

Dartmouth House







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

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

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

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

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

Summary of findings

Overall summary

The chief inspector of hospitals has decided to take Dartmouth House out of special measures. We previously inspected the service in August 2015 where we rated the service as Inadequate in each domain; safe, effective, caring, responsive and well-led and as Inadequate overall. Following our most recent inspection however, CQC has found that significant improvements have been made to the quality and safety of care provided and as such, we have rated each domain; safe, effective, caring, responsive and well-led as good.

We rated Dartmouth House as good because:

- All areas including the clinic were clean, well maintained and fit for purpose. The service had ligature risks but these had been risk assessed to increase the level of independence for patients and were risk assessed for individuals. Staffing levels met the needs of patients and the service only used agency staff who knew the service and patients. Staff training was up to date and staff were knowledgeable about the type of service they provided.
- Patients had care plans, which were detailed, and recovery focussed. Staff used National Institute for Health and Care Excellence guidance when prescribing and dispensing medication and staff

monitored patients physical health needs on a regular basis. Patients had access to a wide range of skilled staff including nurses, healthcare assistants, psychologists, occupational therapist and activities coordinators.

- Patients spoke positively about staff and the care and support they received. Staff showed good knowledge of the patients' needs and used this to build relationships based on trust.
- Patients had access to a wide range of rooms including a clinic and therapy rooms. Staff offered a wide range of activities seven days a week and patients contributed to the discussions about what should take place. Patients could access outside space when they needed to during the day. Patients could lock bedrooms and they had their own secure lockers in the communal area allowing them to be responsible for their own belongings such as mobile phones.
- Staff knew senior managers and said there was a culture where open discussion was encouraged. This helped to ensure staff morale and job satisfaction was high. Access to administrative staff allowed staff to maximise the time spent with patients.

Summary of findings

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Good 

Dartmouth House

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Our inspection team

The team was led by Matt Brute, Inspector Central West

The team comprised Two CQC Inspectors

Why we carried out this inspection

We inspected this core service as a follow up to an inspection that we undertook at this location in August 2015 when it was called Harriet Tubman House. At that time we rated all five domains as inadequate.

At that time we found that:

- The manager and operations director were not aware of the regulations that they needed to meet to ensure a safe service for patients.
- The hospital did not have effective procedures to ensure the safety of patients and staff and to mitigate any risks to them.
- Staff did not identify risks to patients' safety and take action to reduce them.
- Staff did not analyse incidents of harm or risk of harm so they could not identify trends and learn from them to prevent them happening again.
- Care plans and risk assessments did not show staff how to support patients.
- Staff did not demonstrate a good understanding of the Mental Health Act and Mental Capacity Act. This had resulted in inappropriate applications made to deprive patients of their liberty.
- Some staff did not engage with patients in a positive way to promote their wellbeing.
- The environment did not promote patients' recovery and ensure they were comfortable.
- The hospital had no governance structures to assess risks and the quality of the service to promote improvements.

- Builders were renovating the hospital at the time of our inspection and the managers of the service were not taking proper action to prevent avoidable risks to patients and staff. As a result of our concerns and those expressed by a Health and Safety Executive inspector, the provider suspended the work until patients could be moved to alternative accommodation.

At this inspection in 2015 we found breaches in several regulations:

- Regulation 9 of the 2014 HSCA regulations (person centred care)
- Regulation 10 of the 2014 HSCA regulations (dignity and respect)
- Regulation 13 of the 2014 HSCA regulations (safeguarding service users from abuse and improper treatment)
- Regulation 17 of the 2014 HSCA regulations (good governance)
- Regulation 18 of the 2014 HSCA regulations (staffing)

As a result of these breaches Harriet Tubman House was placed in special measures by the CQC November 2015. The organisation took the decision to voluntarily suspend services at Harriet Tubman House at this time and all patients were moved to alternative services.

A complete refurbishment of the building was undertaken and it was re-opened in July 2016 as Dartmouth House.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always 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?

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- Looked at the quality of the environment and observed how staff were caring for patients
- spoke with 3 patients who were using the service
- spoke with the service director and service manager for the unit
- Spoke with 5 other staff members.
- Looked at 5 treatment records of patients.
- Carried out a specific check of the medication management for the unit.

looked at a range of policies, procedures and other documents relating to the running of the service

Information about Dartmouth House

Dartmouth House is a long stay/rehabilitation unit for up to 16 men of working age. It is registered to provide care and treatment to people detained under the Mental Health Act. The philosophy of the service is to provide rehabilitation.

The unit opened in July 2016 and at the time of inspection had seven patients. They provide care for male patients only, aged between 18 and 64 years old.

This unit was inspected in August 2015 when it was called Harriet Tubman House. At that time its purpose was to provide care and treatment to women of working age with mental illness. We found failings in all five domains and it received an overall rating of inadequate. Options for Care, the provider, took the decision to voluntarily close the unit to undertake a full refurbishment. They also changed its statement of purpose from providing care for women to providing care for men.

As a result of the CQC placing this service unit into special measures, several meetings were arranged to discuss risk, forward planning and improvement. The engagement meetings involved staff from CQC, local authority, clinical commissioning groups and the provider.

The CQC and Options for Care undertook a schedule of monthly engagement meetings which were attended by senior management staff from the organisation, the relationship holder and the inspection manager from the CQC. These meetings allowed close monitoring of improvements.

The service had a registered manager at the time of our inspection

What people who use the service say

We interviewed three patients during our inspection. All patients were complimentary about the care they received. They stated that they felt that they were looked

after and the staff cared about their best interests. They were complimentary of the staff that provided their care, happy with the environment and stated that they felt safe.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- Dartmouth House was designed to provide patients with different levels of support depending on where they were in their recovery. Some areas had ligature risks, which had been risk assessed and were intended to reflect a patient's environment at home. These had been risk
- assessed for individuals and staff monitored this closely.
- The service only used agency staff who knew the service and patients to ensure continuity of care. This ensured the service did not have to cancel activities or patients leave.
- Staff completed risk assessments and regularly updated them. They used recognised tools for this process, which started prior to admission and continued throughout a patient's stay.
- Staff knew how to report incidents. Managers reviewed the incidents and gave feedback to staff in team meetings and individually so staff could share learning from this.

Good



Are services effective?

We rated effective as good because:

- Patients care plans were personal and recovery focussed. Staff documented if a patient had chosen not to participate in the process. Staff kept record in a locked cupboard in the nursing office and all staff could access them easily if needed.
- Staff had a range of skills and this gave patients access to a wide range of activities and therapies such as cognitive behavioural therapy and dialectical behavioural therapy. Staff monitored physical health care regularly and patients with additional physical health needs such as diabetes received support to manage this.
- Staff received a full induction, which included mandatory training and had access to a range of supervision including clinical, management and group supervision. Staff could access specialist training to support and enhance their role.
- The service had developed working relationships with outside agencies such as the local authority and patients care coordinators.
- All staff received training in the Mental Health Act and Mental Capacity Act and demonstrated understanding of how these applied to patients in their care. Mental health Act paperwork was complete and in date.

Good



Summary of this inspection

Are services caring?

We rated caring as good because:

- Staff treated patients with respect and showed a good understanding of patients likes and dislikes which helped to build relationships based on trust.
- Staff involved patients in their care plans where possible and patients received a copy to keep. Family and carers had been involved in the process with patients' permission.
- Patients had access to advocacy and staff knew how to refer them to this.
- Patients attended a daily diary meeting to discuss activities and the plans for the day with staff. The service also had a weekly patients meeting where wider issues could be discussed and patients concerns addressed by staff.

Good



Are services responsive?

We rated responsive as good because:

- Staff discharged patients from this service during working hours and at a time to suit the patient. There had been no delayed discharges.
- The service provided a range of suitably equipped rooms for treatment and therapies. Patients could lock their own rooms and had access to a secure locker in the communal area. They were encouraged to keep their own belongings such as mobile phones to increase independence.
- Dartmouth House had disabled access with wider doors for wheelchairs. They provided a range of information leaflets for patients and these could be printed in languages other than English if required. They had access to interpreting and sign language services.

Patients knew how to complain and staff offered support with this if required. Managers responded to complaints and discussed them with staff and patients.

Good



Are services well-led?

We rated well-led as good because:

- Staff knew the values of the organisation and demonstrated these through their working practices. Managers used the values in team objectives to ensure they were embedded throughout the service.
- Staff were motivated and demonstrated high levels of job satisfaction. They knew senior managers and felt they could talk to them at any time. They said they received a great deal of support to help them do their jobs.

Good



Summary of this inspection

- Managers encouraged staff to develop both personally and professionally by providing opportunities for development and specialist training.
- Staff gave feedback on the development of the service at team meetings and felt included in the decisions managers had made.

Detailed findings from this inspection

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.

Dartmouth House employed a Mental Health Act administrator to monitor and audit information relating to the Mental Health Act

At the time of our inspection Dartmouth House had seven patients. Six were detained under the Mental Health Act and one was informal.

We found no errors in the information contained within the patients care records. Information was stored in a paper format. This was stored securely and information relating to the Mental Health Act was given a separate section in the care record.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had considered the mental capacity of all residents in the unit. When it had been established that there was a lack of capacity, recognised tools had been used to provide evidence.

Where decisions had been taken for patients that lacked capacity, this had been done in the best interest of the individual and had considered their wishes and any cultural or religious factors.

All of the patients resident at the time of our inspection were detained under the Mental Health Act which meant that there had been no requirement to use the Deprivation of Liberty Safeguards (DoLS). There was a policy in place relating to the use of DoLS if it was ever required and the unit manager acted in an advisory role relating to its use. Staff were aware of how to make a DoLS application and had received training in this area.






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good 

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good 

Safe and clean environment

- The communal areas of the ward were laid out in a way that allowed staff to observe patients throughout the day. We observed that there were staff in the main seating area at all times. There were some blind spots in the bedroom corridors but these had been mitigated by risk assessments and working practice.
- Dartmouth House had three different bedroom styles in place. This had been done purposefully to slowly increase risk factors that would normally be found in the patients own homes as patients move through their recovery. There were ligature points present in the lounge areas and in the bedrooms that had been designated to have increased risk. These had been mitigated by individual risk assessments and regular ligature audits.
- Dartmouth House is a male only unit and as such complied with guidance on same sex accommodation.
- There was a fully equipped clinic room on site. All the equipment was regularly tested and in date. There was an emergency bag and resuscitation equipment and this had been checked regularly. There was also a process in place to monitor emergency drugs and replace as and when necessary.

- Dartmouth House did not use seclusion and did not have any facilities set aside for this purpose.
- All ward areas were clean and well-presented and all furniture was in good condition. We saw cleaning documentation that demonstrated that there was a plan in place to ensure that cleaning was undertaken. This included regular deep cleans in high traffic areas and patients bedrooms.
- Staff we observed adhered to infection control principles and there was hand sanitiser available for people to use around the unit.
- All equipment we checked was well maintained and, where required, had check stickers attached that were visible and in date.
- Environmental risk assessments had been undertaken. As the unit had only been open for three months there was no evidence that these were updated regularly but we were assured by the unit manager and staff that these would be undertaken as and when required.
- Staff had access to appropriate personal alarms. There was also an automatic alarm system in place in the outside areas that would inform staff of anyone trying to enter the property. This would also inform staff if patients tried to leave without first informing staff.

Safe staffing

- Dartmouth House employed nine qualified nurses, two band six and seven band five. Nine band three health care support workers, one psychiatrist, one clinical psychologist and an assistant psychologist. It also employed an occupational therapist, an activities

Long stay/rehabilitation mental health wards for working age adults

Good 

co-ordination and a Mental Health Act administrator. There were also two domestic staff, two chefs and one administrator. There were two vacancies for qualified nurses at band five.

- Staffing numbers had been estimated using national benchmarking of similar units.
- Agency staff were being used three or four times a week to cover the vacancies. The same staff were used for this and they were viewed as regular staff members at the unit. They had good knowledge of the patient group and working practices.
- The unit manager could adjust staffing levels daily or as a response to any identified need.
- We observed that there was always a qualified member of staff in communal areas of the unit.
- There was evidence in patients notes that there was regular one to one time set aside with their named nurses.
- We were told that leave and ward activities were never cancelled due to a lack of staff. If sessions were postponed due to an unforeseen need on the unit, there was evidence that these were rescheduled for a later time.
- All staff had been trained in the use of physical interventions. This meant that there was always enough staff should this be required.
- Medical cover was provided in the first part by the organisations consultant and middle grade doctor and then by GPs or through the local NHS trust. Emergency services would be called in the case of an emergency.
- All staff had undertaken induction training and as such compliance with mandatory training was at 100%. The mandatory training calendar was complete and had factored in specialist training specific to the unit such as management of violence and aggression and safeguarding. First aid training was not a mandatory requirement, however, a number of staff had been identified as first aiders for the unit and they were all up to date with training in this area.

Assessing and managing risk to patients and staff

- Dartmouth House did not use seclusion and there was no evidence that defacto seclusion had been undertaken since the unit opened in July 2016. There were no incidents of restraint recorded in the period from July 2016 to the date of our inspection.
- We looked at five out of seven care records during our inspection. They all contained up to date risk assessments. There was evidence that this process had been started pre-admission and the risk assessments were updated regularly.
- Staff used the short term assessment of risk and treatability tool.
- We did not find any evidence of blanket restrictions.
- There was a process in place that meant informal patients could leave at will. The front door was locked for security but this was manned by admin staff and patients could request that this be opened if there were no restrictions placed upon them.
- There were policies in place relating to the use of observations and searching patients. These were appropriate to the unit.
- Training in the safe management of violence and aggression incorporated verbal de-escalation techniques. We observed staff using good verbal communication and de-escalation during our visit.
- There had been no use of rapid tranquilisation at the time of our inspection.
- Staff were trained in safeguarding and were able to state to us when it would be appropriate to make a safeguarding alert.
- There was evidence of good medicines management protocols in place. Medication was stored and dispensed appropriately and there was a process in place to reconcile medication upon admission. We also found no errors in recording.
- We did not find evidence of a protocol to manage child visits on the unit but we were informed that these would take place off site if required following a full risk assessment.

Track record on safety

- There had been no serious incidents recorded between July 2016 and the date of our inspection.

Long stay/rehabilitation mental health wards for working age adults

Good 

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to make a report to management. They were able to state the types of incidents that they should report.
- All incidents that should be reported had been. There was recording of minor incidents such as verbal aggression and minor slips trips and falls that had not resulted in any injury.
- We saw good communication between staff and patients. They stated that they would explain to patients if things went wrong and include them in solutions if appropriate though we did not see any examples of this. None were recorded but this was due to the fact that the unit had only recently opened and there had not been a requirement.
- There were regular staff meetings in place which allowed the unit manager to feed back to staff. The unit manager and service director were also a visible presence on the unit and staff stated that they spoke with them daily.

We were told that there was a provision for staff debrief following an incident but to date this had not been required

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- There was evidence that assessments and care plan documentation was undertaken initially at the pre-admission stage and continued throughout the admission process. Assessment and care planning documentation was in order in all five sets of notes we viewed.

- Care records showed that a physical health assessment was undertaken as part of the admission assessment. There was also evidence that, where required, there was ongoing monitoring of any existing health conditions.
- Care plans were personalised and recovery orientated. Where it was possible there was evidence the patient had been involved in the care planning process. Where the patient had not been involved care plans due to refusal or other factors, the care plans were written in the third person. This allowed staff to quickly identify who had expressed their own ideas and opinions throughout the care planning process.
- Dartmouth House used a paper recording system at the time of our inspection. All documentation was well presented and formatted in a way that made it easy to find information. They were stored securely in a locked cupboard in the nursing office. All staff could access care records if required.

Best practice in treatment and care

- There was evidence that staff followed best practice guidance issued by the National Institute for Health and Care Excellence (NICE) when prescribing and dispensing medication. The NICE guidance was referenced by staff when we spoke with them.
- Dartmouth House had staff that are qualified to offer psychological therapies as recommended by NICE. These therapies included cognitive behavioural therapy and dialectic behavioural therapy.
- There was evidence in several care records that there was access to physical health care which included access to specialists when required. Several of the patients had physical healthcare requirements and these were all being managed appropriately.
- Consideration had been given to the individual nutrition and hydration requirements of the patients. This included foods that met with several of the patients cultural nutritional requirements.
- Staff used recognised ratings scales to assess and record the severity of outcomes. These included the short term assessment of risk and treatability and recovery star.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Qualified band five nursing staff currently undertake clinical audits under supervision by band six nurses. We were told that the health care support workers do not currently take part in audit but this is something that the organisation will address in the future.

Skilled staff to deliver care

- There was a full range of mental health disciplines at Dartmouth House. These included a psychiatrist, a psychologist, an assistant psychologist, an occupational therapist and activity co-ordinators. There was also evidence of partnership working with other organisations in the way that Dartmouth House had input from a local pharmacist and local authority social workers.
- Staff we spoke with were qualified for the role that they had been employed to undertake. Dartmouth House had also considered experience in its recruitment processes. This meant that though Dartmouth House had only been open a short time the staff there had a wide range of experience.
- Staff received an appropriate induction which included mandatory training.
- There was evidence that staff received annual appraisal. Some staff had come to Dartmouth House from other units in the organisation and had annual appraisals in place. There was also evidence that supervision was undertaken. This included group, clinical and management supervision.
- Though there was no target for supervision in organisational key performance indicators (KPIs), Dartmouth House had given supervision to 77% of its staff.
- At the time of our inspection Dartmouth House provided us with data that indicated that 63% of staff had been given an appraisal. This, however, did not take into account that 45% of staff were new starters and not due to have an appraisal at the time of our visit.
- There was evidence that, where required, staff had received specialist training to undertake their role.
- We found no evidence of poor staff performance relating to the period from July 2016 to the time of our inspection. There was evidence that staff performance

and disciplinary action had been undertaken relating to staff performance issues from prior to the period of closure and name change. This had been proportionate and appropriate.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary meetings took place weekly and documentation relating to these showed that they were effective.
- Handovers occurred at the start of every shift, morning and evening. There was also evidence that individual handovers occurred for staff that did not start at the same time as the nursing team, for example the assistant psychologist. These were complete and contained relevant information relating to each patient for the last 12 hours.
- We found evidence of effective working relationships with outside organisations. There was evidence that staff from other care teams, for example local social work teams, were invited to MDT meetings where appropriate.

Adherence to the MHA and the MHA Code of Practice

- All staff had undertaken training in the Mental Health Act (MHA). They were able to demonstrate good knowledge when we spoke with them. They were able to relate the guiding principles and how this related to the care that they provided.
- Consent to treatment and capacity was recorded in all care records we checked. In addition, all relevant documentation was attached to medication cards where required.
- There was evidence in care records that patients had their rights read and explained to them on admission or as soon as was possible after. This was repeated at intervals until staff were certain that the patient had understood and then repeated regularly thereafter.
- Dartmouth House employed a Mental Health Act administrator who provided support to staff and undertook regular audits of MHA paperwork.
- All detention paperwork was filled in and stored correctly.
- Dartmouth House use independent mental health advocacy services (IMHA). At the time of our inspection

Long stay/rehabilitation mental health wards for working age adults

Good 

this service was rarely used but was available for patients to access as and when required. Information relating to IMHA services was posted on noticeboards around the service.

Good practice in applying the MCA

- All staff had undertaken training in the Mental Capacity Act (MCA) and were able to relate how it impacted on their day to day delivery of care.
- There was evidence in care records that capacity had been considered in all cases and, where required, capacity was assessed and recorded appropriately. This had been done on a decision specific basis and patients were given every possible assistance to make specific decisions for themselves before they were assumed to lack capacity.
- Where decisions had been made for an individual, they had been made giving consideration to the best interest of the patient taking into account the persons wishes, feelings, culture and history.
- Staff understood the MCA definition of restraint and were able to apply this to their day to day working practices.
- Staff were able to get guidance and advice on both the MHA and MCA from the organisations MHA administrator. There was also good experience of managing MHA and MCA issues at senior management level.
- There had not been any Deprivation of Liberty Safeguards applications made between July and the time of our inspection.
- There were measures in place to monitor adherence to the MCA within the organisation. This included regular audits by the MHA administrator and overview by senior management.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good 

- We observed staff interacting with patients. They were respectful and responsive to patients. They had developed rapport and had good knowledge of the patients likes and dislikes and could engage them.
- All patients were positive about staff when we spoke with them. They were complimentary and stated that they felt the staff were supportive and helpful.
- Staff could talk at length about the individual needs of each patient. In this they considered their health and were knowledgeable about the care plans for each patient. They could also talk in detail about the cultural and historic needs of the patients and had good knowledge of their histories.

The involvement of people in the care they receive

- Admission processes orientated the patients to the unit. A member of staff was nominated to help each patient settle in. this included talking the person through the day to day processes, conducting a tour of the unit and introducing them to the other patients.
- There was evidence in the care records that, where possible, patients had been actively involved in the development of their care plans. Patients were provided with a copy of their care plans and were encouraged to maintain independence wherever possible.
- Advocacy services were provided by Voiceability.
- We found evidence in care notes that, where possible, carers and family were involved in planning of care. They were also involved in the admission process so that a full history could be built up.
- Dartmouth House had a diary meeting every morning with the patient group to look at what would be happening throughout the day. This meeting included asking the patients to raise any issues or concerns. There was also a weekly patients meeting to look at wider issues on the unit.
- At the time of our inspection patients were not involved in recruitment or the wider running of the service. This was due to the acute nature of the patients group. We were informed by the service director that, as the patient group becomes more settled, options for care will revisit this issue.

Kindness, dignity, respect and support

Long stay/rehabilitation mental health wards for working age adults

Good 

There was evidence that patients have advanced decisions in place relating to their care. These were recorded in patients notes and it was clear, from the way that notes are written, that these were the patients own views.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

- The unit opened in July 2016 with one patient. This had steadily increased to seven patients at the time of our inspection.
- There were no out of area placements due to the nature of the service.
- This unit does not have a catchment area and provides independently funded beds.
- Due to funding the bed is always available on return from leave.
- We were informed by staff and management that discharges would only occur between the hours of nine to five, Monday to Friday.
- Psychiatric intensive care and other specialist services would be provided through local NHS trusts.
- There was no evidence of delayed discharges between July 2016 and the time of our inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and equipment to support treatment and care. There was a fully equipped clinic room, several therapy rooms and a visitors room.
- An area had been set aside where patients could meet with visitors away from the main patient areas.
- Patients were able to keep their own mobile phones. In cases where they did not have a phone they could ask to use a phone in private.

- There was a large open air area at the back of the unit that the patients could access throughout the day. This area was closed at night for security reasons.
- Food was prepared on site by two chefs and was of a good quality. There was a range of meals available.
- Patients could make hot drinks 24/7 and there was access to fruit and biscuits outside of meal times.
- Patients were able to personalise their bedrooms with pictures, posters and their own furniture providing this was safe.
- Patients were able to lock their bedroom doors and also had access to a secure locker in the communal area of the unit.
- Activities took place throughout the day, seven days a week. These activities had been planned to engage the patients. Consideration had been given to the likes and dislikes of the patients when delivering sessions.

Meeting the needs of all people who use the service

- Adjustments had been made for people requiring disabled access. When the unit had been refurbished, consideration had been given to disabled access. Wider doors had been fitted to communal areas and there was a disabled toilet and washing facilities. There were doors with access ramps in and out of the building.
- There were information leaflets relating to the service and other services available in the local area. These were all printed in English but we were informed they would be made available in other languages if required.
- There was information posted around the unit on notice boards. This information related to subjects ranging from advocacy, complaints, local services and patients' rights.
- Options for Care use a local interpreter service which includes access to someone who can sign.
- Consideration had been given to the religious and cultural requirements of the patients in developing the food menu.
- Spiritual support could be accessed in the local community if required.

Listening to and learning from concerns and complaints

Long stay/rehabilitation mental health wards for working age adults

Good 

- There had been one complaint in the period from July 2016 to the date of our inspection. It related to the food available and had been addressed by the chefs.
- Patients stated that they knew how to complain and felt that they could if necessary.
- Staff could talk us through the process that would be used if a patient wanted to make a complaint.

We were informed by the management of the unit that staff would receive feedback concerning complaints at handover, staff meetings or individually if required.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good 

Vision and values

- Staff we spoke with knew and understood the organisations values and agreed with them.
- Team objectives, staff development and current projects all reflected the organisations values of improvement.
- Staff all knew who the most senior managers were. They stated that they had developed good relationships with them and they were a visible presence on the unit.

Good governance

- All staff received mandatory training. Compliance with the organisations own targets in this area had been achieved and at the time of our inspection mandatory training figures were at 100%
- Staff were regularly supervised and appraised. This was an ongoing piece of work but the organisation was compliant with its own key performance indicator (KPI) relating to appraisal rates.
- There was an admin team on site to manage day to day administration and paperwork. This meant that care staff could maximise their time on care delivery.
- Qualified staff took part in clinical audit. There was also a plan in place to involve other members of the staff team in the future.

- Safeguarding, MHA and MCA procedures were all followed.
- The organisation had developed a set of key performance indicators (KPIs) to monitor its performance. These were in an accessible format and staff who used them understood them. There was evidence that action plans had been formulated using the information gathered through measuring performance.
- The ward manager stated that they felt that they had enough authority to do their job.

Leadership, morale and staff engagement

- The sickness rate between July 2016 and the date of our inspection was 3.5%. There had been no unauthorised absences for the same time scale.
- There had been no bullying or harassment claims at the time of our inspection.
- Staff stated that they knew how to use the whistle blowing process and would feel confident to do so if required.
- Staff all stated that they felt confident to raise concerns without fear of victimisation.
- Staff morale and job satisfaction was high at the time of our inspection. All staff we spoke to stated that they enjoyed working within the organisation and were very positive about Dartmouth House and Options for Care as a whole.
- There were opportunities for development and this included leadership development.
- We observed team working and staff supporting one another in the day to day delivery of care.
- Staff were offered the opportunity to give feedback at staff meetings and were invited to give input into service development.

Commitment to quality improvement and innovation

- There was evidence that Dartmouth house had used nationally recognised improvement methodologies in the development of care delivery. Staff and management could reference Department of Health and NICE guidance documents when talking about improvement.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Dartmouth House was not involved in any national quality improvement or research projects at the time of our inspection.

There was a patient at Dartmouth House who was using a self-medication programme. The process and policy that

had been created for this purpose was of a high standard. It was clear what the expectations were for staff and the patient. Contingency had been built in to allow for monitoring and suspension of the programme and the patient had been involved in the development of their plan.