Leeds and York Partnership NHS Foundation Trust

Parkside Lodge

Quality Report

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Date of inspection visit: 04 April 2016
Date of publication: 11/08/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RGDPL	Parkside Lodge	Parkside Lodge	LS12 2HE

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Leeds and York Partnership Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership Foundation Trust.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We found the trust could improve in the following areas:

- Not all ligature risks had not been identified by the trust's ligature risk assessment. This could increase the likelihood of patient's ligaturing in the service and impact on the safety of the patients.
- The patient kitchen was not clean.
- The training compliance at Parkside Lodge for the level 2 Mental Health Act inpatient training was 57%. The training compliance for the Mental Capacity Act, including Deprivation of Liberty Safeguards, level 2 was 69%. This training had been introduced into the trust's mandatory training schedule in July 2015. Staff had not received training on the updated Mental Health Act code of practice.

However we found the following areas of good practice:

- Staff had reviewed all patient prescription records had all been reviewed. Staff had followed the medication as required guidance. There was detailed recording of incidents on the trusts datix system.
- The seclusion room was in the process of being altered to comply with Mental Health Act guidance and to ensure patients' privacy and dignity was not compromised.
- Multi-disciplinary team meetings took place twice a week; decisions and information gained during multi-disciplinary team meetings fed into the patients care plan.
- Patients had physical health checks on admission to Parkside Lodge and on a regular basis during their stay in hospital.
- Staff had regular supervisions and annual appraisals. Specialist training was available to staff.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found the trust could improve in the following areas:

- There were several ligature risks some of which had not been identified in the environmental risk assessment.
- The patient kitchen was not clean.

However we found the following areas of good practice:

- Staff had reviewed all patient prescription records. Staff had followed the medication as required guidance.
- There was detailed recording of incidents on the trust's datix system.

Are services effective?

We found the trust could improve in the following area:

- The compliance for training at Parkside Lodge was 57% for Mental Health Act inpatient training– level 2, and 69% for level 2 training on the Mental Capacity Act, including Deprivation of Liberty Safeguards, at the time of the inspection. This training was introduced into the mandatory training schedule in July 2015. Staff had not received training on the updated Mental Health Act code of practice.

However we found the following areas of good practice:

- Multi-disciplinary team meetings took place twice a week; decisions and information gained during multi-disciplinary team meetings were fed into the patients care plan.
- Patients had physical health checks on admission to Parkside Lodge and on a regular basis during their stay in hospital.
- Staff had regular supervisions and annual appraisals.
- Specialist training was available to staff.

Summary of findings

Information about the service

Parkside Lodge in Leeds is a 12 bed mixed sex acute assessment and treatment unit for patients with a learning disability or autism.

We have inspected Parkside Lodge on three previous occasions with no breaches of regulations identified.

Our inspection team

Lead Inspector Karen Bell.

The team that inspected this service comprised of

- two CQC Inspectors
- mental health nurse specialist advisor.

Why we carried out this inspection

We inspected this location because of concerns raised with regard to the seclusion facilities and staffing numbers, and the application of the Mental Health Act.

How we carried out this inspection

To fully understand the experience of people who use services, we usually ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

However, on this occasion we looked at:

- Is it safe
- Is it effective

Before the inspection visit, we reviewed information that we held about this service.

During the inspection visit, the inspection team:

- visited the hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with the managers or acting managers
- spoke with other staff members; including nurses and health care assistants
- observed a hand-over meeting.
- looked at four treatment records of patients
- carried out a check of the medication management and reviewed all 12 prescription charts.

What people who use the provider's services say

Only one patient agreed to speak with us during our inspection. The patient told us they liked most of the staff and would like to go out more.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff are up to date with the Mental Health Act and Mental Capacity Act training.
- The trust must ensure that all ligature risks are identified and added to the local risk register and ensure that ligature risks are mitigated by the removal of those risks where possible.

Action the provider SHOULD take to improve

- The trust should ensure staffing numbers are always adequate to keep patients safe when the service is at full capacity.
- The trust should ensure all areas of the hospital are clean.

Leeds and York Partnership NHS Foundation Trust

Parkside Lodge

Detailed findings

Locations inspected

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The compliance for training on the mental health legislation awareness – level 1 was 75% for staff on Parkside Lodge, and 57% for the Mental Health Act inpatient training – level 2. The trust had introduced this training into their mandatory training schedule in July 2015. Staff had not received training on the Mental Health Act code of practice.

Parkside Lodge had six patients detained under the Mental Health Act. Staff explained patients' rights to them on admission and regularly during their stay.

Patients were referred to independent mental health advocate services.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act and Deprivation of liberty safeguards. We found completed mental capacity assessments in patients care records where these were required. We also saw evidence of best interests meetings being carried out where decisions needed to be made for patients lacking capacity to make their own decisions. Meetings included professionals involved in the patients care and where possible the patients relatives and or their advocates.

Staff used various communication methods to assist patients in making their own decisions. These included for example, British Sign Language, Makaton and easy read material.

At the time of our inspection, there were no patients subject to Deprivation of liberty safeguards authorisations. However, in the year prior to our inspection the trust had notified us of four Deprivation of liberty safeguards authorisations, which the local authority had approved.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Most areas of the hospital were visibly clean and well maintained. However, the patient kitchen had dirty cabinet doors, the oven was not clean and there was debris on the floor. This meant the provider could not be sure that the risk of infection had been mitigated. An external provider carried out cleaning duties. We were provided with an infection control audit carried out in September 2015 which identified that the kitchen was red rated at 65% compliance. There was no evidence of audit since that date to ensure compliance. Items identified during the audit were different to the ones identified during our inspection.

Clinic rooms were clean, tidy and well ordered. The medicines fridge and cabinets were locked and fridge temperatures checked daily. Staff carried out checks of emergency drugs and resuscitation equipment.

Staff regularly carried out and updated environmental risk assessments. This included a hospital ligature risk assessment which showed several areas, which were identified as, ligature risks, these included:

- Shower hose
- Door hinges
- Door handles

The risk assessment action for each ligature risk stated 'individual patient risk assessment – management plan – for local risk register'. We asked the trust for a copy of the local risk register, which did not include the ligature risks. Patient files did not contain the patient's risk of ligaturing in bedrooms where ligature risks had been identified.

The risk assessment did not include wardrobe doors. In some bedrooms the curtains were fixed by curtain hooks, which did not release when pressure was applied. A senior manager told us that an assessment of the curtain rail risks had taken place the previous weekend. We were provided with details that confirmed this.

Areas of Parkside Lodge had blind spots. However, the manager told us staff presence mitigated the risk. Due to the hospital being short staffed we were concerned there may not always be sufficient staff in these areas to safely mitigate the risk.

During a Mental Health Act review in May 2015 it was noted that the location of the seclusion room on the main corridor meant patients being secluded could be viewed as people walked by. The trust agreed to re-site the entrance to the seclusion room and most of the work had been completed. However, some work was outstanding and the room was not safe or appropriate for use. We will review this facility again during our next inspection. Staff told us that the seclusion room was not in use. Records we saw confirmed there had been no recent incidents of seclusion. The trust had designated another room as a de-escalation room. This room was also sited on the main corridor, which we were concerned about. However, the manager assured us that if the room was being used staff would redirect other patients away from it. The manager said a staff member would be sited on the corridor leading up to the room. This would ensure the privacy and dignity of the patient using the room was not compromised.

Safe staffing

Parkside Lodge establishment levels were:

Band 6 Qualified Nurses - 2 whole time equivalent

Band 5 Qualified Nurses – 15 whole time equivalent

Health Care Assistants – 21 whole time equivalent

Vacancies:

Qualified Nurse – 5 whole time equivalent

Health Care Assistants – 5 whole time equivalent (2 whole time equivalent due to commence employment at the end of April)

Agency/Bank Staff Use

There was a high use of bank and agency staff in the three months prior to our inspection. Of the 12360 hours worked, 4246 hours were carried out by bank staff and 306 hours by agency staff.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Parkside Lodge had the capacity for 12 patients; however, there were only six patients on the day of our inspection. On the day of our inspection, there should normally have been three qualified nurses and five health care support assistants on duty. However, with the reduced bed numbers, there were three qualified members of staff and three health care support assistants; this was a higher staff ratio than when the service was at full capacity. One patient required one to one observation, another patient required one to one observation whilst in the building and two to one to support whilst in the community. Four patients were on 15 minute observations. Staff told us that Parkside Lodge was regularly short staffed and that they could not always be relieved after an hour on patient observations. Rotas confirmed that the service was not always fully staffed.

However, the service managed the deployment of staff very well. The clinical team manager told us that one patient became very agitated if they were not able to have their section 17 leave every morning and this needed to be facilitated by two members of staff. Staff never cancelled this patients leave as it had been identified that if the patient did not have their leave it could disrupt the whole service for the rest of the day.

Other patients requiring escorted leave would, where appropriate, be taken out during the 'staff handover' period where staffing numbers were increased for up to three hours. This was because the early shift finished at 4.30pm and the late shift started at 12.30pm. This also enabled regular staff supervision and appraisal.

The clinical team manager told us that staff from another local service would often be able to assist when staffing numbers became unsafe. There was regular use of bank and agency staff. However, managers where possible made block bookings well in advance to ensure staff that were familiar with patients could be obtained.

The trust supplied us with figures relating to staff compliance with mandatory training, which stated compliance was at 82%, this was below the trust target of 90%. Only three subjects were within the trust target and rated at green, 15 were amber and moving and handling principles was at 33% and rated as red. However, 100% of staff had completed moving and handling essentials.

Assessing and managing risk to patients and staff

We reviewed the records of four patients and found there were comprehensive risk assessments completed within 72 hours of admission. Staff updated risk assessments when an incident occurred and staff regularly reviewed risk assessments.

Staff only searched patients' bedrooms where risk was identified and this was done with the agreement of the patient.

We looked at the prescription records for all patients and found they had been reviewed. All prescriptions had route, time and dose administered. All medication administered had been recorded and where a patient had refused their medication this was clearly identified. This followed the national institute for health and care excellence guidance medicines management guidance.

There was guidance for medication to be administered as required. Monitoring forms were completed when medication was administered as required. The monitoring continued over a two hour period.

Track record on safety

There were no serious incidents requiring investigation recorded at Parkside Lodge in the last 12 months.

Reporting incidents and learning from when things go wrong

The trust had a system in place to record incidents occurring within the service. Staff described the type of events that required reporting as incidents. We reviewed incidents recorded on the trusts recording system datix. There were several incidents involving one patient. We found staff had managed this patient very well and had implemented measures to reduce the occurrence of incidents. The patient had been assessed as requiring a more suitable placement; however, this had been a challenge due to the lack of suitable places in the city. The manager told us they were hopeful this would be shortly resolved.

Staff told us that a debriefing took place where appropriate and again, where appropriate, this involved the patient. Patient records detailed incidents, we saw in one patient's progress notes information with regard to an incident requiring de-escalation. Another where the patient had required restraint, and had subsequently been taken to the de-escalation room, administered medication and then we saw a record of the monitoring of the patient.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

Staff said the patient's primary nurse would carry out an assessment with the patient. Staff would obtain information from the patient's previous placement along with any historical information and information from relatives and carers.

Parkside Lodge staff used a system of modified early warning signs to identify physical health concerns. The modified early warning signs enabled staff to recognise when a patient's physical health was deteriorating or giving cause for concern and so trigger a referral to medical staff. Staff had received training in modified early warning signs.

We reviewed four patients' files and found that two did not have completed 'my health' records. We did see evidence that physical health checks had taken place, which included for example respiration, temperature, blood pressure, pulse and weight records.

Care plans included 'rationale', 'important to me' and, 'the outcome I want from this plan' sections. Care plans had not been signed by patients. However, files showed that staff explained and discussed the content of care plans with patients and three patient files included a care plan written in easy read format. The occupational therapist had written some care plans and two patient files had behaviour support plans written by clinical psychologist. Care plans were around skill building, cooking, plans around unescorted leave and physical health. Assessment, care plans and behaviour plans were evidence based, and had used the Roy adaption model assessment tool, Wain, Moody and Nixon, and one plan we recognised as Baker and Allen.

Best practice in treatment and care

The trust had trained staff at Parkside Lodge in positive behaviour support. Positive behaviour support helps staff understand behaviours that challenge and assists in implementing ways of supporting the person, which enhance the quality of life the person. It is based on the values of recognising each person's individuality. We saw good positive behaviour support plans in patients care plans.

Staff used the therapy outcome measures tool. The tool assesses a patients impairment, activity, participation and wellbeing, the tool measures the impact of patients health needs in relation to theses four areas and the outcomes of treatments and interventions in addressing these needs

Parkside Lodge had a psychologist who had carried out psychological assessments of most patients.

Skilled staff to deliver care

Staff told us they were able to request additional training during their supervision sessions. They said not all requests for training resulted in training being available but generally this was possible. A member of staff said they had recently requested epilepsy training which had been agreed. Staff received training in learning disability and autism; most members of qualified staff were learning disability nurses.

The manager at Parkside Lodge told us they thought appraisals, management and clinical supervision were very important as staff were under a lot of pressure due to staffing levels. They said they made sure everyone had the opportunity to spend time with their supervisor even if it did not always take place on the day it was originally planned. Records we reviewed confirmed staff had regular supervisions and annual appraisals.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings took place twice a week at Parkside Lodge. Various professionals were involved in the process, psychiatrists, nurses, psychologists, where appropriate care managers and social workers. The pharmacist for the service attended the multi-disciplinary team meetings on a Wednesday, although staff said the pharmacist was always available by telephone. Staff invited patients to attend their multi-disciplinary team meetings; however, staff said often they chose not to attend.

Decisions and information gained during multi-disciplinary team meetings were fed into the patients care plans. We saw multi-disciplinary team meetings minutes and actions points raised were followed up until completed. Discharge planning took place during multi-disciplinary team meetings, this involved care co-ordinators, carers from the patient's placement, community nurses and family members.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Patients had community meetings every Sunday, during the meeting they spoke about their experience at Parkside Lodge and this was fed into the multi-disciplinary team meetings process.

Staff said handovers were usually 15 minutes, they did not think this was long enough. Handovers involved the nursing team and on some occasions the psychologist attended. During the handover new admissions were discussed, risks to patients, patients' current presentation and what level of observation the patients were on.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff told us Mental Health Act training was mandatory and required an annual refresher. Compliance with mental health legislation awareness – level 1 was 75%. Compliance with Mental Health Act inpatient – level 2 was 57%. The trust had introduced this training into their mandatory training schedule in July 2015, with the aim of meeting the trust target of 90% compliance by July 2016.

At the time of our inspection, five of the six patients were detained under the Mental Health Act. Patients had their rights under the Mental Health Act explained to them on admission. There was evidence in patients paper notes that staff regularly informed patients of their rights. Staff said that this was sometimes difficult, as patients did not always want to engage in the process.

Staff completed Mental Health Act paperwork on admission and then they sent it to the Mental Health Act office. If the patient was admitted late then the documents would be stored in the safe overnight and then taken to the Mental Health Act office during the next day.

We saw a board in the nursing office which detailed which section the patient was on and when the sections required reviewing. There was a section on the front of prescription charts that identified which section the patient was detained under. We saw one patient had a T3 with British National Formulary recommended dosage in one file found. A T3 is a consent form signed by a responsible clinician where detained patients refuse or lack the capacity to consent to medication after their first three months of being detained.

All detained patients at Parkside Lodge had an independent mental health advocate assigned to them. Staff said they made an automatic referral to the independent mental health advocate service for detained patients.

Staff audited patient records by completing a 'Mental Health Act legislation monitoring form'. Audits included, consent to treatment monitoring, monitoring provision of information to service user and monitoring of leave of absence. Where information was missing there were comments stating what needed to be done to rectify the error.

Good practice in applying the Mental Capacity Act

We saw that with the exception of one patient file staff had completed mental capacity assessments. These were decision specific, for example around the capacity to consent to treatment under the Mental Health Act.

Staff had documented information about a best interest's decision made during a multi-disciplinary team meeting. During the meeting, the patient's capacity had been reviewed to ensure they still lacked the capacity to make the decision. Another patient's behaviour plan contained a capacity assessment with regard to interventions. We reviewed a medication care plan where it was identified that a patient had capacity to consent to medication.

Staff we spoke with understood the Mental Capacity Act and how it affected their work with patients at Parkside Lodge. Staff said they ensured they used lots of visual aids to aid communication with patients. This was to make sure patients were given every opportunity to make decisions about their care and everyday life.

Compliance with Mental Capacity Act and Deprivation of liberty safeguards - Level 2 training was 69%. This training had been introduced into the trust's mandatory training schedule in July 2015, with the expectation that compliance would meet the trust target of 90% by July 2016.

At the time of our inspection there was no one subject to a Deprivation of liberty safeguards authorisation. However, our records showed that in the 12 months prior to our inspection Parkside Lodge had obtained Deprivation of liberty authorisations for four patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Ligature risks identified had not been added to the local risk register as stated on the ligature risk assessment. Wardrobe doors and fixed curtain hooks were not on the ligature risk assessment. The trust had not assessed risks to the health and safety of service users of receiving the care or treatment. The trust had not done all that was reasonably practicable to mitigate any such risks. 12 (1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Compliance with Mental Health Act inpatient – level 2 was 57%. Compliance with Mental Capacity Act and Deprivation of liberty safeguards - Level 2 training was 69% at the time of the inspection. 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.