Dorset Healthcare University NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDY10	St Ann's Hospital	Chine Ward	BH13 7LN

This report describes our judgement of the quality of care provided within this core service by Dorset Healthcare University NHS 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 Dorset Healthcare University NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset Healthcare University NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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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Overall summary

We did not rate this service at this inspection.

- We inspected Chine ward as an unannounced, responsive inspection. The purpose of the inspection was to follow up specific concerns regarding patient safety. This was in relation to items on the ward that patients use to injure themselves and incidents involving ligature risks. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- The Care Quality Commission visited the ward in July 2016 as part of an investigation into the death of two patients. One death occurred in 2015 and the second death occurred in 2016. Both deaths related to ligatures.
- CQC undertook a scheduled Mental Health Act visit in March 2017. At this visit, the Mental Health Act reviewer had significant concerns about the safety of the ward. Staff continued to report a number of incidents involving patients using ligatures in an attempt to harm themselves. We found 21 incident reports dating back to January 2017 that staff had not reviewed and signed off. Twelve of these incident reports related to ligatures. At the time of inspection the trust did not have a time scale for signing off or reviewing incidents. The trust told us they are currently revising their policy.
- The Mental Health Act reviewer found a box of loose cables in a cupboard that patients could access. Patients could have used these cables as ligatures. This was a matter of concern because of the two deaths and a number of other incidents when patients who had used ligatures to harm themselves on the ward in 2016 and 2017. The Mental Health Act reviewer raised this with the manager who removed the box from the cupboard immediately. The Mental Health Act visit also found risk assessments were not always accurate and risks identified in the risk assessments were not always included in the care plans.
- At the responsive inspection in May 2017, we saw Chine wards environmental risk assessment. We found that that the trust did not have a robust system in place to ensure that staff checked the environment regularly for general non-fixed ward items that patients could use as a ligature, such as loose cables. However, we found that the trust managed fixed ligature risks well.
- At the responsive inspection in May 2017, we found that staff had removed the box of cables that the Mental Health Act reviewer had raised concerns about. However, we found additional loose cables in communal areas. For example, we found a single long cable in a cupboard in the patient's television room, and several electrical cables in the patients' computer room. We brought this to the attention of the manager who told us they did not know the single cable was there. The manager also checked with other staff members who confirmed they also did not know it was there, or whom it belonged too. Staff removed these cables whilst the inspection team were on site.
- We spoke with the consultant who told us that he had identified ligatures as an area of concern on Chine ward. He told us he had joined a trust group that looked at fixed ligature risks across the trust. The consultant told us he had attended one meeting by the time of the inspection and that he wanted to widen the remit of the group to take account of non-fixed ligatures and encourage other clinicians to attend.
- At the time of the the responsive inspection in May 2017, staff on the ward were was not reporting all incidents. We reviewed ten care records. We found several entries of actual self-harm. For example, one patient had attempted to strangle themselves several times in one day. Out of ten care records, we found that staff had not reported four incidents through the correct reporting process. One incident form had three separate incidents recorded on it, which could affect incident figures that staff submitted to the trust as staff reported these three incidents as one incident.
- Staff had not updated care plans following repeated ligature attempts. For example, one patient regularly used shoelaces in an attempt to strangle them self. Staff had not addressed this as a pattern of behaviour and staff told us they would not consider discussing alternative shoes with the patient, because they would

Summary of findings

just use something else, for example a t-shirt. We raised this with the trust senior management team who assured us they would review patient risk. The trust has submitted a plan with this as an action.

- In August 2016, the trust reported a death. A patient had used a plastic bag that the provider used for transporting laundry away from the ward, to suffocate herself. We discussed this with the ward manager who told us the clinical governance team had reviewed the incident and one of the lessons learnt was to revise the local prohibited items policy for Chine ward. The local policy now stated patients could not bring plastic bags onto the ward. At the responsive inspection in May 2017, staff told us that patients still brought plastic bags onto the ward when they had been shopping. However, staff said they would remove them if they found them and offer an alternative safer bag for patients to use.
- At the Mental Health Act visit on 31 March 2017, we found 21 incident reports dating back to January 2017 that the manager had not signed off. Twelve of these incident reports related to ligatures. At the responsive inspection on 03 May 2017, this had not improved. We reviewed incident reporting for the period of February 2017 to May 2017. We found that the manager had not signed off 14 reports. Four of these incidents reports related to ligatures.
- We raised this with the Trust senior management team who assured us they would review their current incident reporting policy. The trust provided us with an action plan of how they intended to mitigate any further risk to patients. This included how ward staff will ensure regular assessments of non-fixed ligature risks are carried out, how staff will be trained to carry out these assessments, and how the wards policy on incident reporting and learning from incidents will be improved, ensuring the ward is a safe place for patients.

We will return to the ward in due course to ensure that Dorset Healthcare University NHS Foundation Trust has implemented the actions identified.

Summary of findings

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

Are services safe? During this inspection we only looked at the safety of the ward environment and incident reporting under this key question.	
Are services effective? We did not look at this key question during this inspection.	
Are services caring? We did not look at this key question during this inspection.	
Are services responsive to people's needs? We did not look at this key question during this inspection.	
Are services well-led? We did not look at this key question during this inspection.	

Summary of findings

Information about the service

Chine ward was an acute ward for adults of working age. Chine ward provided treatment for women experiencing mental-health difficulties. The ward had 17 beds. At the time of the inspection, eight patients were detained on a section three of the Mental Health Act 1983, four patients were detained on a section two and a further patient was detained on a section 37. The remaining three patients were informal. Patients are usually transferred from Seaview ward, which is the admission and assessment ward within the trust.

There were three registered mental health nurses (RMN) and three mental health support workers (MHSWs) on the morning and afternoon shifts and one RMN and three MHSWs overnight. There were no staff vacancies at the time of the inspection.

The ward had gone through a significant refurbishment. The old four bedded dormitories now catered for two single rooms and there is access to outside space. There were a number of lounges and a dining room. There were now two outside areas, which patients could access. The hospital was a smoke free environment.

Our inspection team

Our inspection team was led by:

Team Leader: Sharon Dyke, Inspector (mental health) Care Quality Commission (CQC)

The team included one other CQC inspector

Why we carried out this inspection

This was an inspection of Chine ward only. We did not look at any other wards the trust provides under this core service.

We carried out this inspection following safety concerns raised by one of our Mental Health Act reviewers who visited the ward as part of our statutory responsibility to monitor wards where patients are detained under the Mental Health Act.

This responsive inspection was in relation to items on the ward that patients use to injure themselves and incidents involving ligature risks. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. For example, we found loose wires that patients could have used as a ligature.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited Chine ward and spoke with one patient who was using the service
- spoke with the ward manager
- spoke with the acute services manager
- spoke with 11 other staff members; including consultant psychiatrist, thehousekeeping staff, ward clerk, support workers, registered nurses and the nurse team leader
- observed the interactions between staff and patients and the care being provided.
- looked at ten care records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke with one patient at this responsive inspection. The patient told us they liked the staff team and that they felt they were well looked after by them.

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Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Chine Ward	St Ann's Hospital

Mental Health Act responsibilities

We did not review the responsibilities under the Mental Health Act 1983 at this inspection. These were reviewed as part of our Mental Health Act reviewers visit on the 31st March 2017. The trust will receive a separate report detailing those findings.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the responsibilities under the Mental Capacity Act at this inspection.

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

During this inspection, we only looked at the safety of the ward environment and incident reporting under this key question.

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

We did not look at this key question during this inspection.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

We did not look at this key question during this inspection.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

We did not look at this key question during this inspection.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

We did not look at this key question during this inspection.