Review of compliance

Sheffield Health and Social Care NHS Foundation Trust The Longley Centre	
Region:	Yorkshire & Humberside
Location address:	Norwood Grange Drive Sheffield South Yorkshire S5 7JT
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Date of Publication:	October 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 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

Our current overall judgement

The Longley Centre was meeting all the essential standards of quality and safety.

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

Why we carried out this review

We carried out this review to check whether The Longley Centre had made improvements in relation to:

Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 08 - Cleanliness and infection control
Outcome 10 - Safety and suitability of premises
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 September 2011, talked to staff and talked to people who use services.

What people told us

During our inspection visit in January 2011 we talked to a number of patients on both acute mental health wards at this location. Comments were generally positive about aspects of their care. Please see the January 2011 report for this location.

During our inspection visit on 22 September 2011 our focus was to review compliance actions previously identified in January. We talked to two patients on Rowan ward. Patient [X] felt attending the multi-disciplinary team meeting "had helped" as it helped them "understand what they had asked [staff] before". They also explained how they felt relaxed during the meeting and felt welcome. Patient [Y] felt "care was alright" and "[staff] all lovely". They explained that members of staff "look after you" and always gave their time when you wanted to talk to them. Patient [Y] also said the "nurses are brilliant".

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

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

We found there are systems in place to gain and review consent to treatment and assess capacity to make decisions for people who use services.

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

We found people who use services generally experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

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

No areas of concern were identified during the assessment of this outcome for this location.

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

No areas of concern were identified during the assessment of this outcome for this location.

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

We found that processes are in place to ensure personal records are accurate, held securely and kept confidential. The provider's records management and process are being improved to ensure patient's health records are appropriately detailed and accessible.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

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

Other evidence
This inspection was arranged to follow up compliance actions we issued as part of the planned review of this location completed in January 2011. During our inspection visit conducted 11 January 2011 we found the location was not meeting this outcome on the acute mental health wards. We were concerned there was no systematic and clear recording of a person's capacity to make decisions and we found limited evidence of medical staff recording explanations of the risks, benefits and alternative treatment options in patient records.

In response the provider conducted a thorough review of these concerns and developed an action plan containing a range of measures to ensure improvements were made. Since January the provider has sent us regular updated action plans and discussed these with us at our regular engagement meetings.

During this responsive review we reviewed the latest provider action plan and conducted an inspection visit on 22 September 2011 to determine if the improvements being implemented by the provider would address the issues we identified.

The provider action plan included a number of measures to improve the recording of capacity assessments, for example, raising awareness through communication and information regarding the Mental Capacity Act 2005. The provider has developed new documentation to record capacity, including on admission, and this has been made available on both the paper based and electronic records systems.

On our inspection visit in September we found the appropriate recording of capacity assessments had significantly improved. On Maple ward the ward manager was able to promptly find the recently introduced capacity recording form through the provider's electronic records system. One of these patients had been assessed as not having capacity and the record provided an explanation why the patient did not meet all the four criteria used to assess capacity. We later reviewed four records on Rowan ward and found these capacity documents had also been completed with an appropriate level of detail.

We talked to the ward manager and nurses on both wards about the new capacity recording form and all felt the new approach was a good improvement. The ward manager on Maple ward explained how completed forms were easy to find and update on the electronic system and this view was shared by staff members on both wards. A staff nurse on Rowan ward confirmed they had received updated information from the provider regarding the mental capacity act.

The ward manager on Maple ward explained that around 75% of capacity assessment forms had been completed for those patient's on the ward. On Rowan ward a lesser number had been completed in comparison with Maple ward and the other acute mental health wards at the Michael Carlisle Centre. We talked to the consultant psychiatrist about this comparison and they explained how they were currently working through completing forms for patients already admitted. The consultant explained how they found the form easy to find and complete.

In January we were concerned that medical staff did not always capture explanations of the benefits and side effects of medication or treatment in medical records. The provider action plan included measures to address this concern and explained how an agreement had been reached on the best way of recording these matters by the medical staff and other interested parties.

On our inspection visit in September we found the appropriate recording of medications discussions with patients had improved. The ward manager on Maple ward thought the capacity assessment been particularly beneficial in capturing the explanation of side effects of medications where capacity had been assessed as part of a patient's medication review. We saw several capacity forms on both wards with a completed record relating to the discussion of medications.

Our judgement
We found there are systems in place to gain and review consent to treatment and assess capacity to make decisions for people who use services.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
During our inspection visit in January 2011 we talked to a number of patients on both acute mental health wards at this location. Comments were generally positive about aspects of their care. Please see the January 2011 report for this location.

During our inspection visit on 22 September 2011 our focus was to review compliance actions previously identified in January. We talked to two patients on Rowan ward.

We talked to patient [X] because they had attended the multi-disciplinary team (MDT) meeting on the day of our inspection and we wanted to gain their views. The ward had previously not allowed patients to attend the MDT but had recently introduced a new system that gave patients the option to attend. Patient [X] felt attending the meeting "had helped" as it helped them "understand what they had asked [staff] before". They also explained how they felt relaxed during the meeting and felt welcome. Generally the patient felt "staff are okay" and "everything is fine". They did feel that the ward was "cold all the time" and explained that they were not happy with the food choice at supper because it was basically the same food offered at breakfast.

Patient [Y] felt "care was alright" and "[staff] all lovely". They explained that members of staff "look after you" and always gave their time when you wanted to talk to them. Patient [Y] also said the "nurses are brilliant". This patient also raised a concern regarding supper being the same as breakfast and other food choices were sometimes limited. We asked this patient if they ever felt cold but they explained they were "warm enough". We passed on both patients' concerns to the ward manager.

Other evidence
This inspection was arranged to follow up compliance actions we issued as part of the planned review of this location completed in January 2011. During our inspection visit conducted 11 January 2011 we found the location was not meeting this outcome on the acute mental health wards.

In response the provider conducted a thorough review of these concerns and developed an action plan containing a range of measures to ensure improvements were made. Since January the provider has sent us regular updated action plans and discussed these with us at our regular engagement meetings. During this responsive review we reviewed the latest provider action plan and conducted an inspection visit on 22 September 2011 to determine if the improvements being implemented by the provider would address the issues we identified.

The inspection we conducted in January was triggered in part by previous concerns raised with us by the Sheffield Adult Mental Heath Association. The association had concerns about high bed occupancy levels across the provider's acute mental health services. The provider had already put in place various measures to lessen the impact of bed occupancy so we asked them to undertake a further review to see if any other measures could be taken. In response the provider explained how various measures had improved the bed situation since January. For example, four additional "step down" beds had been introduced as part of a pilot funded by the primary care trust, which has been explained as giving a reduction in bed usage. A bed manager has been recruited and acute care pathway discharge documentation has been streamlined.

On the site visit in September we talked to several staff members on both wards about bed occupancy. All staff appeared positive about the impact of the four step-down beds with some recognising it released acute beds. The ward manager on Maple ward explained how the bed manager had helped and gave examples of how bed allocation was arranged efficiently. All staff also explained how the discharge coordinator role had also contributed to the efficiency of managing beds, for example, one staff nurse said this role had "made a real difference". We talked to the discharge coordinator on Rowan ward who gave examples of how various changes were making bed management more efficient, for example, the streamlining of discharge documentation. Overall staff explained that the wards are generally full though both ward managers had found over last year overall demand for beds in relation to over – occupancy rates had fallen. One staff member did feel demand did still occasionally cause issues though they did feel the situation was better overall.

In January we found the acute wards at this location generally complied with mixed sex accommodation guidelines though we were concerned that one cubicle in the female area of Rowan ward was occupied by a male patient. This was because the room was the designated area for people with a physical disability. In response the provider moved the patient to the male area of the ward and reviewed current provision of disabled facilities across the location.

On the January inspection visit we were concerned that there was no robust systematic process of individualised risk assessment for mental health. We found that the patient's risk assessment process was subjective, not supported by any guidance or policy and not evidenced based which placed patients at potential risk of harm. In response, the

provider developed a number of actions designed to address these concerns. The provider has developed an individualised mental health risk assessment tool along with user guide and other supporting processes. The provider explained it has ensured all qualified acute ward staff are trained in use of the tool and reported in August that the tool had been rolled out for use.

On the inspection visit in September we found the provider had actively introduced its risk tool known as the DRAM (detailed risk assessment and management plan). We reviewed a number of these tools on both Maple and Rowan wards. We found the tools covered a large number of associated mental health risks, which were split into several domains. Each tool we reviewed included a detailed assessment and where necessary captured a management plan where a risk had been identified, for example, suicide or absconsion. The tool is 'live' and may be updated by the multi-disciplinary team.

We talked to a number of staff nurses and the ward managers on both wards. Generally all staff felt the DRAM was a positive step forward because it provides a formalised detailed mental health risk assessment that helped identify risks. For example, one nurse said "I really like it" and then went on to explain how it provided "useful prompts to consider every potential risk area". Other nurses explained how useful it was for gaining a quick update about the patient's current needs and risk, with one nurse describing it as a "one stop shop" for all the information you need. The consultant on Rowan ward reiterated these views and said "I'm happy with it".

The ward managers and some nurses on both wards recognised that the medical team needed to become more involved in updating the risk assessment and this view was recognised by the consultant on Rowan ward. The ward manager on Maple ward was "really pleased with the DRAM" though he thought it could be further developed to include an overall rating system based on 'consequence' and 'likelihood'. Another nurse had similar views and thought it would be useful to have a summary of risk on the front page.

During our January inspection visit we had found that improvements could be made regarding patient involvement in care planning in partnership with their named nurse and consultant. On Rowan ward no patients had been allowed to participate in the multi-disciplinary team (MDT) meeting, which did not reflect current best practice guidance regarding patient involvement.

During our visit in September we talked to the ward manager and nurses on Rowan ward. The ward manager explained that the ward had very recently introduced the option for patient's to attend the MDT meeting based on a system agreed between the consultant and other staff. We found this change in practice had been very positively received by staff and patients. For example, one comment from a nurse about the change included, "It's wonderful patients are allowed into the MDT". The consultant was also happy with the change though remained concerned that it should not take so much time that it might impact on their individual patient sessions. On Maple ward the ward manager explained they had definite plans for inclusion of patients at MDT though these had yet to be introduced. We saw documented evidence of patient involvement in care planning on both wards.

We reviewed the section 136 suite in January located on Maple ward and found it was not ideally placed and had occasionally caused un-necessary disturbances for patients.

We asked the provider to review the location of this suite to see if it was possible to identify a more suitable area within the building. The provider has subsequently held a liaison meeting with South Yorkshire Police and other interested parties to discuss the issue. On the inspection visit in September we talked to the ward manager on Maple ward who explained that a business case had been approved for the short term re-provision of the suite on Maple ward. The ward manager talked through the proposed changes to the current suite which will ensure much improved privacy for the person detained by the police while they are being assessed. The planned changes also include increased space and a separate external entrance to the suite which will ensure the police will not have to enter the main ward area.

Overall on the September inspection visit we found good improvements had been made in relation to concerns we identified during the January visit. We found staff members were aware of the provider's actions to improve areas highlighted previously and were supportive of the improvements made so far.

Our judgement
We found people who use services generally experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

Outcome 08:
Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

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

Our findings

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

Other evidence
During our inspection visit conducted 11 January 2011 we found the location was not meeting this outcome on Maple ward. During a tour of the premises we saw that the seclusion room had not been cleaned following use, which was addressed on the inspection day. In response, to minimise the risk of this issue occurring again, the provider has reviewed cleaning schedules to ensure all necessary checks have been carried out at the commencement of each shift. The provider also explained that it had reviewed options regarding the provision of hygiene equipment in the seclusion room toilet. During our visit in September we reviewed the amended cleaning schedules.

Our judgement
No 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

The provider is compliant with Outcome 10: Safety and suitability of premises

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
During our inspection visit conducted 11 January 2011 we found the location was not meeting this outcome on the acute mental health wards. We were 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 also found that inadequate heating was being provided in various areas of the Longley Centre and in a number of patient bedrooms.

In response the provider conducted a review of these concerns and developed an action plan containing measures to ensure improvements were made. Since January the provider has sent us regular updated action plans and discussed these with us at our regular engagement meetings. During this responsive review we reviewed the latest provider action plan and conducted an inspection visit on 22 September 2011 to determine if the improvements implemented by the provider would address the issues we identified.

The provider action plan dated 18 August 2011 explained how these areas of concern had now been completed. Obscured film had been applied to the clear glazing we identified in January to ensure privacy for patients. It was explained in the action plan how our concerns about the adequacy of heating had been addressed by various measures. Radiators have been bled to remove any airlocks and a new pressurised gas

fired boiler had been installed by March 2011. A further action in progress was to fit low surface temperature radiators in rooms located at the end of the heating system.

On the inspection visit in September we confirmed the glazing had been obscured where necessary. The ward manager on Rowan ward confirmed that the work identified in the action plan had been completed. Some staff members we talked to during the visit expressed that they thought the decoration of the wards could be improved by incorporating more colour and made "more homely". This was because currently the ward areas have more of a 'clinical' feel than in comparison with the adjoining 'Intensive treatment service' ward.

Our judgement
No 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

The provider is compliant 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.

Other evidence
During our inspection visit conducted 11 January 2011 we found the location was not meeting this outcome on the acute mental health wards. We found that the standard of record keeping by senior medical practitioners was not satisfactory, particularly in relation to recording key assessments such as a person's capacity (see outcome 2 above). We found that the ongoing use of paper based and electronic records carried some risks; including there may be potential failure to document clear, factual and accurate records for individual patients. We also found the current systems limited the accessibility of records because it was difficult to find specific items of information.

In response the provider conducted a thorough review of these concerns and developed an action plan containing a range of measures to ensure improvements were made. Since January the provider has sent us regular updated action plans and discussed these with us at our regular engagement meetings. During this responsive review we reviewed the latest provider action plan and conducted an inspection visit on 22 September 2011 to determine if the improvements being implemented by the provider would address the issues we identified.

The provider's action plan for records management has been developed to include a substantial review and development of the current records systems used by clinical staff. For example, there is a wholesale review of documentation used along with a staged introduction of the inpatient electronic records project. The provider explained how the action plan is in progress and we recognise full implementation will not be completed until the end of the year.

On the site visit in September we were able to evidence how the electronic records system known as 'Insight' had been improved so far. In comparison with our inspection visit in January we observed nurses accessing the system to find various records. We observed a clear improvement in the ability to find certain records promptly. For example, capacity assessments were easily accessible along with mental health risk assessments and associated risk management plans. Staff also seemed to be able to find useful examples of evidence located within multi-disciplinary team meeting minutes.

We talked to a number of staff members on both wards to ascertain their views regarding the Insight records system. The nursing team on both wards felt the system was improved with the changes made so far, for example, the ward manager on Maple ward thought the system had improved markedly. One nurse commented it was a "great working tool", whilst another nurse on Rowan ward thought the information was "more interlocked" and also explained how it was easier to find information. The consultant on Rowan ward also said it was "easier to get around" regarding the system.

We found sufficient improvements had been made to records management which gave us confidence to remove the compliance action from this outcome. However the provider should continue with its own detailed plans for improvement to ensure all actions are completed.

Our judgement
We found that processes are in place to ensure personal records are accurate, held securely and kept confidential. The provider's records management and process are being improved to ensure patient's health records are appropriately detailed and accessible.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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