Good

Dorset Healthcare University NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

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)
RDYFX	Nightingale House	Nightingale House	BH14 8EP
RDYFX	Nightingale Court	Nightingale Court	BH14 8EP
RDYFX	30 maiden castle road	Glendinning Mental Health Rehabilitation Unit	DT1 2ER

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.

Summary of findings

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	Good
Are services safe?	Requires improvement
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 / 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

Contents

Summary of findings

Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as good because;

- Staff on the three wards used safe procedures to manage medicines. Staff maintained emergency equipment to a high standard. Staff completed medicine audits in line with trust policy. All healthcare support workers that witnessed the administration of controlled drugs had completed the trust competency framework to enable them to do so safely.
- Staff on all three wards provided patients with a full and comprehensive programme of therapeutic, recovery focused activities. Staff on Glendinning ward had created a new arts and crafts room and had audited the success of its patient led activities programme. Activity plans were patient led and designed around personal needs and choices.
- Learning took place after incidents. The trust had introduced a new policy regarding legal highs. This and some collaborative work with the local police had significantly reduced the number of incidents regarding legal highs on the wards.
- Patients we spoke with told us that they knew how to make a complaint and felt confident that staff would listen to them. Staff knew and understood how to use the trusts complaints procedure. Since our last inspection (June 2015) there had only been one complaint submitted across all three services.
- Risk assessments were completed on admission and reviewed after every incident and during care programme approach (CPA) meetings.

However

- On both Glendinning ward and Nightingale House there were multiple ligature points. We were concerned that the management of ligature risks was not robust.
- Department of Health guidelines on same sex accommodation were not being followed on the ground floor of Nightingale Court. Female patients had to cross male areas to use bathroom facilities. There was no female only lounge. However, the bedroom areas on the lower ground floor did comply with single sex accommodation guidelines.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Both Nightingale House and Glendinning ward had multiple ligature points. These were present in both communal areas and within patient bedrooms. Since the last inspection, the risk assessments have been updated but work to resolve some of the risks, including items rated as high risk had not been completed. While we saw financial quotes for the work, there were no plans to start or completion dates indicated. The trust continues to mitigate the risk of ligatures by risk assessments and increased observation. However, at Nightingale House we were concerned that the management of ligature risks was not robust.
- Nightingale Court did not meet the requirements set out in the Mental Health Act Code of Practice guidance for same sex accommodation. Whilst the ground floor could be used for either male or female patients, two male and one female patient currently occupied it. Whilst the female patient had access to her own toilet, to use the bathroom facilities she had to cross areas occupied by male patients. On Nightingale Court there was no female only lounge. Whilst a capital bid had been submitted we were told that it had not been accepted.
- On Glendinning ward, there were alarms in only some of the patient rooms and bathrooms and none in communal areas. This made it difficult for patients or staff to raise the alarm in an emergency. One patient told us that they were concerned that there was no alarm in their bedroom or bathroom, as they felt vulnerable if they should fall or have an accident.
- On Glendinning ward, we found out of date medication in the clinic room fridge which belonged to the community team. Staff told us that the clinic room was shared with the community team based in the office next door and were therefore not able to say who had been responsible for the medicines.

However:

- Staff completed risk assessments on admission, and reviewed them during care programme approach meetings and after an incident.

Requires improvement

Summary of findings

- All three wards had fully equipped clinic rooms with accessible resuscitation equipment. They had emergency medicines that were checked regularly. On Glendinning unit there was now a resuscitation trolley in place. We found that the contents were checked daily and well maintained.
- Learning took place after incidents. Nightingale House worked in conjunction with the local police to address the issue of distribution of legal highs in the area. This had significantly reduced issues of substance misuse across the wards.
- With the exception of the out of date medication on Glendinning ward, there were procedures in place for safe medicine management.

Are services effective?
Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Good

Are services caring?
Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Good

Are services responsive to people's needs?
We rated responsive as good because;

- There was a comprehensive list of activities, which ran over a seven day period, designed around what patients told staff they wanted. On Glendinning ward staff followed the occupational therapy complex care pathway. Staff completed a personal programmes audit in November 2015. Staff and patient feedback from this audit was overwhelmingly positive.
- Staff in all three wards knew how to support patients who wanted to make a complaint. All staff that we spoke with knew the trust complaints policy and procedure. Patients on all three wards told us they knew how to raise a complaint and how they would receive any feedback about the complaint they had made. The patient welcome packs included information on how to make a complaint.
- Patients were mostly complimentary about the quality and range of meals available on the wards. There was a varied menu so patients with particular dietary needs could eat appropriate meals.

Good

Summary of findings

- Patients across all three services had direct access to outside space.

However

- Whist a screen had been put up on the glass-panelled door on Glendinning ward for the privacy and dignity of the patients, the clinic room was shared with the community team via direct access onto the main ward corridor. Therefore, patients using the community services and all the community team could see the full length of Glendinning ward and could compromise patients dignity and privacy.

Are services well-led?
Not inspected – see previous report published in October 2015 where this was rated Good

Good

Summary of findings

Information about the service

Dorset HealthCare University NHS Foundation Trust provides an inpatient complex care and rehabilitation service, which supports patients with complex, enduring and severe mental illness to regain their independence prior to integrating back into the community.

Nightingale Court is a 13 bedded unit and Nightingale House is a 16 bedded unit. These services are located in East Dorset. The Glendinning Rehabilitation service consists of a nine bedded unit and is located in West Dorset. The wards were all mixed sex.

Patients who use the rehabilitation services predominately live in the county of Dorset but patients from outside the locality can also be admitted to the service. All three wards worked closely together. The staff from the wards meet regularly with the service manager to discuss patients requiring admission to determine the most suitable ward for each patient.

Our inspection team

Team leader: Gary Risdale, Inspection Manager, CQC

The team that inspected Nightingale Court and Nightingale House comprised:

- a Care Quality Commission Inspector
- a Mental Health Act Reviewer

The team that inspected Glendinning ward comprised:

- a Care Quality Commission Inspector
- a Mental Health Act Reviewer
- a pharmacist specialist advisor

Why we carried out this inspection

We carried out this focussed short notice announced inspection to review the progress the trust had made following our comprehensive inspection in June 2015. In that report we rated two key questions for wards for long stay rehabilitation wards as requires improvement. We published the report from the comprehensive inspection in October 2015.

We issued two requirement notices because we found that the trust was in breach of Regulation 10 and12 of the Health and Social Care Act (2008) (Regulated activities) Regulation 2014.

We said the trust must take action to address the issues we identified in respect of each regulation:

Regulation 10

The trust must ensure that patients' privacy is respected at all times by reviewing the glass panelled door at Glendinning ward and the use of the treatment room as an activity room in Nightingale Court

Regulation 12

The trust must protect patients against the risks associated with the unsafe use and management of medicines on Glendinning ward by ensuring the record of the administration of medication is accurate.

The trust must ensure that ligature risks are appropriately managed in Nightingale House.

This inspection reviewed the progress the trust had made.

How we carried out this inspection

Summary of findings

We undertook a focussed inspection of the areas where we had identified the need for improvement. We only re-inspected the key questions that we had rated as requires improvement and this report details our findings related to;

- Is it safe?
- Is it responsive to people's needs?

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

During the inspection visit, the inspection team:

- visited all three of the wards and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with eight patients
- spoke with the managers for each of the wards
- spoke with 11 other staff members; including doctors, nurses, support workers and therapists
- spoke to one service manager
- looked at 13 care records
- at Glendinning ward we carried out a detailed check of medicines management.

What people who use the provider's services say

We spoke with eight patients. Across all three wards, the comments were mostly positive about the care received in the rehabilitation service. Patients felt involved in their care and were happy with the support they received from staff.

Good practice

- Staff on Nightingale House had been working collaboratively with the local police on a pilot scheme to address the issues around legal highs on the ward. Staff explained the detrimental effect of legal highs on the patient group and the effect it had on the local community. The police approached the local shop that sold legal highs and explained that they could be served with a community protection order and a large fine. The shop handed over all its legal highs to the police. The ward set up a focus group for patients. Staff told us that the incidents with legal highs had reduced significantly, from more than five a month to one and sometimes none each month. There was now a new standard operating procedure in place across the trust. Staff had found no legal highs on Glendinning ward since the new policy had been implemented.
- On Glendinning ward, the team had audited the progress made since instigating the new occupational therapy programme. Feedback from the patients was overwhelmingly positive and patients said they felt involved.
- Glendinning ward had transformed a disused room, previously only accessed from the outside, into a dedicated art and crafts room. This greatly benefitted the patients.
- The dining room and kitchen on Nightingale Court had been knocked through to provide a large and airy space that could be used for group activities. This encouraged patients to become involved in more activities.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve long stay rehabilitation mental health wards for working adults

- The trust must ensure that prompt action is taken to mitigate the risk posed by potential ligature points on both Nightingale House and Glendinning ward, especially bedroom areas.

Summary of findings

- On Nightingale Court, the trust must ensure it meets the requirements set out in the Mental Health Act Code of Practice in respect of same sex accommodation.

Action the provider SHOULD take to improve

- The trust should ensure that staff monitors the contents of the shared fridge in Glendenning's clinic room to ensure safe medicines management.
- The trust should ensure that the planned works to install alarms in the communal areas of Nightingale House are completed promptly. The trust should install alarms in the communal areas and remaining patient bedrooms and bathrooms on Glendinning ward.
- The trust should review the use of the shared clinic room by the community team staff and patients as access to the clinic is directly via the main Glendinning corridor.

Dorset Healthcare University NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Glendinning Mental Health Rehabilitation Unit	30 Maiden Castle Road
Nightingale House	Nightingale House
Nightingale Court	Nightingale Court

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.

Not inspected – see previous report published in October 2015

Mental Capacity Act and Deprivation of Liberty Safeguards

Not inspected – see previous report published in October 2015

Requires improvement

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

- The ward layout in Nightingale House, Nightingale Court and Glendinning enabled staff to observe all parts of the ward. In Glendinning ward, there was a CCTV system in operation in all communal areas and a CCTV policy was in place. At the last inspection in June 2015, we were concerned about the vulnerability of patients using the upstairs bathroom in Nightingale House. We found that staff could not observe the upstairs bathroom used by male patients at the very end of a long corridor as it was outside the main thoroughfare. There were multiple ligature risks and the flooring had many burns from cigarettes indicating patients used the room to smoke unobserved by staff members. The area smelt of residual smoke and there was no alarm to alert staff should patients place themselves at risk or become unwell. At this inspection in March 2016, the manager had arranged for CCTV to be installed in communal areas, including corridors. Staff told us that the work had started and would be completed in the next few weeks. We saw that the bathroom flooring had been replaced and some of the ligature risks had been addressed.
- Both Nightingale House and Glendinning had multiple ligature points. At the June 2015 inspection of Nightingale House we found 51 ligature risks. Since that inspection the manager had updated the risk assessment with the aid of staff from the trusts health and safety department but the work to resolve some of the risks, including items rated as high risk, had not been completed. The manager at Nightingale House told us that they had completed a capital bid for the work and was awaiting the decision on this. There were letters from estates staff to contractors to get quotes for the work. However, there were no dates set for completion. The service manager emailed the manager to say that the work had been agreed but no date for completion had been set. The trust risk register, seen at inspection, had a review date of December 2017. On Glendinning in one patient's bedroom the risk assessment in both 2015 and 2014 had identified bathroom doors as being high risk. Since the 2015 inspection a patient had tried to harm themselves using the door as a ligature. We were concerned that the matter had not been resolved promptly following this incident. We brought it to the attention of the trust who assured us that this would be actioned immediately.
- All staff we spoke with on all three wards, knew where the ligature cutters where located. They were able to describe the technique for using the cutters.
- Nightingale House and Glendinning met the requirements set out in the Mental Health Act Code of Practice guidance on same-sex accommodation but Nightingale Court did not. On the ground floor of Nightingale Court there were three patient bedrooms close to the office. These were for patients who required greater observation from staff observations due to their increased risk. Two of the bedrooms were next to each other in a small side corridor. On the same corridor, there was a wet room with a shower and toilet. On the day of inspection both bedrooms were occupied by male patients. The manager told us the rooms were either both occupied by males or occasionally two females making the side corridor exclusively for one gender. There was another small side corridor with a single bedroom, a separate toilet and a cleaning cupboard. A male patient occupied this room at the last inspection making the entire area exclusively occupied by male patients. However, a female patient occupied this bedroom during this inspection. She had access to her own toilet as it was in an adjacent room but had to use the female bathroom downstairs to have a shower as the wet room on the floor was being used by male patients. To do this she had to cross areas occupied by male patients. We spoke with the female patient who said she would prefer to shower on the same floor as her bedroom.
- The building did not have a separate lounge for female patients, so female patients shared the lounge with the male patients. The manager told us that plans for a female only lounge had been submitted via a capital bid but had recently found out that this had not been accepted. The manager said they intended to put in another bid for next year (2016/2017).

Requires improvement

Are services safe?

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

- All three wards had a fully equipped clinic room with accessible resuscitation equipment. All had emergency medication that staff checked regularly. At the last inspection (June 2015), we found that in Glendinning there was no grab bag for use in an emergency and the suction machine was not available in the clinic room. At this inspection, we found these were now in place. On Glendinning ward there was a resuscitation trolley in place. We found that the contents were fully checked daily, well maintained and the contents were in date. Pharmacy replaced medicines if staff had opened the box and this was now standard operating procedure. Oxygen cylinders were full and in date.
- The ward did not keep flumazenil (used to treat patients who experience an adverse reaction to benzodiazepines) as doctors had not prescribed injectable benzodiazepine to any of the patients at the time of inspection.
- None of the wards had a seclusion room.
- All wards seen were clean, had good furnishings and were well-maintained. Patients told us that the standard of cleanliness were generally good. Staff completed regular infection control and prevention audits to ensure that both staff and patients were protected against the risks of infection. Staff in Nightingale House and Nightingale Court carried hand sanitiser to ensure their hands were clean. Staff at Glendinning used wall mounted soap dispensers. The manager at Nightingale Court said that the wall mounted soap dispensers were not in use as the soap contained alcohol which posed a potential threat to patients.
- Some of the patient-led assessment of the care environment (PLACE) scores for wards were above the national average. Nightingale Court (89%) and Glendinning (90%) scored above average in privacy, dignity and wellbeing. Glendinning scored above average in both food (90%) and ward food (95%).
- Staff undertook environmental risk assessments regularly in all three wards. For example, in Glendinning there were weekly mattress audits and monthly sofa cover audits to ensure they were hygienic and clean. In Nightingale House there was a falls risk assessment about the risks associated with the raised floor level in one corridor. There was also a monthly audit of the window restrictors to ensure they were working correctly. There was also a prompt sheet for support workers to remind them about checking the environment. This ensured staff kept communal items like the dishwasher and tumble dryer clean by either cleaning it themselves or encouraging patients to do so.
- Patients did not have access to appropriate alarms and nurse call systems. Information from the manager, and records we reviewed confirmed that alarms were being placed in the corridors and communal areas in Nightingale House in the next three weeks (post this inspection). The manager told us that this risk was managed by hourly staff observations. More frequent observations were carried out on patients who had been assessed as a higher risk. In Glendinning ward, there were no alarms in patient rooms or communal areas for patients to call staff in an emergency. One patient told us that they were concerned there was no alarm, as they felt vulnerable should they fall or have an accident.

Safe staffing

- There was a full complement of registered nurses across all three wards. The staff sickness rate had decreased over the last 12 months across all three wards.
- Generally, the wards covered all the shifts. However, the wards were unable to cover 10 shifts across all three wards over the three-month period prior to the inspection due to staff sickness. Staff told us that bank staff covered the majority of shift vacancies and that in the event of needing agency they would always try and request staff that were familiar with the ward.
- There were no episodes of section 17 leave being cancelled across all three services due to lack of staffing.
- There was a comprehensive training program in place with 97% of all staff across all three services having completed their mandatory training. 53% of staff across all three wards had been trained in basic life support.

Assessing and managing risk to patients and staff

- None of the wards had seclusion rooms and there were no incidents of seclusion in the last six months.
- Staff showed us the new policy for the management of legal highs and staff we spoke with were able to explain it to us. On all three wards, there were posters on the walls explaining the systems in place. Staff at Nightingale House told us that prior to the new policy, incidents regarding legal highs happened frequently.

Requires improvement

Are services safe?

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

However, since its introduction there had only been five incidents of legal highs on the ward. There were no incidents of legal highs on Glendinning. Nightingale House worked in conjunction with the local police to address the issue of distribution of legal highs in the area.

- We looked at four patient records on both Nightingale Court and Nightingale House and five patient records on Glendinning. We saw evidence in all the records that all the patients had a risk assessment on admission and staff updated this regularly. Staff updated risk assessments depending on the patients' needs and following any incidents.
- There were no blanket restrictions in place across all three wards.
- We reviewed ward practice for medicines management on Glendinning ward. We found that there were robust practices in place to ensure patients safety. Managers had introduced measures to reduce the number of missed signatures on prescription charts that had significantly reduced the number of gaps. Routine access to medication was restricted to trained nurses. Health care assistants across all three wards had undergone training to witness the administration of controlled drugs.
- We saw evidence that there were low accurate stocks of medication on the ward and these were checked regularly in line with policy. We saw that staff ordered controlled drugs for individual patients and not as stock and these were ordered in a timely manner. A doctor countersigned all orders for controlled drugs. We saw evidence that pharmacy staff conducted routine delivery of stock to the ward but there was also good access to medicines at other times. Staff told us that expired medication was placed in pharmaceutical waste bins on the unit and controlled drugs were denatured using approved kits. However, we found expired inhalers for a patient on the ward and a lorazepam injection in the fridge in the treatment room that the community team shared with the ward.
- There was low incidence of missed doses of medication seen on inpatient prescription charts; with any gaps highlighted by the pharmacist and reported via incident forms. When shifts changed, a nurse from each shift would review all the medicine charts together to check for missed signatures. This had significantly reduced the number of gaps and there had been only one gap highlighted in last four weeks by pharmacist.
- There was a five-stage self-administration of medicines scheme in place, with a risk assessment for each patient. Staff moved patients along the stages when appropriate to do so. The aim was for patients to be completely self-administering medicines by the time of discharge. Where concerns had been raised, individual arrangements had been put into place. Staff dispensed medicines into seven-day blister packs to facilitate the self-administration scheme.

Track record on safety

- There were no reported serious incidents on any of the wards since the last inspection.
- Staff reported information about adverse events or incidents on the trust's electronic incident recording system. This was regularly reviewed on the ward and was discussed by the staff team in multidisciplinary team meetings. Information about serious incidents that occurred outside the ward were emailed from the trust and discussed at staff meetings.

Reporting incidents and learning from when things go wrong

- Staff we spoke with across all three wards knew how to recognise incidents and demonstrated they understood the process to report them on the trust's electronic incident recording system. Ward managers reviewed and monitored all incidents and forwarded details to the trust.
- The ward managers on all three wards explained how they maintained an overview of all incidents reported on their wards. There were changes made because of learning from incidents. At Nightingale House, staff had set up a substance misuse group to provide additional support to patients regarding legal highs. In addition, the local fire brigade had visited Nightingale House to talk to patients and staff about the dangers of smoking in bed.
- Staff and patients on all wards told us they felt the trust had provided sufficient support and time to talk about the impact of incidents on the ward. For example, in Nightingale House staff had access to external

Requires improvement

Are services safe?

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

debriefing experts. The trust investigation lead also offered staff support. There was a new incident reflection form for all wards. Staff and patients gave feedback and received support regarding an incident.

- On Glendinning ward, we saw evidence of a staff debrief following a ligature incident. Staff showed us documented evidence of the incident, how it had been addressed and the lessons learned.

Are services effective?

Good

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

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Good

Are services caring?

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

Our findings

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Information provided by the trust and the ward data confirmed that a bed was available for patients requiring admission based on their clinical need. The occupancy rate for the period January 2015 to June 2015 at Nightingale Court was 100%, Nightingale House was 91% and on Glendinning ward 90%.
- There were few out of area patient placements in the service. In the last six months there had not been any across all three wards.
- Admission information confirmed that patients usually stayed for up to a two-year period although this was variable across the wards. Patients in Glendinning ward had shorter lengths of stay. These patients required less support and were moving towards independent living. Patients who required more support where accommodated at Nightingale House and they were more likely to remain for longer periods. In Nightingale Court there had been three discharges since the last inspection. All three wards actively worked towards discharging patients and to ensuring they could live as independently as possible, depending on their individual needs.
- Patients could have weekend leave to visit home. Staff and patients confirmed that on all wards patients always had access to a bed on return from leave.
- Patients were not routinely moved between wards during an admission episode unless there was a clinical need or a medical emergency. In such cases, the patient may be taken to an accident and emergency (A&E) for assessment and possible admission to a general hospital. In Glendinning, there were two occasions in the last year that patients had been moved from the trust's acute inpatient wards to free up beds but we were assured that this happened infrequently.
- Staff told us that once discharge had been agreed, patients and their relatives decided upon the actual time of discharge to suit their personal needs. Information from the trust said that there were no delayed discharges for all three wards. However, staff members on the wards told us discharge could be delayed. For example, if patients were waiting for funding for placements in the community to meet their specific assessed needs or if placements were difficult to find.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients' privacy was not always maintained. At the June 2015 inspection, we saw that in Nightingale Court, the treatment room was also being used as the activity room with the room being divided only by a curtain. On the day of that inspection, patients involved in an activity could hear a staff member taking medical observations of a patient behind the curtained area. During this inspection, the manager and staff team confirmed this was no longer the case. They had worked with the staff team and discussed the matter at staff meetings. At the June 2015 inspection of Glendinning ward, the premises were on the ground floor of a building shared with other teams in the trust. There was a dividing door between the ward and the corridor of one team's workplace. The door was glass panelled so patients in any state of undress could be easily seen by staff or visiting members of the public. At this inspection, we saw that patients could no longer be observed, as there was a screen in place. The clinic room was shared with the community team who were able to access Glendinning ward via an adjoining door into the main ward corridor. People who used services and staff from the community team office had to go onto the ward to enter the clinic room and were able to see Glendinning patients in any state of undress which could compromise patients dignity and privacy.
- At the June 2015 inspection, patients expressed mixed views about whether there were enough high quality activities on offer. There was a range of therapeutic activities available, on both an individual and a group basis. However, on Glendinning ward activities, such as cooking groups, had only recently started and patients complained of being bored. However, since that inspection, Glendinning had transformed a disused room into an art studio and a full time occupational therapist had been employed. At this inspection, there was a comprehensive list of activities over a seven day period designed around what patients told staff they wanted. These varied greatly, from groups such as getting to know horses and pamper groups, to the

Are services responsive to people's needs?

Good

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

'fakeaway' group, which encouraged patients to make healthy home cooked versions of take away meals. Staff followed the occupational therapy complex care pathway and, in November 2015, a personal programmes audit was completed. Feedback from both patients and staff showed an overwhelming positive result. We saw evidence of individual activity plans on Nightingale Court that were designed around the patient's goals and interests. Staff showed us evidence that they used the model of human occupation as a way of individualising each patient's activity plan and had completed a formal assessment after four weeks to make sure the patients using the service were happy with their plans. On Nightingale House there was a full and comprehensive range of activities displayed on the notice board.

- The three wards had a range of rooms and facilities, including areas for activities, therapeutic interventions, clinics, kitchens and communal areas. There had been some renovation work since the 2015 inspection. For example, on Nightingale Court there was a large open plan dining area where staff and patients could eat together and undertake activities. Activities included baking, an occupational therapy led cookery group and a shabby chic group where patients restored furniture. We spoke with two patients who had been present at the last inspection and they all said the range of activities had increased significantly since the last inspection. Patients spoken with confirmed this was a useful space and said that watching other patients cook encouraged them to have a go at cooking. They felt it made the whole process a social experience. At Glendinning ward, there was a new activity room that opened into the garden. We saw it was full of patients art work and patients confirmed it was well used. The ward had purchased a good range of art materials and patients told us they enjoyed the groups. The ward had also started a gardening group where patients were encouraged to grow their own produce such as potatoes.
- There were no dedicated quiet rooms on the wards so patients used their own rooms to meet visitors in private. However, staff in all three wards said they could easily find private space if needed and patients and relatives confirmed this was the case. At both Glendinning ward and Nightingale House, there was a female lounge. However, in Nightingale Court there was no female only lounge. The manager had recently put in a capital bid to the trust, which had been turned down. They stated that they would put in another bid for 2016/2017.
- Patients told us that they had sufficient privacy to make telephone calls. All wards had a dedicated pay phone or ward phone that patients could use if they were unable to use their personal mobiles.
- There was direct access to garden areas on all wards. In Nightingale House, patients had access to a small courtyard. At the 2015 inspection, we saw that this area was mostly used by smokers supervised by members of the staff team. The manager had addressed this issue by unlocking the area so patients could smoke there unsupervised. This freed up staff time so they could work more closely with patents and as a result, there were more activities for patients like walking groups, cooking and one to one time. Patients also took responsibility for their own smoking patterns as a step towards independent living. Three patients spoken with said they found they had greater autonomy.
- Nightingale Court was more secluded, was surrounded by woodland and was close to a beach. Patients and staff took regular walks to the beach via a picturesque route. In Glendinning ward there was a large outside garden with a gazebo and a water feature. This created an area for patients to relax.
- Patients were mostly complimentary about the quality and range of meals available on the wards. There was a varied menu so patients with particular dietary needs could eat appropriate meals. In Nightingale House and Nightingale Court, the meals were prepared at hospital kitchens off site, and only snacks were made on the wards. However, patients could contribute to the menu. At Glendinning ward, patients had much more autonomy as they shopped for and prepared their own meals with support from staff if required. There was a popular 'fakeaway' group led by the occupational therapist at Nightingale Court; patient made a small financial contributed and they cooked foods from scratch that they might otherwise buy from a takeaway. All patients spoken with were positive about this group and said it taught them how to make healthy meals and it gave them the opportunity to socialise with each others.

Are services responsive to people's needs?

Good

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

- Patients worked closely with the occupational therapists to ensure they could prepare their own food and/or snacks safely and independently. They could then make their own drinks, snacks and main meals in the dining area or the occupational therapy kitchen. Staff we spoke to told us that patients were also encouraged to use the kitchen area to prepare their Patients confirmed there were no time restrictions on accessing these areas.
- Patients in all wards could personalise their bedrooms with their own pictures, possessions and bedding. We saw examples of family photographs, posters and ornaments.
- Patients had a small lockable cabinet in the bedrooms along with a cupboard and chest of drawers in which to store their possessions. On Glendinning ward, patients also had a lockable cabinet in which to store their medicines.
- Patients on Glendinning has access to a quiet / family room where patients can meet visitors in private.

Meeting the needs of all people who use the service

- The staff teams in all wards had ensured that adjustments had been made for patients requiring disabled access. These included modified door openings, ramps to outside areas, and designated toilets for patients with a disability. There were also handrails and wet rooms to assist wheelchair users. Corridors and doorframes were wide enough to facilitate wheelchair use. There were no lifts in Nightingale House or Nightingale Court, so patients with limited mobility could only be accommodated on ground level rooms.
- Patients could access information leaflets in different languages and formats via the trust communication team which staff were able to access. Information on the wards included information about local services, advocacy services, how to raise a complaint, mental health treatments and local services. Staff could also access a translator if required to assist patients.
- Patients had access to a choice of meals if they did not want the meal that was provided. The menu on each ward had evidence of patient's choices and ensured patients with particular individual assessed needs, or cultural or religious preferences ate appropriate meals.
- Patients could see a chaplain who visited the wards on a regular basis. In Nightingale Court, the chaplain visits the ward every four months, however is available to visit at other times if requested to do so. The wards had identified other religious groups in the local areas and patients were supported to attend these by staff, if requested.

Listening to and learning from concerns and complaints

- There was one complaint made in the last twelve months in Nightingale Court and there were none on the other two wards.
- Patients on all three wards told us they knew how to raise a complaint and how they would receive any feedback about the complaint they had made. The patient welcome packs included information on how to make a complaint. On each of the three wards there was information about the patient advice and liaison service (PALS), which also supported patients raise to concerns. There was also information about how to access advocacy support to help patients make a complaint. Staff could assist patients to access this via the trust's own website.
- Staff in all three wards knew how to support patients who wanted to make a complaint. All staff we spoke with knew the trust complaints policy and procedure. The staff team on each ward held a weekly community meeting where patients were encouraged to raise any concerns that they had. If any complaints were made these were addressed by the team. For example, in February 2016 patients at Glendinning complained that they had no Wi-Fi and the staff team installed this at the end of March 2016. In February 2016 the staff team introduced the 'no box' in line with the implementing recovery through organisational change (ImROC) action plan. ImROC involved helping people with mental health problems through the recovery process with a focus on ways to live a meaningful life. The no box was a small letterbox where patients could send the staff a letter to remind them when they had said no to a request they had made. For example, if a patient had requested an outing and staff had not been able to take them then they could write this up and post it into the box. The staff team then discussed all the letters at the next staff meeting. The manager said this helped them look for themes and trends and sort out any issues.

Are services responsive to people's needs?

Good

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

Patients then received feedback on the action that the staff were going to take. Three patients told us they thought it was a good idea and one person said they had used it and found it useful.

- Ward managers investigated any formal complaints. These were logged in line with the trusts complaints policy and procedure. For example, at Nightingale Court they had investigated a complaint made by a patients' relative about take home medications, which were not ready in time for the patients weekend leave. We saw evidence this was investigated promptly by both the staff team and the pharmacy department at Saint Anne's Hospital.
- Managers and staff told us they responded to verbal, informal comments or complaints immediately to resolve them. For example, in Nightingale House patients complained that the weekend activities were limited and they wanted helped with the cost of the activity. The manager quickly resolved this by giving additional money to patients who chose to go on activities. The manager told us they did not formally record these complaints but they wrote it up on the 'you said, we did' board in the ward. Staff regularly updated the boards and this gave the manager the opportunity to monitor, analyse and look for trends in complaints made by patients. For example, in Nightingale House we saw patients asked for bikes and these were purchased by the staff team.
- The managers of each ward ensured that staff received feedback on the outcome of investigation of complaints and acted on the findings. For example, staff meetings minutes from Nightingale Court confirmed the complaint about the availability of patients' medicine for when they went on leave was discussed and the staff team implemented additional checks on medicines within the unit. All staff spoken with were aware of these changes.

Are services well-led?

Good

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

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

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 We found that there were multiple ligature risks on both Nightingale House and Glendinning unit. Whilst the trust had plans in place to mitigate identified risks and we saw evidence that works were due to take place, there was no completion date for this. The trust had failed to act promptly to address ligature risks following an incident in a patient bedroom on Glendinning unit. This is a breach of regulation 12 (2)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found that the physical environment on Nightingale Court did not promote privacy. There was no female only lounge on the ward and plans to create one had been rejected. On the first floor, females had to walk though male occupied areas to access bathroom facilities. This is a breach of regulation 10 (2)(a)