of people admitted out of town. The provider has developed an action plan to reduce acute ward pressures, including the appointment of a senior manager for six months to lead the implementation of the acute care pathway. NHS Sheffield and the provider had together formed a senior level 'out of town review group' and "there is a range of initiatives in place or being developed to reduce out of town placements."

As part of the assessment of this location the provider submitted a provider compliance assessment which explained in detail against each individual prompt how it was being met. The range and breadth of information provided means it is not possible to give a summary of some examples as we have given for other outcomes in this review. Once this self assessment was received we reviewed it against our

Essential Standards of Quality and Safety along with our Judgement Framework. Where possible examples were further tested by accessing the provider's website, for example, the assessment explained how staff may be contacted and described a help button available on the home page of the website. Also the provider's website allowed access to a range policies and other information. We found no gaps in assurance during review of the provider compliance assessment.

The QRP contained two negative commentaries and both were letters from the Sheffield Adult Mental Health Association (the association). Letter one dated 10/06/2010 relates to concerns regarding bed over occupancy rates at the acute inpatient wards at the trust. The comments are general in nature and it was not possible to highlight specific matters that are covered by this outcome. Letter two dated 27/08/2010 was the result of engagement ourselves and a representative of the association. This letter highlighted a number of negative impacts that the association feel arise out of high bed occupancy levels.

We reviewed each area of concern but found that some would be too difficult to assess and demonstrate non compliance as they were broad in nature and some where we had other evidence that demonstrated that the provider was likely to be compliant, for example, the 2009 staff survey found that staff suffering work related stress in the last 12 months was rated positively and 'work pressure felt by staff' was found to be 'much better than expected' (see outcome 14). The MHA commissioner had noted positive interaction between staff and people who use services.

We recognise bed over occupancy is a recognised issue for acute mental health services across England. The Essential Standards of Quality and Safety outcome 10 (safety and suitability of premises) only sets out guidance on bedrooms for nursing and residential care homes and there is no specific regulation or outcome prompt to cover mental health services. However we can consider the impacts of high bed occupancy where it may negatively impact on the care and management of people who use services and staff members. We decided to conduct site visits at the Longley Centre and Michael Carlisle Centre:
"Community services become frustrated and challenged because ill patients need to be in hospital to have the best treatment, and there may also be no place of safety available."
"Over-occupancy causes stress for service users and staff alike. Wards with 'high activity' promote more chaotic situations and is certainly not a calming and healing environment." (mapped to outcome 4a \ staff outcome 14d)
"Patients returning from leave find there is no bed for them, which is upsetting for patients and staff are often challenged."
"There is a lack of 1:1 engagement and quality time with the patient because the staff are busy."
"Because the staff are busy there is less awareness and alertness for ill patients who are likely to abscond and arrive home unexpectedly causing disruption. Absconsions from acute inpatient psychiatric wards occupy police time."
"There is the temptation for staff to give leave earlier than would normally be the case because beds are needed, and there is a drive for discharge. Again, unexpected arrival of ill patients at home or in the community causes disruption and imparts significant stress on the family."
"Provision for staff training comes under pressure." (outcome 14a)

We decided to conduct a site visit based on the concerning information we had received. We designed a specific set of semi-structuted questions for people who use services and staff members to see if any of the issues raised by the association had been experienced on the acute in-patient wards. We also included a period of observation to monitor how the ward felt generally and monitor staff engagement with people who use services.

We found on the site visit conducted 11 January 2011 that bed usage was 'stretched' though we did not find evidence to suggest bed occupancy rates and usage impacted to the extent of the concerns raised by the association. Staff members also told us in response to some of our questions:

1. Do you have regular discussions with service users about their care and do you adapt or individualise their care based on these views where possible?

"Yes although some [patients] refuse to sign",
"Yes although [patients] do not attend MDT …sometimes I feel it would benefit them if they do…others not",
"Yes patients do have input although some staff better at involving people than others",
"Feel patients should go in MDT, if they want. No policies in trust on whether they should go in or not",
"Yes try to make sure everyone sees their own if they want to",

2. Do you ever feel high bed occupancy rates make the ward too busy to allow you to provide effective care or allow adequate one to one time with service users/patients?
"Sometimes even today we have 28 people on books people at home still need support…",
"Bed occupancy no but more clinical needs of patient…",
"More dependency levels than occupancy…",
"More of a problem trying to special more than two people than occupancy rates…"

3. How often does a service user or patient return from approved leave to find there is either no bed for them, or that their bed space has changed?

"Just some people can be reluctant to go on leave in case they lose their bedroom",
"Never although bed managers deal with this",
"Not sure no pressure to discharge though",
"some SU do not want to go on leave for fear of losing their bed which could impinge on their recovery".

4. ): Does bed occupancy issues cause tension or disagreements between service users and staff?

"Sometimes between the patient and staff not patient to patient",
"Some patient's get angry maybe happens once a month".

None of the staff members interviewed thought bed occupancy issues had affected relations between ward and community staff nor had it lead to any increase in

absconsions. However, in relation to it's affect on staff, we was told "staff dread telling people if bed has to be given up" and, "it can cause stress".

Though we recognise the provider has put in place various measures to lessen the impact of high bed occupancy levels we continue to have some concerns that high bed occupancy may be occasionally having some negative impact on staff and patients.

On the site visit performed 11 January 2011 we found that both Maple and Rowan wards along with the Intensive Treatment Service (ITS), despite them being fully occupied, had a positive, calm and welcoming atmosphere. We found staff members to be competent, knowledgeable, friendly and helpful and had a positive commitment to the care of patients on the ward.

On Maple ward we spent some time with the ward manager discussing how mental health risk assessments are completed in relation to risks such as suicide, aggression, self harm and sexual vulnerability. A subjective assessment is used based on a rating of low, medium or high and we found no evidence to show how the patient is involved in the risk assessment process. The ward manager talked us through how a patient with a risk of suicide would be managed and assessed. Though it was explained an initial brief assessment would be followed by a more detailed assessment and plan, it was acknowledged that the assessment would be subjective and not completed via a formal evidence based tool.

To highlight the how subjective the current assessment is we used a pathway tracking approach with the ward manager to review a patient's journey in relation to risk assessment. We found the patient carried various risks due to their diagnosis and presentation. We found two admission summaries from the same period which in fact were transfer summaries for the patient between Stanage ward and Maple ward. Both documents stated different risk ratings of medium and high. Neither document contained sufficient detail explaining what the risk was to others and how it should be managed. Later in the patient journey, the ITS had rated the risk 'low' but immediately on return to Maple ward this had again changed to 'medium' with no clear explanation. We found the patient did have a risk management plan though it was not clear how the plan mitigated the risk. We found that the risk assessment process in all clinical areas was highly subjective, not supported by any policy and not evidenced based, which places patients and others at potential risk of harm.

Later, when we visited the ITS it was confirmed by the ward manager that no formal risk assessment process is used. Both managers explained the provider had developed a formal risk assessment tool which was soon to be piloted on Rowan ward. We discussed the proposed formal mental health risk assessment tool with the ward manager on Rowan ward who showed us the template. We found the tool would be an improvement when compared with existing arrangements as it appeared to be a slimmed down version of a recognised evidence based tool, but because the provider has adapted an existing tool it would mean that it won't be evidence based. The tool which is to be piloted shortly will enable a more robust approach to risk screening though we found that it does not actually enable an assessment in relation to identifying impact, likelihood and consequence of that risk identified.

Generally we were concerned that there was no robust systematic process of risk assessment which is based on a recognised evidence based tool for all acute ward areas. (The DH framework document “Best Practice in Managing Risk” 2007 sets out a range of evidence based risk tools for mental health practitioners that should be used to make individual risk assessments to ensure best practice.)

We did not specifically assess patient involvement in the sharing and development of care plans, though following our review of records and discussions with the ward managers we were not confident that patients had been consistently involved in developing their care plans in partnership with their named nurse. A number of people who used services raised concerns that they were not allowed to be present or involved in the weekly multi-disciplinary team (MDT) meetings where their care is planned and reviewed. During the site visit we explained this to the consultant psychiatrist on Rowan ward who gave his reasons as to why patients were not invited to these meetings. We explained ‘new ways of working’ and our own standards that expect greater involvement of patients regarding their care. The ward manager and consultant explained that actually they were looking at how they could promote greater involvement and had developed a short survey. The consultant on Rowan ward stated that they were prepared to look at how people who use services may have better involvement with the MDT. We later identified that patients on Maple ward are also not included in MDT meetings. Staff members also told us “Support workers should be allowed in to MDT as they spend most time with people and are able to develop the deepest relationships with people”.

On the site visit we reviewed arrangements regarding same sex accommodation. All ward settings must now comply with national guidance for same sex accommodation which requires that men and women should not share sleeping accommodation, toilets or washing facilities. We discussed the arrangements with both ward managers and we found that the staff do all they can within the restrictions of the building. On Maple ward we found that the area was generally compliant with these guidelines because there is a clearly defined “female only area” with 9 beds containing it’s own facilities. The ward manager on Maple ward explained that female only staff are allocated to the area and where extra female beds are required they are placed in cubicles adjacent to the area.

Similarly, Rowan ward has a female area, which is clearly separated from the rest of the ward. However, the ward manager explained that one cubicle within the female area has wider access facilities and is identified as a room for persons with a disability. On the day we visited a male patient was occupying this room in the female area. The area should only contain female patients to meet same sex guidelines.

We reviewed the section 136 suite which we found it is not ideal as it is located right in the centre of Maple ward adjacent to a widened area of corridor where there is a seated area for admitted patients. The only access to the suite is via the ward area which means uniformed police will be seen by patients escorting persons to the suite for assessment. Our discussions with the ward manager confirmed that patients can become unsettled when police are on the ward. This was also

confirmed in our interviews of the nursing team where one member stated “when 136 bed is used can be very upsetting for some patients…can’t this be done in another area.” We recommend, via an improvement action, that the provider works with its partners, South Yorkshire Police, and NHS Sheffield to try to see if it is possible to identify a more suitable location for the suite or find ways of managing section 136 detentions that may have a lesser negative impact on the ward.

**Our judgement**

We found that the location is not meeting this outcome on the acute mental health wards. We were concerned that there was no robust systematic process of individualised risk assessment which is based on a nationally recognised evidence based tool for mental health. We found that the patient’s risk assessment process was subjective, not supported by any policy or guidance and not evidenced based, which places patients and others at potential risk of harm. We were not confident that patients are adequately involved in developing their care plans in partnership with their named nurse and consultant and we found they are not involved in multi-disciplinary meetings. Though we found Maple ward generally meets same sex guidelines we were concerned that one cubicle in the female area of Rowan ward was occupied by a male patient. The provider should work with its partners, South Yorkshire Police, and NHS Sheffield to try to see if it is possible to identify a more suitable location for the section 136 suite or find ways of managing these detentions that may have a lesser negative impact on the ward. We recognise the provider has put in place various measures to lessen the impact of high bed occupancy levels but we continue to have some concerns that bed occupancy may be occasionally having some negative impact on people who use services.

# Outcome 5:
# Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

## What we found

**Our judgement**

**The provider is compliant** with outcome 5: Meeting nutritional needs

**Our findings**

**What people who use the service experienced and told us**
The 2009 mental health in-patient survey question "How would you rate the hospital food?" placed the trust at the higher end of the intermediate 60% when compared nationally with other NHS mental health trusts. The provider gave an example of how two people who use raised issues of food choices available on a ward location via PALS. This was in turn raised with kitchen staff and the ward manager who set up a session to get ideas from people who use services and explain how nutritional guidelines are followed. The provider reported that a service user sits on the NICE nutrition group and has assisted in devising menu choices.

The provider offered additional evidence which was the Complaints and Complements Quarterly Report for the period 1 July to 30 September 2010. The report contained a number of direct quotes regarding complements received from people who used services across services. From the Longley Centre the following is a positive example regarding this outcome, "…And the food is as good as any hotel I've been in on holiday". (Hawthorn ward, The Longley Centre).

We asked some patients what they thought about food during our site visit performed 6 January 2011:

"Fine",
"Quality choice and amount of Food very good",

“Can’t fault the food, there’s enough of it, can always ask for a different meal, get a choice every meal time”…I was 10 stone 4 pounds when I come in and now I’m 12 stone 6 pounds so food must be o.k.”,
“Its alright, make meals sometimes, for me".

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained mostly positive information relating to PEAT (Patient Environment Action Teams) assessments of food provision. In these assessments The Longley Centre was found to be very positively rated for food menu, choice, quality, portions, temperature, presentation, service and beverages. Also rated as expected for proportion of wards using a nutritional screening policy, wards that operate a protected mealtimes policy and existance of a nutritional screening group.

None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a provider compliance assessment for this outcome, which explained how a range of measures are in place to meet this outcome. A review of the self assessment was undertaken against the individual prompts of this outcome and we found that the provider had demonstrated compliance. In outline, the provider demonstrated that assessment and/or nutritional screening have been performed on people who use services depending on the type of service provided at each location. The provider had a physical health policy, training for staff members and healthy living groups to promote the physical well being of people who use services. People who use services in older adult’s locations have access to a trained dysphagia nurse and learning disabilities services have access to a range of measures to assess, assist and promote nutritional needs. The provider demonstrated that it had involved and sought the views of people who use services through questionnaires, audit and responding to individual feedback.

The provider explained that options are available in some locations for people who use services to purchase additional food and snacks that include initiatives that allow patients paid employment and rehabilitation opportunities. The Longley Centre includes the ‘Sweets and Treats’ shop and people who use services may have the option of ordering ‘take away’ meals with guidance and support. Occupational therapy groups, and groups such as the breakfast club and healthy eating groups are reported as actively supporting people who use services to plan and prepare own meals if required, for example, if they were going to be moving to a self catering environment. The report also included a detailed section regarding the NICE nutrition steering group.

**Our judgement**
We found evidence that people who use the services were supported to have adequate nutrition and hydration. No areas of concern were identified during the assessment of this outcome for this location.

# Outcome 6:
# Cooperating with other providers

## What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

## What we found

**Our judgement**

**The provider is compliant** with outcome 6: Cooperating with other providers

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome on this review. The 2010 survey of people who use community health services found that this provider scored 8.5 out of 10 (expected range 8.1 to 8.7) in comparision with other NHS trusts nationally against three questions about the care coordinator role. The survey demonstrated that the majority of respondents to the survey were aware of who their named care coordinator was at this provider.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. The current provider level QRP was not currently risk rated as it contained insufficient information.

None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome. NHS Sheffield made a number of positive statements regarding this provider including that they had developed productive and effective relationships over the last two years and engaged well at strategic and operational levels, which included stating that they had strengthened the monitoring and management of quality elements of the contract.

As part of the assessment of this location the provider submitted a detailed provider compliance assessment for this outcome which explained how the provider was meeting each individual prompt. To highlight just a few examples, we found that the provider was able to demonstrate an identified lead responsible for the care, treatment and support of persons who use services was able to coordinate transfer or discharge between other services and providers. A range of policies and other guidance documents were available that make this coordinators role clear, for example, the CPA pathway and process to ensure relevant information about people who use services is passed confidentially between services, and other providers.

We found that all those services involved in leading the coordinator role was set out in a range of documents with key stakeholders, for example, the partnership agreement with Sheffield City Council, the contract with NHS Sheffield and memorandum of understanding agreement with South Yorkshire Police. These documents have been reviewed regularly at the appropriate meetings, for example, quality and performance meetings with NHS Sheffield. The provider explained how it has been able to cooperate in a planned and coordinated way toward a major incident or emergency situation. The provider has an emergency planning manager, named executive lead and processes are in place as set out in a major incident plan, which includes consideration of the Civil Contingencies Act 2004. An example was given as to preparations were made across the community for the potential flu pandemic during 2009 which showed partnership working across the NHS, City Council and emergency services.

The provider explained a range of ways how it provides information and supports people who use services to access these other services should they require. For example, there is a booklet called the Sheffield Mental Health Guide (available in hard copy and electronically). This was reviewed and found to contain a large range of services with contact details from the voluntary, private and public sectors.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report contained a section on ‘partnerships’ and outlined updates regarding a range of services with other partners.

**Our judgement**
We found systems and processes in place to ensure people who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or where they are moved between services. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# 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**
It was not possible to gain the direct views of people who use the service for this outcome on this review.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. The current provider level QRP is not currently risk rated as it contains insufficient information. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a detailed provider compliance assessment for this outcome which explained how the provider was meeting the prompts. In outline, in relation to some of the key areas of this outcome, the provider explained that its staff had accessed city wide multi agency safeguarding training along with its own training, which included indicators of abuse and how to support people who use services who may be experiencing abuse. Various policies, procedures and other processes were in place, for example, the providers safeguarding adult policy and instances of alleged abuse being recorded

via incident reporting procedures and Sheffield City Council safeguarding adult office. The provider was able to indicate areas of collaborative working along with confirming regular attendance at the area safeguarding adult and children board.

People who use services are able to gain information and report alleged abuse themselves and have been made aware by the 'Keeping Safe in Sheffield' poster (including access telephone number) which was reported as being available in all areas. Care plans indicated action to take to reduce the likelihood of abuse where this had been identified via risk assessment of an individual being at risk of the victim (or perpetrator) of abuse. Given the nature of services and in relation to restraint people who use services have been involved in a review of the 'positive management of violence and aggression training' and the 'management of violence and aggression policy'.

**Our judgement**
We found systems and processes in place to help ensure people who use services are protected from abuse, or the risk of abuse, and their human rights upheld. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# Outcome 8:
# Cleanliness and infection control

## What the outcome says

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

## What we found

**Our judgement**

**There are minor concerns** with outcome 8: Cleanliness and infection control

**Our findings**

**What people who use the service experienced and told us**
We asked some patients what they thought about cleanliness during our site visit performed 6 January 2011:

“Ward kept clean and tidy”,
“Bedding clean”,
“Some areas need more attention but generally clean”,
“Environment on ward, is always clean and tidy, if its not it’s because of people here who are ill, if you get my meaning, can’t help it, but staff then clean up after them”.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained mostly positive information of which a number related to PEAT assessments of hygiene and infection control measures for this location. One individual PEAT assessment for this location found the proportion of applicable wards with adequate hand decontamination provision was rated negatively. However this should be considered against the NHS staff survey 2009 finding for 'availability of hand washing materials' which was rated positively.

None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome. NHS Sheffield contributed the following commentary “Infection Control - Last year the

trust made a significant investment, appointing a senior infection control nurse and also secured microbiology support from Sheffield Teaching Hospitals NHS Foundation Trust. The trust is compliant with the hygiene code of practice and has set up assurance systems at ward level via regular audits and training programmes."

As part of the assessment of this location the provider submitted a provider compliance assessment for this outcome which explained how the provider was meeting the applicable criterion of the Code of Practice for health and social care on the prevention or control of infections and related guidance. We found no gaps in assurance when this self assessment was reviewed.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included a detailed section on infection control written by the staff member on Rowan ward who takes the lead on infection control. The report demonstrated that positive actions had been undertaken following audit, for example, a mattress audit resulted in the removal of unfit ones which was replaced by new mattresses.

During the site visit performed 11 January 2011 we found that the location was generally clean and tidy in all areas of the building we walked through with the exception of one area. On Maple ward while undertaking a tour of the ward we reviewed the seclusion room. The room was found to have a washable stain on the floor that mirrored the shape of the specialist seclusion bed, which showed that the room had most likely not been cleaned following it's last use by a patient. We asked for this to be cleaned straight away. The seclusion room's toilet facility is located in an adjoining room. The toilet roll was on the floor and there was no toilet roll holder in the room. The stainless steel hand basin had a used soap bar on the sink and no soap dispenser was located in the room. The room did not meet current infection control guidelines.

**Our judgement**
We found most of the location was generally meeting this outcome. However during the site visit performed 11 January 2011 we found that the seclusion room on Maple ward had not been cleaned following use, did not include a recommended soap dispenser secured to the wall and did not include a toilet roll holder.

# Outcome 9:
# Management of medicines

## What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine 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**
It was not possible to gain the direct views of people who use the service for this outcome on this review. In the mental health acute inpatient survey 2009 the provider was rated within the best performing 20% of NHS trusts nationally regarding two questions relating to the explanation of the purpose and possible side effects of medications. The provider gave an example of how a person using the service did not agree with taking prescribed medication and would not consent to receiving medical treatment in the community. The PALS service liaised with the person's doctor to arrange a meeting to ensure they had clear and relevant information. Once the person using the service was better informed, consent was given to care and treatment and they were able to be discharged into the community.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained no negative information. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

The provider's chief pharmacist acts as the controlled drugs accountable officer who actively partcipates in the NHS Sheffield controlled drugs local intelligence network meetings. Reports are regularly submitted to the network who also share with CQC. No concerning information is currently held regarding the management of controlled drugs. In the mental health acute inpatient survey 2009 the provider was found to be in the best performing 20% of NHS trusts nationally regarding two questions relating to the explanation of the purpose and possible side effects of medications.

As part of the assessment of this location the provider submitted a provider compliance assessment which outlined how the provider was meeting the outcome. We found the provider had appropriate systems and processes in place with no identified gaps in assurance when this self assessment was reviewed.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included a section on medicines and explained that all medication incidents are followed up regarding lessons learned. Under a section entitled clinical effectiveness two examples of medications audits were outlined.

**Our judgement**
We found systems and processes in place to ensure people who use services had received their medicines when they needed them and received had information about the medicines being prescribed. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# 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**
The provider stated that people who use services had participated in the PEAT assessments. The provider explained that the 'partners in improving quality group', which consists of a group of people who use services, had begun to do site visits to identify any areas for improvement at the various locations.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included a section on 'estates' and explained that last year gardeners did a "makeover" of the ward's enclosed garden area which received positive feedback from people who use services.

On the site visit conducted 11 January we sought the views of patients about this outcome. Most are captured under outcome eight. Patients did raise concerns over some of the cold patient bedrooms.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained positive information, including a number of location specific positive information from PEAT assessments of the environment such as décor, furnishings, outdoor recreational facilities and access for people with disabilities. None of the external stakeholders

referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

The MHA Commissioner visits have noted positive commentary and matters of good practice regarding the last visit 19 July 2010 at the Maple Ward and Rowan ward. On Maple ward it was noted that this 24 bedded ward (including one section 136 bed) was large and provided quiet areas for patients within its boundaries. The commissioner also found that levers for the observation blinds on most doors of patient rooms had been replaced with a key operated system. On Rowan ward it was noted the ward was large and spacious with quiet areas for patients. The commissioner commended the change in use of the former smoke room into an activities room and noted that dormitories were longer being used and being adapted for other purposes. All levers for the observation blinds had been converted to a key operated system.

The MHA commissioner visits to Rowan and Maple ward had noted some environmental recommendations for improvement, including that a door to the passage at the bottom far right side of the garden posed a ligature risk and the decking fence in the garden area could also pose a ligature risk. On Rowan ward, though overall the ward is clean and tidy, grouting to tiles in the patients en-suite areas needed attention.

As part of the assessment of this location the provider submitted a detailed provider compliance assessment which explained how the provider was meeting the outcome. We found the provider had appropriate systems and processes in place that are required to meet this outcome with no identified gaps in assurance when this self assessment was reviewed. To provide a few examples, the provider reported that a “red box” system had been implemented at all locations, which contain a suite of essential maintenance and safety related information. The provider has ensured that there is 24 hour on call response available to cover estates related emergencies.

People who use services have access to a range of facilities and equipment to support assisted use and meet requirements of the Disability Discrimination Act. All provider locations are reported to have a range of spaces for social, therapeutic, cultural and educational needs including lounges, quiet rooms, women only lounges, craft areas, gymnasiums, multi-faith rooms and clinical rooms to meet the needs of people who use services, including access to outdoor spaces.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report explained that weekly health and safety checks are performed on the ward using a checklist and where necessary this had resulted in requests for repairs being made. The report also explained that the lounges had received new settee’s, chairs and new televisions along with some other improvements.

As we had identified areas of concern in relation to outcome four that required a site visit to gain additional evidence we decided to include this outcome to review those areas recommended by the MHA commissioner for consideration by the ward.

On the site visit performed 11 January 2011 we found that Maple and Rowan wards

along with the ITS, despite them being fully occupied, had a positive, calm and welcoming atmosphere. We observed that the building was generally clean and tidy and relatively spacious though 'bland' in terms of décor in places. We specifically reviewed the seclusion rooms on Maple ward and the ITS and neither appeared ideal though this was likely to be because of the physical limitations of the building. Some staff members felt that the seclusion rooms should be somewhere more private. Other staff members expressed that the whole layout of the wards are poor and they would prefer smaller purpose built units as currently it can be difficult for them to maintain everyone's safety as "they can spend ages looking for people".

Both Maple and Rowan wards had access to open enclosed spaces which included walking out onto wooden decking areas. The banister of each decking area carried ligature risks though all these areas had undergone full ligature risk assessments. Both ward managers explained that there are plans to remove the decked area and generally modify the open spaces. The ITS had access to a recently refurbished open space which was pleasant in appearance and secure. The ITS ward had been decorated a few years ago via external funding and was noticeably brighter in appearance when compared with Maple and Rowan wards.

On Rowan ward in the female part of the ward there is a locked link corridor that leads to the main open hospital corridor. Both sets of doors had square un-obscured windows that would allow individuals to potentially see into patient bedrooms should the cubicle doors be open. At the end of the female open corridor is an external fire door which also had un-obscured glass allowing people outside the building to view the female patient area. We are concerned that clear glazing to the link corridor doors and fire exit door may be affecting the privacy and dignity of patients who are residing in the female area of Rowan ward.

On Rowan ward concerns were raised by patient's and staff members about low temperatures in certain parts of the ward, but in-particular patient bedrooms MO1 – MO8. It was explained that the temperature a few weeks ago was recorded at 12 degrees Celsius. This is not acceptable. Since September 2010 we viewed maintenance sheets that demonstrated heating problems had been reported on 15 separate occasions. The ward staff has been having to find other ways of keeping patients warm, including the use of additional quilts and use of electric fan heaters which increase risks. We are concerned that inadequate heating is being provided in various areas of the Longley Centre.

**Our judgement**
We found not all areas of this outcome were being met, though we found the building had a positive atmosphere on the day of our visit, and was generally clean and tidy. We are concerned that clear glazing to the link corridor doors and fire exit door may be affecting the privacy and dignity of patients who are residing in the female area of Rowan ward. We are concerned that inadequate heating is being provided in various areas of the Longley Centre and in a number of patient bedrooms.

# Outcome 11:
# Safety, availability and suitability of equipment

## What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

## What we found

**Our judgement**

**The provider is compliant** with outcome 11: Safety, availability and suitability of equipment

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. The CQC QRP contained no information for this outcome. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a detailed provider compliance assessment which explained how the provider was meeting the outcome. We found the provider had appropriate systems and processes in place that are required to meet this outcome with no identified gaps in assurance when this self assessment was reviewed.

**Our judgement**
We found no gaps in assurance that may suggest people who use services would be put at risk from unsafe or unsuitable equipment and we generally found that they

would benefit from equipment available to meet their needs.

# Outcome 12:
# Requirements relating to workers

## 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

## What we found

**Our judgement**

**The provider is compliant** with outcome 12: Requirements relating to workers

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome on this review. Though not directly demonstrating the views of people who used the service the provider explained in the provider compliance assessment tool that a number of people who use services and carers have received recruitment and selection training alongside staff members to enable them to participate in the recruitment of staff into the organisation. The provider reported that “between September 2009 and September 2010, 78 recruitment panels have included a service user or carer and this figure will increase as more people who use services are trained to become involved in recruitment”.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP carried no concerns relating to this outcome. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome. In key finding 36 of the 2009 staff survey, 'staff recommendation of the trust as a place to work or receive treatment the trust was found to be in the highest 20% when compared with other NHS trusts nationally.

As part of the assessment of this location the provider submitted a detailed provider

compliance assessment which explained how the provider was meeting the outcome. We found the provider had appropriate systems and processes in place that are required to meet this outcome with no identified gaps in assurance when this self assessment was reviewed.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included a section covering staffing we noted no areas of concern during the period covered by the report.

**Our judgement**
We found no evidence that recruitment and selection procedures for workers were not effective. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# Outcome 13:
# Staffing

## 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 sufficient numbers of appropriate staff.

## What we found

**Our judgement**

**The provider is compliant** with outcome 13: Staffing

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome on this review.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained mostly positive information. One positive comment related to a letter from the provider outlining improvements to sickness levels. Staff sickness absence was reported as expected when compared nationally. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a detailed provider compliance assessment which explained how the provider was meeting the outcome. The provider was found to have systems and processes in place such as recruitment and selection procedures, competency requirements of a job role, people who use services involvement in selection who can identify qualities and attitudes important to them along with ongoing monitoring via performance development reviews that should ensure staff are in place with the right

competencies, knowledge, qualifications, skills and experience to meet the needs of people who use services. Where staffing had not been available from the existing establishment, the provider has an in-house flexible staffing service which included over 300 flexi-staff along with over 1000 trust employees registered with the service.

The provider has given a number of examples of how it had worked to continually develop improvements to systems surrounding staffing requirements, for example, work streams on five QIPP (quality, innovation, productivity and prevention) programmes, which focus on how to maintain services and improve quality alongside a reduction in resources. The provider reported that staffing skill mix and profiles have been worked through in detail across these programmes.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included a section on staffing which overall showed staff sickness to be on average just below the 5% area. No particular areas of concern regarding staffing were identified in the report.

**Our judgement**
We found people who use services should be safe and have their health and welfare needs met by sufficient numbers of appropriate staff. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# Outcome 14:
# Supporting workers

## 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 workers

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome on this review.

**Other evidence**
At registration this location declared that it was not meeting this standard due to the results of the 2009 staff survey identifying that insufficient members of staff had received an annual personal development plan/appraisal. An action was put in place with an expected completion date of summer 2010. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

Our provider level QRP for this outcome contained mostly positive information. Negative information centred around personal development areas and appraisal, support regarding violence, well structured team environment and some areas of training. However these areas should be considered against some 2009 staff survey findings. Key finding 28 ' perceptions of effective action from employer towards violence and aggression was found to be 'tending towards better than expected' when compared with other trusts nationally along with key finding 28 'staff receiving job relevant training, learning and development in the last 12 months'. The clear theme from the negative staff survey findings are centred on staff personal development and appraisal, which the provider had identified.

As part of the assessment of this location the provider submitted a detailed provider compliance assessment which explained how the provider was meeting the outcome. The self assessment explained the various measures in place to ensure that staff members are properly supported, trained, supervised and appraised. No gaps in assurance or concerns were identified following review of this self assessment.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included a section on appraisals which showed all available staff on Rowan ward had received an appraisal. As the provider had declared it was not meeting this outcome due to appraisals in its registration application (submitted February 2010) we had continued to have a minor concern about this outcome at The Longley Centre. However email confirmation received 7 December 2010 from the provider demonstrated all available staff had received a completed appraisal for the whole location and we no longer have a minor concern over this area of the outcome.

The governance report also included a detailed section on training and education which showed that in addition to the providers mandatory training the various staff groups had been able to access a wide range of training and raised no concerns.

Some concerns had been raised via local intelligence regarding bed over occupancy matters in acute mental health locations causing increased stress levels and pressure for staff members (explained in outcome 4). However the staff survey 2009 found that staff suffering work related stress in the last 12 months was rated as 'tending towards better than expected' and work pressure felt by staff was found to be 'much better than expected'. It had also been suggested bed over occupancy may affect training opportunities for staff members but we found no evidence to demonstrate this.

We asked staff members as part of the site visit performed 6 January 2011 a number of questions relating to this outcome. All those asked stated they had received a completed appraisal and that they “Feel very well supported by colleagues, management and senior management of trust”, and there are “good training opportunities”. When asked what additional training opportunities they would like to receive staff members mentioned specialist subject areas such as Bi-polar disorders and similar.

**Our judgement**
We found evidence to demonstrate that people who use services would have their health and welfare needs met by competent staff. The provider had declared at registration prior to April 2010 that it was not meeting this outcome because insufficient numbers of staff across several locations had received a recent appraisal. For this location we found evidence to demonstrate all appraisals had been completed for available staff and we no longer have a minor concern regarding this outcome at The Longley Centre.

# Outcome 16:
# Assessing and monitoring the quality of service provision

## What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

## What we found

**Our judgement**

**The provider is compliant** with outcome 16: Assessing and monitoring the quality of service provision

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome on this review. Of particular relevance to people who use services the provider explained how it has taken various active steps to involve and seek the views of people who use services (some examples have been outlined within other outcomes in this report). The provider's Annual Quality Accounts 2009/10 was available on the trust website http://www.sct.nhs.uk/_documentbank/Quality_Accounts_final_09_10.pdf , and it was explained in the provider compliance assessment tool that the provider had been commended by the Audit Commission in an external audit for its involvement and inclusion of people who use services in its development.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010.

Our provider level QRP for this outcome contained mostly positive information and the two negative pieces of information do not require further follow up in this review. We found the provider is meeting requirements regarding National Patient Safety

Agency (NPSA) notification submissions, which form part of the required statutory notification alerts to CQC. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

There was two positive comments included in the QRP for outcome 16 from the Sheffield LiNK. The LiNK participants work on recovery wards has been fed back to managers and staff, leading to changes in care respect of service users' sexuality, spirituality and problems with social interaction. The LiNK also reported that the provider had cooperated with ongoing research involving members of LiNK which had lead to real care quality improvements in long term wards. It was noted with both these comments that further work is planned involving the acute wards.

NHS Sheffield contributed the following commentary relevant to this outcome regarding serious untoward incidents (SUI's). The provider had reported SUI's timely and appropriately. High numbers of SUI's had been reported, however though was in line with other mental health trusts. There was previously a backlog of open SUI's and during the last 6 months the provider has worked closely with NHS Sheffield to deliver action plans and a significant number have now been closed.

As part of the assessment of this location the provider submitted a provider compliance assessment which explained in detail against individual prompts how the outcome was being met. The self assessment set out a range of policies systems and processes that monitor and provide quality improvement and assurance. As part of the assessment process these explanations was reviewed against CQC's individual prompts in the essential standards and no gaps of assurance were identified. The Quality Framework set out the provider's vision and was available on the trust website http://www.sct.nhs.uk/about-us/quality-and-performance .

In a local engagement meeting held 21st October 2010 we found the board had received monthly performance reports and dashboards and relevant operational governance groups had monitored various outcomes of quality and patient safety along with key performance indicators. We also found that the provider had invested in "Inform", a new web based system being introduced that captured a range of quality information from different sources.

A range of team level governance reports have been produced at least annually which the provider considered are crucial to ensure ongoing quality and safety of people who use services. These reports had been found to be reviewed by senior management team and clinicians as explained in the provider compliance assessment. Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. We found the report to be a detailed and informative document containing a large range of information demonstrating how the area monitored and reported on quality for people who use services.

**Our judgement**
We found effective systems were in place to assess and monitor the quality of service provision so that people who use services will benefit from safe quality care, treatment and support due to effective decision making and the management of

risks to their health, welfare and safety. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# Outcome 17: Complaints

## What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

## What we found

**Our judgement**

**The provider is compliant** with outcome 17: Complaints

**Our findings**

**What people who use the service experienced and told us**
We asked patients on the site visit if they knew how to raise a complaint. All were aware and one had made a complaint who felt action had been taken to address the issues raised.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained positive information. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a provider compliance assessment which explained in detail against individual prompts how the outcomes were being met. The self assessment explained the policies, systems and processes that have been used to handle complaints and that it “sees complaints as an opportunity to improve and make things better”. We found the Complaints procedure to contain a locally agreed protocol for handling inter-agency complaints across the city of Sheffield along with a range of additional templates and tools. Quarterly and annual complaints reports have been produced and the

provider explained these are available on request from the complaints and litigation manager.

People who use services have been able to make their concerns known verbally, electronically via the website, or in writing. A ‘Fastrack’ system has been made available to allow people who use services or carers to raise a concern, comment or compliment at any location with staff support if required. Additionally people who use services have been able to access a range of advocacy services, for example, the mental health advocacy services to raise any concerns they may have.

The provider offered additional evidence which was the Complaints and Complements Quarterly Report for the period 1 July to 30 September 2010. The report was a detailed and informative document containing a number of direct quotes regarding complements received from people who used services. The report also contained service specific sections outlining issues raised in formal complaints along with the outcome and recommendations for each one. A number of action plans were also included demonstrating that the provider listens to and actions improvements arising out of complaints.

Additional evidence was sought from the provider in the form of an annual team governance report for Rowan ward covering the period April 2009 to March 2010. The report included sections on complaints and compliments covering all acute wards. The numbers of formal complaints ranged from none to well below 10 and verbal complaints averaging between 10 and 20 for each ward area showing the numbers of complaints received was low during the period of the report.

**Our judgement**
We found evidence that comments and complaints were listened to and acted on effectively. No gaps in assurance or areas of concern were identified during the assessment of this outcome for this location.

# Outcome 21:
# Records

## What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

## What we found

**Our judgement**

**There are minor concerns** with outcome 21: Records

**Our findings**

**What people who use the service experienced and told us**
It was not possible to gain the direct views of people who use the service for this outcome on this review.

**Other evidence**
The provider declared compliance with this outcome at this location at registration with CQC in April 2010. Our provider level QRP for this outcome contained mostly positive information. None of the external stakeholders referred to within outcome one who responded raised any areas of concern specifically relating to this location or outcome.

As part of the assessment of this location the provider submitted a provider compliance assessment which explained in detail how the outcome was being met. For example, the provider explained how a suite of information governance policies, procedures and other systems provides compliance. The provider also explained how it had recently completed a Data Protection Act audit follow up report with the Information Commissioners office who stated a level of “reasonable assurance”.

Additional evidence was sought from the provider in the form of an annual team

governance report for Rowan ward covering the period April 2009 to March 2010. The report included information regarding records management, which raised no particular concerns.

On the site visit to the Michael Carlisle Centre conducted 6 January 2011 staff members on Stanage and Burbage wards spent considerable effort with our help in trying to find documented records of an individual's assessment of capacity relating to our assessment of outcome two. This was not helped by the complex system of records management the provider currently has in place due to a rolling changeover from paper based records to the electronic NHS Insight system. Staff members had informed us when they had to compile a report for any appeal to the mental health tribunals it took considerable time as it was difficult to find information in the NHS Insight system. Our experience showed us that the system contains a series of individual records rather than a facility that would allow an easy view of a chronological flow of nursing and medical records. Similarly the 'acute care pathway' was captured in the Insight system via long list with no detail of the pathway. For example, we looked at one patient's pathway record and the capacity entry just contained a date it was assessed but not the actual outcome of the assessment. A large number of the acute care pathway individual prompts were left blank giving no indication if the item was applicable or had been assessed. Most nursing records were transferred to the Insight system with the exception of individualised care plans.

On the site visit conducted 11 January 2011 to Maple and Rowan wards we found that medical staff were at different stages regarding the transfer of record keeping from paper based records to the Insight system. On Maple ward we reviewed a sample of notes that showed most medical notes were still hand-written. On Rowan ward we talked to the consultant psychiatrist who explained that doctors on this ward had decided to proactively move medical notes to the Insight system over twelve months ago. We asked the ward managers and the consultant if there was an identified end date for the transfer of all records to the electronic system and none were aware of specific dates. We asked the consultant what they thought were the biggest difficulties or weaknesses of the electronic Insight system. They outlined what we had also experienced in that the system is very difficult to search for specific items of information and thought that it would be a real struggle in future to identify which junior doctor had completed certain medical records (junior doctors do a 4 month rotational placement). The ward manager on Rowan ward felt that the system was difficult to use when reviewing records to complete an incident investigation report.

We found that the ongoing use of paper based and electronic records carries some risks; including there may be potential failure to consistently document clear, factual and accurate records for individual patients. We also found the current systems limit the accessibility of records because it was difficult to find specific items of information, such as the current status of a person's capacity.

**Our judgement**

We found that the location is not fully complying with this outcome. We found that the ongoing use of paper based and electronic records carries some risks; including there may be potential failure to consistently document clear, factual and accurate records for individual patients. We also found the current systems limit the

accessibility of records because it was difficult to find specific items of information, such as the current status of a person's capacity.

## 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 |
|---|---|---|
| Treatment of disease, disorder or injury.<br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br>Diagnostic or screening procedures. | 18 | Outcome 2: Consent to care and treatment |
| | **How the regulation is not being met:**<br>We found that the location is not meeting this outcome. We are concerned that there was no systematic and clear recording of assessments of a person's capacity to make decisions for people who was either detained or informally admitted.<br><br>We were concerned that medical staff did not always record explanations of the risks, benefits and alternative options of treatment in patient records. | |
| Treatment of disease, disorder or injury.<br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br>Diagnostic or screening procedures. | 9 | Outcome 4: Care and Welfare of people who use services |
| | **How the regulation is not being met:**<br>We found that the location is not meeting this outcome on the acute mental health wards. We were concerned that there was no robust systematic process of individualised risk assessment which is based on a nationally recognised evidence based tool for mental health. We found that the patient's risk assessment process was subjective, not supported by any policy or guidance and not evidenced based, which places patients and others at potential risk of harm.<br><br>We were not confident that patients are adequately involved in developing their care plans in partnership with their named nurse and consultant and we found they are not involved in multi-disciplinary meetings.<br><br>Though we found Maple ward generally meets same sex guidelines we were concerned that one cubicle in the female area of Rowan ward was occupied by a | |

| | | |
|---|---|---|
| | male patient.<br><br>The provider should work with its partners, South Yorkshire Police, and NHS Sheffield to try to see if it is possible to identify a more suitable location for the section 136 suite or find ways of managing these detentions that may have a lesser negative impact on the ward.<br><br>We recognise the provider has put in place various measures to lessen the impact of high bed occupancy levels but we continue to have some concerns that bed occupancy may be occasionally having some negative impact on people who use services. | |
| Treatment of disease, disorder or injury.<br><br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br><br>Diagnostic or screening procedures. | 12 | Outcome 8: Cleanliness and infection control |
| | **How the regulation is not being met:**<br>We found that the seclusion room on Maple ward had not been cleaned following use, did not include a recommended soap dispenser secured to the wall and did not include a toilet roll holder. | |
| Treatment of disease, disorder or injury.<br><br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br><br>Diagnostic or screening procedures. | 15 | Outcome 10: Safety and suitability of premises |
| | **How the regulation is not being met:**<br>We are concerned that clear glazing to the link corridor doors and fire exit door may be affecting the privacy and dignity of patients who are residing in the female area of Rowan ward.<br><br>We are concerned that inadequate heating is being provided in various areas of the Longley Centre and in a number of patient bedrooms. | |
| Treatment of disease, disorder or injury.<br><br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br><br>Diagnostic or screening procedures. | 20 | Outcome 21: Records |
| | **How the regulation is not being met:**<br>We found that the ongoing use of paper based and electronic records carries some risks; including there may be potential failure to consistently document clear, factual and accurate records for individual patients. We also found the current systems limit the accessibility of records because it was difficult to find specific items of information, such as the current | |

| | |
|---|---|
| | status of a person's capacity. |

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 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

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## Care Quality Commission

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