# Action Plan – Quality and Safeguarding

| Findings | Agreed Recommendations | Action taken |
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| The standard of the premises varied from site to site. The quality of some buildings was better than others.<br><br>Warminster Road was highlighted as needing urgent improvement. | A review of all Sheffield City Council day service and supported living buildings should be carried out.<br><br>The future use of these premises should be decided by the Learning Disabilities Commissioning Team as part of a wider review of LD services. | • All sites have been assessed and action plans put in place to address any issues. Checks will be carried out regularly.<br>• Improvements have been made and repairs carried out. Some buildings have been closed and services transferred to more suitable buildings.<br>• Warminster Road was closed and a range of improvements were made.<br>• An electronic action log for the whole service will be held and monitored by the Quality and Governance team.<br>• The LD Commissioning Strategy was agreed at Cabinet in December 2014 and commissioning plans are now being developed. Consultation on these plans will be carried out. |
| The Learning Disabilities Service and its staff did not pay sufficient care and attention to premises. | Senior management should consider whether disciplinary action is required. | • Investigations were carried out and are now complete. Actions have been taken to address individual performance concerns in line with the Council's Human Resources procedures. |
| There was an inconsistent approach to managing health and safety, including fire safety.<br><br>Regular checks were not carried out. | Management should put new procedures in place across the service and ensure that regular monitoring is carried out. | • A range of new procedures have been put in place across the service.<br>• Monthly monitoring is now carried out to ensure staff carry out the correct checks.<br>• Any issues are discussed with staff during supervision sessions.<br>• Monthly health and safety meetings are held and any actions are recorded and followed up with relevant managers.<br>• An electronic action log is held and managed by the Quality and Governance team. |
| Several known health and safety issues had not been dealt with. | There should be action to deal with the outstanding issues.<br><br>Senior management should consider whether disciplinary action is required for the staff responsible. | • A plan was put in place to ensure the issues were dealt with. Many were dealt with straight away but some complex issues are being completed as part of wider work highlighted in other areas of this document.<br>• Regular monitoring of actions plans is now taking place.<br>• Investigations were carried out and are now complete. Actions have been taken to address individual performance concerns in line with the Council's Human Resources procedures. |
| Issues were raised by the Chief Fire Officer regarding Grimesthorpe Road, Malinda Street and Ecclesfield Support Unit (ESU). | Immediate action is required to ensure sites meet relevant safety standards. | • A wide range of improvements were carried out to improve safety and to ensure standards were met.<br>• The Service now meets the relevant fire testing requirements at ESU.<br>• The recommended works at Grimesthorpe Road are being completed by SCC property services and the registered social landlord.<br>• The service at Malinda Street is now provided by another organisation. |

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| There were inconsistent approaches to maintenance, cleaning and decoration. | A review of current arrangements should be carried out | • Staff now have a daily schedule of tasks which includes cleaning and maintenance.<br>• Regular checks are now carried out by managers. |
| The quality of record- keeping varied and was sometimes poor.<br><br>. | The purpose and function of each record should be reviewed and understood by staff and managers.<br><br>Training should be given to staff where needed.<br><br>Records should be reviewed regularly and be up to date and accurate. | • Current documentation has been thoroughly reviewed and a range of changes made. New documents have been created where needed.<br>• Consultation with staff has been carried out and their feedback helped to improve the quality of documentation. Staff were given support to understand the new documents.<br>• Operational managers carry out a regular audit of service user files to ensure they are up to date and accurate. |
| The quality of support plans was poor, lacking in information and appeared not to be used in day services. Basic information was inaccurate. | A review of what is required for good quality support planning is needed as soon as possible.<br><br>Current support plans should be updated with a clear focus on the service user. | • A new support plan based on research of good practice across learning disabilities services was implemented in December 2014. The support plans are now more person focused.<br>• Managers are now clear where responsibility for the completion of support plans lie. The approach will be applied consistently across the service.<br>• Current support plans have been reviewed and transferred to the new format.<br>• Staff have been recruited specifically to carry out this work. |
| Care plans did not fully take account of people's needs as assessed by Assessment and Care Management (A&CM). | Services provided in supported living and day services should link better to A&CM.<br><br>There should be a person focused care plan in place for all service users which includes all of their care requirements.<br><br>Staff should have access to A&CM support plans and be included in the annual review process. Reviews should be carried out at an agreed frequency depending on the needs of the service user.<br><br>Every service user should have a thorough review that focuses on creativity and positive outcomes. Service users and families should be involved and supported by advocacy services if required. Service users' communication needs should be taken into account and appropriate tools used. | • Service managers now ensure closer working with A&CM so that assessed needs are reflected in the service user's care plan.<br>• The new care plan ensures that information is shared with other services and external organisations, who also have the opportunity to input into care plans.<br>• A&CM are working with professionals from Sheffield Health and Social Care Trust to ensure health- related needs are fully taken account of.<br>• The Service now tracks and records the progress of reviews to prevent delays occurring.<br>• Work is underway to ensure all plans are reviewed in line with the recommendations. Service users and families are now more involved in the process.<br>• There is a new communication passport to help assessors better understand service user's needs. |

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| The Service restructure led to confusion about who should carry out reviews. | service user<br>Management should decide which staff should carry out reviews. | • An investigation into how the situation occurred was carried out and is now complete.<br>• A new staffing structure has been put in place with clearer roles and responsibilities. Staff are aware of their roles and this is monitored through supervision sessions.<br>• Front line managers now carry out the reviews using the new format as outlined above. |
| There is no evidence of the involvement of advocacy services. | Advocacy services should be in place and used where appropriate. | • Advocacy services are now available and will be used during reviews process if required. |
| It was not clear what difference (outcomes) care plans had for day service users. | The way the day services operate should be reviewed. There should be a focus on support that provides goals and opportunities. | • The Learning Disabilities Commissioning Team is developing a new approach to day time opportunities.<br>• There is now more choice of activity at Ecclesfield Support Unit and some other day services. |
| Staff did not put enough importance on good communication with service users. | Good communication should be a key part of all elements of the service including planning, staffing and delivery.<br><br>A new way if sharing information and supporting staff should be put in place. | • Clearer communication across the Service has been put in place.<br>• Regular meetings are now held with staff and information shared.<br>• Team meetings are held more frequently and managers set the agenda to pick up key issues.<br>• Service user documentation has been made available in appropriate formats.<br>• A new approach to communication with service users is being developed with the Learning Disabilities Commissioning Team.<br>• Investigations into how management put in place previous communication procedures has taken place. |
| Staff and managers were not always aware of good practice relating to communication methods. | Best practice guidance such as the Royal College of Speech and Language Therapists' five good communication standards should be in place and referred to as standard.<br><br>Managers should know and understand policy and guidance documents.<br><br>Training on good communication methods should be provided to staff.<br><br>A&CM and the Service should work together to improve communication methods for those service users at increased risk of displaying challenging behaviour. | • The recommended best practice guidance is being used to develop a new approach to communication. This is being led by the Quality and Governance team.<br>• Inclusion North are supporting the Service to improve communication and engagement across all areas. This includes training for staff.<br>• Communication needs are now part of the A&CM assessment and reviews. Staff refer for Speech & Language Therapy and psychology assessments where appropriate. |

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| A lack of attention to good communication methods was affecting decision making, choice and control. | A review of the communication needs for all service users across the Service should be carried out. Following this, new communication methods should be put in place.<br><br>A plan to incorporate choice and decision making for every service user should be put in place.<br><br>Services should be developed in a way that promotes positive social interaction and communication. | • Every service user now has a communication passport. The new care plan supports this approach.<br>• Work to develop new communication methods is ongoing and the Service aims to review and improve the new approaches. Inclusion North are supporting the Service to improve methods of communication. |
| Appropriate accessible forms of communication were not in place and there was little evidence of personalised communication techniques. | A review of the communication needs of each service user should be undertaken and recorded in care plans.<br><br>Communication passports should be developed for every service user.<br><br>Tools such as distress and pain identifiers should be in place for any service user who needs them. | • Further work is required on communication tools and methods.<br>• Inclusion North are supporting the Service to improve methods of communication.<br>• The new care plan and risk assessment identifies pain management and how this links to medication management |
| Safety, safeguarding and complaints information were not displayed in accessible formats. | Hospital passports and other communication tools must have the same information as communication passports. | • The introduction of the new care plan is helping with this. |
| | Communication plans must be monitored for quality and completion at regular periods. | • Managers now carry out monthly checks. |
| | Accessible safety, safeguarding and complaints information should be developed. | • These documents have been produced in accessible formats and distributed throughout the Service. |
| | Monitoring and review of communication plans must be carried out rigorously and on time. | • A user friendly document has been produced for all service users.<br>• Monitoring and review is part of the support plan. |
| | Service users must be able to understand this information.<br><br>Staff should receive training in good communication techniques. | • A user friendly health and safety guide has been produced and distributed.<br>• Inclusion North are supporting the Service to improve methods of communication. Following an audit of Speech & Language Therapy needs, assessments will be checked to ensure service user needs and up to date information is on file. |

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| Intensive interaction was only in place for some people in some places and for some of the time.<br><br>Most service users were unlikely to be able to access information relevant to them. | Every service user must have a communication assessment and plan in place that meets their needs.<br><br>A review of the quality of the one to one support provided should be undertaken to ensure it meets the needs of service users.<br><br>All general communication must be available in accessible formats. | • A&CM is changing support planning and the panel's decision making. This includes ensuring activities on the support plan are meaningful and appropriate.<br>• The Learning Disabilities Commissioning Strategy calls for different approaches to ensure providers offer access to personalised, meaningful activities that enrich people's lives. |
| Many of the one to one activities were centred around very similar sorts of activities. | More thought should be given to the needs of service users as part of the wider review and response to the Council's duties under the Deprivation of Liberty Safeguards. | • Deprivation of liberty assessments are taking place as part of a council wide approach.<br>• Extra staff have been brought in to carry out overdue reviews which will identify any deprivation of liberty issues. |
| One to one supported activities were mainly going shopping, going out for lunches, going to local parks or museums and attending hydrotherapy sessions.<br><br>There was limited attention to meaningful activities taking place within people's own homes. | The Service should ensure that the time people spend in their own homes is as stimulating and meaningful as the service user wants and needs.<br><br>Day services currently provided that are not based in a building should be reviewed as part of an overall model for future day opportunities. | • The new care plan has ensured that managers address this need and clearly describe how the recommendation will be met when the one to one support is provided.<br>• Day services are being reviewed as part of a longer term plan.<br>• Care plans aim to identify opportunities for meaningful activities in people's homes. |
| Some people were unable to leave their homes without one to one support and relied on staff. | A new model for future services should be urgently decided based on national policy and good practice guidance.<br><br>Plans should be put in place to ensure that current service users' needs are re-assessed alongside service users and their families. | • The Learning Disabilities commissioning plans will identify a new approach and standard for day time activities, and encourage more good quality support providers.<br>• Care plans now aim to be more focused on service users' needs and carried out alongside the needs of relatives. |
| Building based day services at Ecclesfield Support Unit were found to be out dated. | ESU should be closed. Alternative, meaningful day opportunities should be planned, based on people's assessments. Family members should be involved in the re-assessments. | • The quality, safety and appropriateness of the services provided at ESU have been reviewed and there is a programme of work in place to improve services and ensure care plans are reviewed to make sure they include good outcomes for people. |
| There was no evidence of planning or development for the Service.<br><br>Many staff did not have regular supervision. | Staff supervisions and performance reviews must be carried out as required. | • Supervisions are now carried out regularly and this is checked.<br>• This has got much better and staff are getting used to the new approach. |
| Fire safety checks were not being carried out. | Fire safety checks should be carried out as required and monitored by managers. | See 'Health and safety' for actions taken. |

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| Staff did not think enough about safeguarding.<br><br>There was confusion between confidentiality and secrecy.<br><br>. | Safeguarding must become everybody's responsibility.<br><br>Experienced managers working in the Service, Safeguarding and Commissioning should help make staff aware of safeguarding.<br><br>There must be guidance to help staff understand confidentiality and what information should be shared and recorded. | • A new team is now leading on safeguarding in the Service.<br>• The Service is developing a new way to deal with safeguarding issues and make sure they are followed up.<br>• There is now better recording and monitoring of safeguarding cases.<br>• Safeguarding is now talked about in all meetings and supervisions.<br>• There is good information and posters about safeguarding in the Service. |
| | There should be more effort to let staff know about safeguarding issues.<br><br>Managers should check to see if the same kind of safeguarding issues are coming up. | • Safeguarding is now talked about in all meetings and supervisions. Safeguarding training sets out what staff need to know.<br>• Managers now check all safeguarding issues every month. Actions plans are developed where required. When there is a safeguarding investigation, action plans are written and these say what lessons have been learned. The Quality and Governance Team will look for safeguarding patterns or trends. |
| Communication and record keeping was inconsistent. | Senior managers must ensure normal safeguarding policies and practice are kept to. | • Managers within the Service have been supported to fully understand safeguarding. All safeguarding issues are raised in the correct way. |
| The Service wanted to deal with safeguarding issues itself ("in house"). | Best practice advice contained in this action log must be followed. Abuse must be prevented before it happens.<br><br>There must be clear roles and responsibilities.<br><br>The new safeguarding procedures should be jointly reviewed by the Safeguarding team and Provider Services after six months to ensure they are good enough. | • An investigation into past safeguarding issues and practice was carried out and has now ended.<br>• A review of safeguarding practice in the Service was completed in June 2015.<br>• The Quality & Governance team now manage all safeguarding alerts, investigations and lessons learned across the provider service. This will help the Service know how to deal with issues better and more consistently.<br>• Staff have received safeguarding training relevant to their role. |
| There was inconsistent understanding of safeguarding issues. Staff were not always clear on their roles and responsibilities. | There must be guidance to help staff understand their roles and responsibilities.<br><br>Staff should receive training.<br><br>There should be a review of how investigations are carried out. | • Staff have received safeguarding training as required by the Care Act.<br>• All safeguarding cases that require further investigation have been jointly led with colleagues in Assessment & Care Management.<br>• The new care plan assesses the risk that people face. |

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| The Service was not checking enough if people were at risk. | Every service user should have easy access to information to support them to avoid abuse or report it if it happens.<br><br>The Service must make it straightforward for service users, family and friends to report concerns or abuse<br><br>How service users access advocates should reviewed and improved. This is particularly important for those at increased risk due to communication needs or limited family involvement.<br><br>A system to ensure good joint working must be put in place. | • A new user friendly document that meets these requirements has been shared with staff and service users.<br>• Monthly reviews now require staff and managers to have contact with service users families. Concerns can be discussed easily.<br>• Safeguarding is a standard agenda item on supervisions to allow staff to raise concerns. Supervision sessions are carried out regularly.<br>• The A&CM reviews identify clients with additional advocacy needs. More advocates are now available.<br>• A review of safeguarding across learning disability services has taken place and the Service is putting the new system in place. |
| There was a lack of joined up working with other parts of the service. The outcome of safeguarding alerts and investigations was not always clear. | | • All Serious Incidents are now routinely monitored and actions taken as appropriate.<br>• More effective staffing levels, supervision, team meetings and other measures are helping with this – see above. |
| It was not clear if recommendations following an investigation into “institutional abuse” had been carried out. | Senior managers must review the findings and recommendations of the investigation and ensure that all necessary actions have been taken. | • Health action plans are looked at with the new care plan and discussed with service users and families.<br>• The Service has checked who required a health action plan.<br>• The Service has used health assessments to help produce the health action plans. |
| There was no evidence that people are supported or encouraged to have an annual health check.<br><br>Only a few service users had a Hospital Passport in place | Discussions should take place with health colleagues to determine how many users have had health checks<br><br>Health Action Plans should be explained, encouraged and supported.<br><br>Specific plans should be in place to assess the health needs of each service user.<br><br>Hospital passports must be in place for all service users. | • As described above the same approach has been taken for hospital passports. |
| There was little evidence of pain and distress tools being used. | Easily available tools should be used. Staff should receive training to use them.<br><br>These tools should be monitored to ensure they are being used properly to support people. | • The new care plan and risk assessment includes pain management. This encourages managers to consider how pain may show itself and how they can support the service user to communicate their pain. Pain assessment tools are used. |

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| There was an example of a long delay in physiotherapy assessments. | A review should be carried out to make sure physiotherapy and other health needs assessments are up to date.<br><br>Where physiotherapy or other therapy is used, a system to monitor its effectiveness should be put in place.<br><br>Health services should be involved in this. | • The care plan review has highlighted service users who required physiotherapy. Referrals have been made where needed. |
| Feeding and swallowing plans were not always easily accessible. | Feeding and swallowing records should be made easily accessible and always available. | • The care plan and risk assessment introduced ensures a more detailed and thorough approach in this area – see above.<br>• All eating and swallowing plans have been reviewed using the old format and all plans are being transferred onto the new documentation.<br>• The Service and Sheffield Health & Social Care Trust have agreed that they will jointly carry out an audit across all services to check the number of people being assessed with eating and swallowing needs, the date of Speech and Language Therapy assessments and how medication is accessed and managed. |
| The Service was not checking enough for signs of depression or dementia. | Training should be delivered so that staff have an understanding of the issues of depression and dementia in people with learning disabilities.<br><br>Staff should work closely with health colleagues to develop tools to help identify issues and refer on appropriately. | • Staff will receive training on mental health and dementia during 2015 / 2016.<br>• Good practice information regarding dementia has been made available to all staff and team meetings regularly focus on this topic. |
| There were a significant number of errors and lack of up to date information in medication records.<br><br>There was an inconsistent approach to record keeping including receipt, dispensing and stock control.<br><br>A further review found that medication errors had not been alerted to safeguarding. | Records should be accurate, consistent and up to date. All information should be kept in service users' files.<br><br>A new system should be put in place to ensure records are accurate and consistent. Different ways of checking medication records should be trialled.<br><br>The style of record keeping used by pharmacists is recommended.<br><br>The risk caused by medication errors should be understood by all staff. | • A review of the medication documentation was carried out and a new range of documents is now in place.<br>• The Service now links in with the Council's medication steering group ensuring best practice is adopted and implemented in line with other services.<br>• Medication errors are reported and recorded. The Quality and Governance team will work out why errors happen to help make sure the process is improved.<br>• The current medication policy is being reviewed. |

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| Service reviews were overdue.<br><br>The Service review carried out for Warminster Road found standards to have been met. Two months later the Interim Head of Service found the premises to be so unsafe that they were immediately closed. | Service reviews should be carried out in every service area.<br><br>Senior management should review the reasons for the difference between the two assessments. | • An investigation into why service reviews were not carried out has taken place.<br>• Following a period of major changes, service reviews were arranged in every area from April 2015.<br>• Service plans are now complete for all parts of the service.<br>• An investigation into this issue was carried out and has now ended. |
| There was a lack of structure, systems, processes and consistency across services.<br><br>There was evidence of standard practice not being carried out properly. | Recommendations made elsewhere in this report should be carried out and any further gaps dealt with. | • Much work has been undertaken to ensure that systems are consistent across the Service. New ways of working have been put in place consistently across all service areas.<br>• The Service now has the same approach citywide and not locality based as it once was. Managers are working together in all areas to ensure there is consistent management. |
| There was concern about the changed arrangements for managing staff rotas. | The arrangements should be reviewed to ensure they work for staff and the Service. | • Work has been carried out to examine the current rota system to ensure it is working to benefit staff and the Service. |
| The two locality Area Managers were not working together and there was no evidence that this was being addressed. | Discussions should take place with the Deputy Head of Service, the Area Managers and relevant staff to understand this issue. | • An investigation was carried out and finished.<br>• The Service now operates citywide and not in areas (localities) so the risk of inconsistent approaches is reduced. |
| Staff morale was low, particularly in day services.<br><br>There was evidence that staff and managers were aware of poor practice but that nothing was being done to address this. | A clear plan should be put in place and shared with staff as soon as possible. The views and feelings of demoralised and demotivated staff should be listened to. | • Service planning days have taken place involving staff. Staff feel included in decision making.<br>• Changes have been communicated to staff through regular meetings. Attendance at meetings is monitored and staff can give feedback. Minutes of the meetings are available and accessible to all staff.<br>• Regular supervision sessions are scheduled with all staff. |
| Ligature risk was highlighted as an issue. | The Service should ensure that a risk assessment and policy is put in place. Attention should be given to ligature risk. Advice should be sought from Sheffield Health and Social Care Trust. | • The Council developed a risk assessment and this was put in place in April 2015. All risks identified are recorded and actions are being undertaken to address them. |
| Choking risk was not identified in care plans. | See above.<br><br>A review of care plans should be carried out to ensure any risk is identified and dealt with. | • A review of the care plans was carried out. The new care plan identifies risk. |

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| There were no First Aid plans in care plans. | This is good practice that should be adopted. | • A generic First Aid risk assessment is now in place.<br>• Service user issues, e.g. allergies to plasters, are in the risk assessment and hospital passports. |
| There was no protocol in place for the administration of PRN. | The Service needs to ensure that protocols are in place for PRN administration indicating why the medication is prescribed, and the symptoms for which the medication should be given. | • The new care plan has a section that covers this. |
| There was no record of discussions with service users about medication, why it was used and its side effects. | This point has been challenged as social care staff are not clinically trained to describe medication prescribed. | |
| There was no protocol in place for controlled drugs. | There were no recommendations. | • There are now clear protocols in place for the management of controlled drugs. These are in the medication policy, shared with staff through annual training and monitored through monthly medication audits. |
| Medication MAR sheets were A4 loose documents. | Sheets should be stored securely. | • All MAR sheets issued by a pharmacist are loose documents. To ensure the safe storage, all MAR sheets based at Warminster Road are now stored in a file for the residents. The file remains with the medication cabinet locked in a secure room.<br>• In supported living it is stored with the medication. |
| Some staffs medication training was out of date. | All staff must be trained each year. | • There is a rolling programme of training dates for the year.<br>• Staff will also receive a direct observation of their practice that includes medication administration. |
| The medication policy was being poorly followed. It seemed unlikely that the policy would become standard practice in the Service. | The current policy should be reviewed. | • The policy review was carried out. The Service is about to ask the medication steering board to approve a new policy.<br>• Following approval, the Service will ensure that all managers and staff understand the new policy. The implementation will be carefully managed through workshop sessions and the policy will form the basis of annual training. |