Review of compliance

Southern Health NHS Foundation Trust Antelope House	
Region:	South East
Location address:	Brintons Terrace Southampton Hampshire SO14 0YG
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people with mental health needs Community based services for people who misuse substances
Date of Publication:	September 2011
Overview of the service:	The service is owned and managed by Southern Health NHS Foundation Trust. It offers care and treatment for people with mental health issues. People may

	be informal or detained under the Mental Health Act. The service works with individuals to promote independence, well being and where possible move to a more independent living.

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

Our current overall judgement

Antelope House was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 11 August 2011, observed how people were being cared for and talked to staff.

What people told us

The inspection was a joint visit between a compliance inspector and a mental health act commissioner. The purpose of our visit was to follow up on a recent review of action taken following the death of a service user. On this occasion we spent our time on one of the wards and looked at records relating to the treatment of patients and arrangements for their care. During our visit we spoke with six staff and observed interaction on the ward between staff and patients.

What we found about the standards we reviewed and how well Antelope House was meeting them

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

The records did not demonstrate that patients consistently received safe care that met their needs. Staff have not always responded to patients needs or taken action to minimise the risks to people who use the service in timely manner. On the basis of the evidence provided we found the service not compliant with this outcome

Outcome 07: People should be protected from abuse and staff should respect their human rights

Despite the trust providing training for staff, there is concern that staff are not fully aware of the action they should take when reporting concerns and are detaining individuals inappropriately. On the basis of the evidence provided we found the service not compliant with this outcome.

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

People are at risk of receiving care and support from staff that may not be up to date with the latest guidance on how to provide support and care to people. On the basis of the evidence provided we found the service needs to make improvements to remain fully compliant with this outcome.

Actions we have asked the service to take

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

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

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 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We were unable to speak with people on this occasion; this will be reviewed at any future visits.

Other evidence
The care plans and associated records are maintained in two ways; electronically and on paper and we were able to look at both. Care plans we looked at did not always reflect the specific needs of people that staff had told us about.

We found that the doors to the ward were locked and we were told this was because two informal patients were asking to leave. The records we saw indicated that they had been asking to leave for several days prior to our inspection.

One of the patients, diagnosed as having a borderline personality disorder, had indicated that they wanted to end their life. On one occasion they managed to leave the ward and were persuaded to return. There was no record of any assessment as to whether this patient should be detained. After we had expressed concern about this patient, arrangements were made for the patient to be reviewed. We subsequently read the notes of the review on the electronic system (RIO) and even after medical input there was no clear action plan for staff as to what should happen if the patient tried to leave.

Records showed that one person had hurt themselves on the ward and had indicated to staff that they wanted support not to do this. The risk assessment was not updated and

there seemed to be conflicting views on how the system could be changed to reflect any changes. We were told that trust policy is to record all accident, incidents and near misses. However we found several examples where this had not been done and again staff gave different views on trust policy expressing in one case that 'it depends on the severity of the self harm and presentation of patient, whether it is recorded'. One of the incidents we saw a record for which had not been transferred to the incident log, stated that staff had 'helped to wash wounds'. There was no record whether a dressing had been used, or of any follow up action.

We saw that one person was at risk of not eating or drinking and the action was to "monitor". There were no further records that we could see. Another record, a nutrition information sheet, said that 'appetite was poor' and the care plan said 'review risk behaviours, deliberate self harm. Neglect of dietary and fluid intake'. However, there was no record of any being taken.

We saw for a recent admission that observations were to take place every fifteen minutes. The sheet to be completed had times written for example 0600 – 0700 but the record did not show at what time the observation took place. Other records had gaps where nothing was written sometimes for two or three hours.

We were shown ring binders which contained paper information on each patient. Included in this was a copy of the signed care plan. However, the care plan was not dated and had no space for the date.

We saw evidence that people were asked whether there were people they did not want informed or updated about their health issues.
In the same file we saw risk assessments for leave away from the ward for informal patients. Antelope house designed the ones for informal patients and they were not always completed with level of risk or who had completed the form. The risk assessment did not reflect the information found in daily records or how staff drew the conclusion that someone was safe to have leave from the ward when records said that people were experiencing 'depressive episodes and suicidal ideas'.

Information was not always transferred to RIO to enable an update to take place. For one of the patients where we expressed concern regarding the locked door staff had not completed their daily records leaving a sentence half completed.

The risk assessments were of concern as they had not all been updated regularly with one not being updated since March 20011 although daily notes showed that changes had occurred.

The Mental Health Act (MHA) Commissioner examined the legal documents for all six patients who had been detained. With one exception, all were in order. With one patient, the H3, which is the record of detention in hospital, was dated for the day before the medical recommendations and the application was made. This matter was brought to the attention of the Mental Health Act team to arrange for the Mental Health Act Manager to correct the error. The detention papers were contained in another file rather than in RIO. The files referred to previous administrative processes relating to the Act which were changed some years ago.

During our inspection the Mental Health Act Manager informed us that one of the

detained patients had written to the Mental Health Act office in Nottingham to complain about fire precautions on the ward we were visiting and the future of the High Dependency Unit.
The patient had also asked when a Commissioner was next visiting the ward so that they could speak to them. The MHA Commissioner agreed to see the patient but they were on leave for the afternoon. Following our site visit the MHA Commissioner telephoned the ward and spoke to the patient who additionally expressed their anxieties about possible changes to Antelope House. We shall be responding to the issues that the patient has raised with us separately.

Our judgement
The records did not demonstrate that patients consistently received safe care that met their needs. Staff have not always responded to patients needs or taken action to minimise the risks to people who use the service in timely manner. On the basis of the evidence provided we found the service not compliant with this outcome

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We were unable to speak with people on this occasion; this will be reviewed at any future visits

Other evidence
We saw on a patient file that a safeguarding alert had been made following a disclosure from a patient on the 30th July 2011 alleging an assault by a member of staff at another unit. The form was competed on the 30th July, sent on the 1st August and an incident report completed on 3rd August. The Commission was not aware of this allegation.

Senior staff told us that training in basic awareness of safeguarding is mandatory and senior staff must attend further training. Basic awareness is given in staff induction training.

Staff we spoke with confirmed that they had attended training. However, they were not clear about the decision making process which led to the door being locked for all patients on the ward, when they would use holding power under the Mental Health Act, or when they would request a medical assessment of a patient if they were concerned about their mental well being and leaving the ward.

Our judgement
Despite the trust providing training for staff, there is concern that staff are not fully aware of the action they should take when reporting concerns and are detaining individuals inappropriately. On the basis of the evidence provided we found the service

not compliant with this outcome.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We were unable to speak with people on this occasion; this will be reviewed at any future visits.

Other evidence
Some staff told us that they sometimes experienced difficulty in accessing to the website to book training courses. Problems with staffing meant that some staff could not be released to attend training. As a result some staff experienced difficulty in accessing courses as they were no longer available. Some staff were unhappy with e-learning as they preferred a different approach.

Staff said they had undertaken a wide variety of training including safeguarding. However some had not attended substance misuse training at all, or had undertaken it a while ago and had not attended any updates. Substance misuse was a key issue in a recent review and staff should have received up to date training.

Our judgement
People are at risk of receiving care and support from staff that may not be up to date with the latest guidance on how to provide support and care to people. On the basis of the evidence provided we found the service needs to make improvements to remain fully compliant with this outcome.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: People are at risk of receiving care and support from staff that may not be up to date with the latest guidance on how to provide support and care to people.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The records did not demonstrate that patients consistently received safe care that met their needs. Staff have not always responded to patients needs or taken action to minimise the risks to people who use the service in timely manner.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Despite the trust providing training for staff, there is concern that staff are not fully aware of the action they should take when reporting concerns and are detaining individuals inappropriately.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

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

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

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

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

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

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

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

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and 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
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