The Dallingtons

Quality Report

116 Harlestone Road
Northampton
Northamptonshire
NN5 6AB
Tel: 01604 581181
Website: www.smhc,uk.com

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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

Our rating of the service stayed the same. We rated The Dallingtons as Good because:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts as de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery orientated.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- The design, layout and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom. Patients could keep their belongings safe. There were quiet areas for privacy.
- The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. These were shared with the whole team and the wider service.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Managers engaged actively with other health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

However:

- We found out of date bandages, saline, dressings, tape and sterile gloves in the first aid kits and emergency fire grab bag. Staff immediately rectified this when it was bought to their attention.
- Two patients who were on high dose medications did not have an appropriate monitoring tool in place. Staff put these in place immediately when this was bought to their attention.
- Not all staff were up to date with their Mental Health Act training.
- Not all staff were able to articulate the organisations vision and values.
- Staff sickness and turnover was above the national average.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working-age adults	Good	

Summary of findings

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Good

Location name here

Services we looked at

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

Summary of this inspection

Background to The Dallingtons

St Matthews Healthcare Limited provides an open rehabilitation service for men in Northampton at The Dallingtons. The hospital consists of two separate units on one site, Dallington House and Dallington Lodge. Each unit can accommodate up to 20 patients with a variety of mental health needs, to include chronic mental illness, functional illnesses and dementia. Patients who are living with dementia or have cognitive impairment reside at Dallington Lodge. The hospital has a well-established garden and has a shared therapy space.

The hospital was registered with the CQC in June 2012 to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Assessment of medical treatment for persons detained under the Mental Health Act 1983.

The hospital has a registered manager in place and a nominated individual for the service.

The hospital has been inspected on four occasions previously. The last inspection took place in December 2017. The hospital achieved a rating of good in each key question, and so overall the hospital was rated as good. There were no identified breaches under the Health and Social Care Act at this time. We told the provider action they should take to improve the service:

- The provider should ensure that safeguarding notifications are submitted to the CQC in a timely way.
- The provider should ensure that appraisals include a discussion around individual development.
- The provider should ensure that care plans are personalised where possible, with patients views and wishes captured. Evaluations of care plans should be detailed.
- The provider should ensure that all staff receive mandatory training in line with their policy.
- The provider should ensure they carry out regular fit and proper person checks for directors of the company, and hold on file, necessary documentation relating to this regulation.

During this inspection we found that the hospital had met these actions.

Our inspection team

The inspection team comprised four CQC inspectors and one specialist nurse advisor, who had experience in rehabilitation, for one day.

The team would like to thank all those who met and spoke with inspectors during the inspection.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information about the service.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 11 patients who were using the service and two carers
- spoke with the registered manager and two deputy managers
- spoke with 16 other staff members; including doctors, nurses, occupational therapy staff, psychology staff, health care support workers, driver and a student
- attended and observed two multi-disciplinary team meetings; a music group; a mindfulness group and a patient meeting
- looked at 13 care and treatment records of patients
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documentation relating to the running of the service.

What people who use the service say

We spoke with 11 patients who were using the service and two carers.

Patients at the hospital felt safe and well cared for.

Patients we spoke with were happy with the range of activities on offer. Most patients we spoke with had leave from this hospital and said that this was rarely cancelled.

Patients enjoyed the food and told us that there was a good choice.

All patients we spoke with told us that the staff were kind and caring.

Most patients we spoke with felt they had been involved in the planning of their care.

Patients told us that there was always staff around when you needed them.

Some patients had some families involved in their care, which the hospital had encouraged.

The two carers we spoke with relayed no concerns around the environment of the hospital. They had felt involved in their relatives care and told us that staff offered support for them. Both spoke highly of the kindness of the staff.

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?

Good

We rated safe as good because:

- Staff fully understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Managers fully supported staff to do so.
- Safeguarding adults at risk of abuse, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding. Staff took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse, and worked effectively with others to implement protection plans.
- Staffing levels and skill mix were planned, always implemented and reviewed to keep people safe. Any staff shortages were responded to quickly and adequately.
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviours that challenged.
- The wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

However:

- We found out of date bandages, saline, dressings, tape and sterile gloves in the first aid kits and emergency fire grab bag.
- We found that two patients who were on high dose medications did not have an appropriate monitoring tool in place.

Are services effective?

Good

We rated effective as good because:

- Staff carried out comprehensive assessments of patient's needs upon admission. This included consideration of clinical needs, mental health, physical health, wellbeing, nutrition and hydration.

Summary of this inspection

- Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified, and training was put in place to meet these learning needs. Managers supported staff to maintain and further develop their professional skills and experience. Staff received regular supervision and annual appraisals.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with relevant services outside of the organisation.
- Staff participated in local clinical audits, as well as quality improvement initiatives across the hospital. These had been shared across the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff routinely explained patients' rights to them in a way that they understood and repeated this as necessary.
- Staff supported patients to make decisions on their care for themselves. They understood the organisations policy on the Mental Capacity Act 2005. Staff assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Not all staff were up to date with their Mental Health Act training. We found that 74% of unqualified staff, and 64% of qualified staff were up to date with this training.
- We identified that documented consent / capacity for one patient with bed rails in situ was absent.

Are services caring?

Good

We rated caring as good because:

- Staff truly respected patients and valued them as individuals and empowered them as partners in their care.
- Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who used the service to have a voice and to realise their potential.

Summary of this inspection

- Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff recognised and respected the totality of patient's needs. They always took patients personal, cultural, social and religious needs into account.
- People's emotional and social needs were highly valued by staff and are embedded in their care and treatment.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- There was a proactive approach to understanding the needs of different groups of patients. Staff delivered care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.
- The involvement of other organisations and the local community was integral to how services were planned and ensured patients' needs were met. Staff supported patients with activities outside of the service, such as work, education and maintaining effective relationships.
- Patient's individual needs and preferences were central to the planning and delivery of tailored services. Staff helped patients with communication, advocacy, cultural and spiritual support. Staff had the skills, or access to people with the skills, to communicate in the way that suited the patients.
- There was an active review of complaints and how they were managed and responded to. Improvements were made as a result across the services.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe.
- The food was of a good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Summary of this inspection

Are services well-led?

Good

We rated well led as good because:

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. Staff said the organisation promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the patients.

However:

- Not all staff were able to articulate the organisations vision and values.
- Staff sickness and turnover was above the national average.

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.

At the time of our inspection there were 40 patients at the hospital. Of these, five were informal, and so were there of their own free will, five were under Deprivation of Liberty Safeguards, and 30 were detained under the Mental Health Act.

Staff we interviewed had an adequate understanding around the Mental Health Act, the Code of Practice and the guiding principles. Not all staff were up to date with their Mental Health Act mandatory training. We noted that 74% of unqualified staff and 64% of qualified staff had not received refresher training in the Mental Health Act. Additional training sessions had been arranged to raise these numbers.

Staff had access to administrative support and legal advice upon the implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were, and how to contact them.

Staff had easy access to the hospitals Mental Health Act policies and procedures and to the Code of Practice so they could refer too.

Patients had easy access to information about independent mental health advocacy. We saw posters on each ward with details and contact numbers.

Staff explained their rights to patients under the Mental Health Act in a way that they could understand. Staff repeated this information as required and recorded if each individual patient understood.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Staff had rescheduled some leave on occasions but had not cancelled due to staffing issues. Additional staff were sourced to escort patients if needed.

Medical staff requested an opinion from a second opinion appointed doctor as and when necessary in line with the Mental Health Act.

Staff stored copies of patients' detention papers and associated records securely. These were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely. We saw posters on each of the two wards.

Care plans referred to aftercare services to be provided for those who had been subject to detention under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

In total, 94% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had a good understanding of the Mental Capacity Act and knew what the key principles of the Act were.

Staff made Deprivation of Liberty Safeguards applications when required and monitored the progress of applications to supervisory bodies. Over the last 12 months, the hospital had made five Deprivation of Liberty Safeguards applications, to protect patients without capacity to make decisions about their own care. Patients were awaiting assessments at the time of inspection.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff gave patients help to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

Detailed findings from this inspection

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. Staff did this on a decision-specific basis with regard to significant decisions.

We identified that documented consent / capacity for one patient with bed rails in situ was absent. However, the provider addressed this immediately.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act alongside the Mental Health Act. The Mental Health Act administrators oversaw this and worked with nursing and medical staff to address any queries or inaccuracies.

Overview of ratings

Our ratings for this location are:

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

Notes

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Staff undertook regular risk assessments of the environments. The layout of the buildings did not enable staff to effectively observe all areas of the service, although managers had completed a detailed ligature risk assessment of the internal and external areas. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The hospital risk assessment identified potential risks, with details on how staff mitigated these. For example, staff supervised some areas. If any patients were assessed as a high risk, they would be cared for under enhanced observations.

Both wards were male only and therefore followed the Department of Health guidance on eliminating mixed sex accommodation.

Each patient had access to a call bell in their bedrooms, as well as call bells in communal areas. Staff could be summoned quickly by patients and by other staff members.

All ward areas were clean, had good furnishings and were well maintained. We saw dedicated housekeepers throughout the inspection. Cleaning records were up to date, which showed that ward areas were cleaned regularly. The communal areas were homely and welcoming.

Staff adhered to infection control principles. We saw that protective personal equipment, such as aprons and gloves were available to staff. The wards had adequate hand washing facilities, with hand sanitizing gel available in different areas of the hospital.

Clinic rooms were fully equipped and appropriately stocked. Accessible resuscitation equipment and emergency drugs were available. Staff checked these regularly.

We found out of date bandages, saline, dressings tape and sterile gloves in the first aid kits and fire emergency grab bag. However, staff rectified this immediately when it was bought to their attention.

Safe staffing

In addition to the two deputy ward managers, the hospital had an establishment of nine qualified nurses, 28 healthcare support workers, and 14 senior healthcare support workers. At the time of inspection, the hospital had 1.5 registered nurse vacancies, 1.5 healthcare support worker vacancies and three senior healthcare support worker vacancies. This equated to 11%. Recruitment was an ongoing process across the organisation. The manager was pro-active in the recruitment of staff. Recruitment initiatives included attending recruitment fayres and conducting interviews monthly.

The provider had estimated the number of staff required, based upon the acuity and dependency of the patients. During the inspection, the hospital had a total of 40 patients. Staffing across the hospital consisted of two registered nurses, and 12 healthcare support workers, two of which were senior healthcare support workers. The manager told us that the minimum number across both

wards, was two registered nurses and nine healthcare support workers. The hospital had not worked below these numbers. One deputy ward manager was supernumerary, as were therapy staff.

The duty rota showed that the number of nurses and healthcare support workers matched the planned number of staff on all shifts. If staff had identified that additional staff may be needed, due to several patients requiring escorted leave, the manager approved this. Staffing levels could be adjusted daily to ensure that patients' needs were effectively met.

The hospital used some bank and agency staff to cover for vacancies, sickness, absence, holidays and training. Between April 2019 and February 2020, the monthly use of bank and agency staff had varied between zero and 9.8%. Overall, the average use was 3.8%. No shifts were left unfilled. When bank and agency staff were used, these tended to be staff who had worked at the hospital before. Any new bank or agency staff received an induction and were made familiar with the ward and the patient group.

Staffing sickness levels were reported to be at 6.6% which is above the UK national average. Most reported sickness was short term. This did not impact upon patient care.

Between November 2018 and November 2019, the provider reported that the total number of substantive staff was 53. The total leavers during this time was 27, which equated to 51%. The manager reported that some staff had emigrated, and other staff had been promoted within the organisation, which accounted for some of this figure.

We saw that a healthcare support worker was always present in communal areas of the wards. If a nurse was required, they could be easily found. Staffing levels enabled patients to have regular one to one time with their named nurse. There were enough staff to carry out physical interventions, to include observations and restraint. Staff had been trained appropriately in correct restraint techniques.

Staff did not cancel escorted leave or ward activities due to staffing issues. They may have been some instances whereby plans might have been re-scheduled for later in the day. Staff made every effort to honour patient leave, and to ensure there was a variety of activities on offer. The hospital employed a driver who worked three days a week, who transported patients and staff in one of the two hospital vehicles. One vehicle was able to facilitate a wheelchair. The hospital also had some other identified staff who could drive the hospital vehicles, in the absence of the driver. In addition, the organisation had access to larger vans if staff wanted to take larger number of patients out for the day. Staff could book these in advance.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The hospital had a consultant psychiatrist rota for out of hours. For new admissions, an associate specialist doctor attended and completed an initial assessment. All patients had been registered with a GP surgery. A GP held clinics at the hospital bi-weekly. Staff could request additional visits as and when needed. During a patient meeting, we observed staff asking patients if anybody wanted to see the GP, who was scheduled to attend the hospital later that day.

Staff had received and were mostly up to date with their mandatory training. Overall, during inspection, the overall compliance rate for mandatory training was 85%. We identified that only one element was slightly under at 74%, which was Mental Health Act training for healthcare support workers, and 64% for qualified nurses. However, we saw that the provider had identified this, and had arranged some upcoming additional training dates to address. The hospital used an electronic system to record training, which enabled staff to be alerted when their training was due to expire.

Assessing and managing risk to patients and staff

We examined 13 care records. Staff completed a risk assessment of every patient upon admission and updated these regularly. We saw that staff had updated risk assessments following incidents, or if there had been any significant changes in risk.

All staff we spoke with were aware of any patient specific risk issues. Staff at the hospital worked across both wards and knew the patient group. Staff dealt with risk issues in a prompt and sensitive way. Staff identified and responded to changing risks too or posed by patients.

Staff followed the hospital observations policy effectively to maximise patient safety. For example, we saw that patients who were at a risk of falls, were being checked every 15 minutes. There were no patients on one to one observations at the time of inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. We did not identify any blanket restrictions across the hospital. Any specific restrictions placed upon patients, were justified, risk assessed and agreed.

Informal patients were able to leave the hospital at will, and they were aware of this. We also saw notices on each ward informing patients of this.

Staff adhered to best practice in implementing a smoke-free policy. We saw that some patients used vapes in designated areas outside. Nicotine replacement therapy could be requested and prescribed. A smoking cessation support group had been recently initiated for patients.

The hospital had no seclusion facilities. There had been no incidents reported involving seclusion or long-term segregation in the twelve months prior to the inspection.

Staff used restraint only after verbal de-escalation had failed and used correct techniques to apply this. The hospital had used restraint on nine occasions over the previous 12-month period. One of these occurred at The House, which resulted in prone (chest down) restraint for a very short time, until staff repositioned. This patient was transferred to a different hospital due to their escalation of risks. There were eight recorded incidents of restraint at The Lodge. Most of these were low level restraints, none of which were prone.

The hospital had some ongoing work in the form of a steering group, which focused upon least restrictive practices and closed cultures. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Rapid tranquillisation was rarely used. However, the hospital did have appropriate guidelines and a policy in place for nursing staff, to ensure effective monitoring of physical health following administration, as per National Institute of Health and Care Excellence guidelines.

Safeguarding

All staff were trained in the safeguarding of adults at risk of abuse and children. Qualified staff knew how to raise an alert and did so as and when appropriate. Healthcare support workers reported any safeguarding concerns to the nurses, who acted upon this. The hospital had a safeguarding lead, who kept an active log of concerns with actions taken. This included whether staff had submitted notifications to the Care Quality Commission or had liaised with the local authority where required.

Staff gave us examples of how they helped to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering from, significant harm.

Staff followed safe procedures for children who wanted to visit their relative or friend at the hospital. Visiting took place outside of the main ward areas, if a patient was unable to leave the hospital.

Staff access to essential information

The hospital was in the process of transferring from paper records to electronic records. This did not hinder getting access to any patient information. Everything was accessible and staff knew where to find documents with ease. All information needed to deliver patient care was available to all relevant staff, including bank and agency staff, when they needed it.

Medicines management

Staff followed good practice in medicines management and did this in line with national guidance. The clinic rooms were clean, tidy and ordered. Nurses stored, handled and administered medicines safely. Stock medicines were checked routinely. Clinical waste was disposed of appropriately. We did find that there were some out of date bandages, saline, dressings, tape and sterile gloves in the hospitals first aid kits, and in the fire bag. However, staff rectified this immediately.

We also found that two patients did not have specific monitoring forms when they were prescribed high dose medications. However, the nursing staff implemented these as soon as it was bought to their attention.

Track record on safety

There had been no reported serious incidents in the hospital in the last 12 months.

The manager informed us that the two top themes of incidents over the past year had been patient to patient aggression and falls.

Long stay or rehabilitation mental health wards for working age adults

Good

Reporting incidents and learning when things go wrong

All staff knew what incidents to report and how to report them. We found that staff had reported all incidents they should have reported. Incident forms were electronic and included a workflow of actions. For example, the form prompted staff to make a safeguarding referral or a CQC notification if appropriate.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Duty of candour training was mandatory for all staff.

Staff across the hospital received feedback from investigation of incidents, both internal and external to the service. At the hospital, incidents and learning were shared daily through the staff handover meetings. Staff also discussed incidents at team meetings and in each patient's multidisciplinary meeting. Managers reviewed incidents monthly at the managers meeting, and at the monthly quality forum meeting. The organisation created a monthly learning alert which was cascaded to all staff across other hospitals within the St Matthews Healthcare group.

There was some evidence which demonstrated learning from incidents. Individual patient care plans were reviewed following incidents and updated accordingly. The hospital had invested in some sensor mats following patient falls. These were mats placed close to the patients' bed, which alerted staff to any movement. This alerted staff. Patients at risk of falls were placed under 15-minute observations so staff could monitor their whereabouts more frequently.

We observed that most learning had been around individual patients and their care. Staff had purchased a padded floor mat for one patient who had injured himself on numerous occasions in his bedroom. Staff had consulted the patient, who had no objections to the proposed mat. This intervention had reduced injury to this patient.

Staff told us that they would be debriefed and offered support after a serious incident or following an incident which had affected them. We saw evidence of this on site, during the inspection

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We examined 13 care records. Staff completed a comprehensive mental health and physical health assessment of the patient upon, or shortly following admission.

Staff developed comprehensive care plans from the initial patient assessment and evaluated these routinely. Care plans were individualised, holistic, recovery orientated and meaningful.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. For example, the hospital offered different medicines alongside psychological therapy, occupational therapy and recreational activities. The hospital had links with external agencies who could facilitate training and work opportunities.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. All patients at the hospital were registered with a GP practice. The GP made referrals as required to other healthcare professionals, including the speech and language therapist, diabetic specialist nurse, and tissue viability nurse. A doctor from the surgery attended the hospital bi-weekly to see any patients who had requested an appointment.

Staff supported patients to live healthier lives. The hospital had arranged for external visitors from a dentist to give a talk to the patients about the importance of good oral health. There was also a monthly "men's health group" which ran throughout the year, as well as continued emphasis upon healthy eating and exercise.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff monitored patients dietary and fluid intake when they had concerns. Staff recorded these within the patient's records. We saw staff regularly make and offer drinks to patients who were unable to make their own.

Staff used The Health of the Nation Outcome scale to measure patient progress throughout admission.

Staff used technology to support patients effectively. We observed staff entering patients notes electronically on handheld devices throughout the inspection. Entries therefore were timely and accurate.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients. The multi-disciplinary team consisted of doctors, nurses, healthcare support workers, occupational therapy staff and psychology staff. The hospital worked with a pharmacist, who visited the wards weekly. The GP referred patients to other healthcare professionals as the need arose and followed these up if there appeared to be any delay.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. The hospital employed registered nurses with different experiences. As well as registered mental health nurses, the service employed a general nurse and a learning disability nurse. This was valuable due to the complexity of the patient group.

Managers provided new staff with an appropriate induction. This consisted of set time for mandatory training, followed by some supernumerary time on the wards (two weeks). This enabled staff to become familiarised with the patients, before being counted in the daily staffing numbers.

Managers provided staff with regular supervision and annual appraisals of their work performance. Appraisals included a discussion around learning and development. The percentage of staff that had received an appraisal in the last 12 months was 93%. The recorded staff supervision rate was consistently over 75%. At the time of inspection, we found it to be 89%. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.

The hospital had introduced a new initiative from October 2019, which was titled "back to basics". All existing and new staff completed this training, to ensure staff worked to the same standard. This training was set over the course of one day and consisted of mental health awareness and physical health; engagement and observation; dignity and respect and customer services. The two-day corporate induction had been extended to three days to allow facilitation of this for all new staff. Existing staff were scheduled to attend at the earliest opportunity.

Managers ensured that staff had access to regular team meetings. Minutes were circulated for those who could not attend.

Managers ensured that staff received the necessary specialist training for their roles. For example, we saw that some senior healthcare workers had been trained to take blood.

Managers dealt with poor staff performance promptly and effectively with support from human resources and senior managers.

Multi-disciplinary and inter-agency teamwork

Staff held regular and effective multidisciplinary meetings. Meetings were held weekly, rotating over a four-week period to ensure that every patient was seen at least once a month. We observed two MDT meetings. There was attendance from the entire multi-disciplinary team. We observed respectful interactions with patients. Staff knew the patients well. In-depth discussions were held around the care and treatment of patients. For example, to include medications, work placements, leave, therapy and relationships with significant others. Staff openly discussed positive risk taking with the patients. Care plans and risk assessments were reviewed.

Staff shared information about patients at effective handover meetings within the team at the commencement of each shift.

The ward teams had effective working relationships with other relevant teams, for example, care co-ordinators and community mental health teams.

The ward teams had effective working relationships with teams outside the organisation, such as the local authority and the GP.

Adherence to the MHA and the MHA Code of Practice

Long stay or rehabilitation mental health wards for working age adults

Good

Staff we interviewed had an adequate understanding around the Mental Health Act, the Code of Practice and the guiding principles. We noted that 74% of unqualified staff and 64% of qualified staff had received refresher training in the Mental Health Act. Additional training sessions had been arranged to raise these numbers.

Staff had access to administrative support and legal advice upon the implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were, and how to contact them.

Staff had easy access to the hospitals Mental Health Act policies and procedures and to the Code of Practice so they could refer to.

Patients had easy access to information about independent mental health advocacy. We saw posters on each ward with details and contact numbers.

Staff explained their rights to patients under the Mental Health Act in a way that they could understand. Staff repeated this information as required and recorded if each individual patient understood.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. Additional staff were sourced to escort patients if needed.

Medical staff requested an opinion from a second opinion appointed doctor as and when necessary in line with the Mental Health Act.

Staff stored copies of patients' detention papers and associated records securely. These were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely. We saw posters on each of the two wards.

Care plans referred to identified care needs of patients who had been detained under The Mental Health Act.

Good practice in applying the MCA

In total, 94% of staff had received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards. Staff had a good understanding of the Mental Capacity Act and knew what the key principles of the Act were.

Staff made Deprivation of Liberty Safeguards applications when required and monitored the progress of applications to supervisory bodies. Over the last 12 months, the hospital had made five Deprivation of Liberty Safeguards applications, to protect patients without capacity to make decisions about their own care. Patients were awaiting assessments at the time of inspection.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff gave patients help to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

We identified that documented consent / capacity for one patient with bed rails in situ was absent. However, the provider addressed this immediately.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. Staff did this on a decision-specific basis with regard to significant decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act alongside the Mental Health Act. The Mental Health Act administrators oversaw this and worked with nursing and medical staff to address any queries or inaccuracies.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Long stay or rehabilitation mental health wards for working age adults

Good

We observed all staff interacting with patients in a respectful and dignified way. When required, staff were discreet and responsive when assisting patients. Patients had the help, emotional support, advice and company at the times when they needed it.

Staff always supported patients to understand and manage their care, treatment or condition. Staff took time to explain different conditions, medications or other areas of concern. This was done either more formally in the multi-disciplinary meetings, or outside of the meetings on a one to one basis.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. One example of this was local charity which offered a vocational pathway for patients with mental illness. The charity offered patients the opportunity to gain skills and build confidence.

All patients we spoke with said staff treated them well, behaved appropriately towards them, were kind and caring. Two carers we spoke with also stated that staff were kind and cared for their relatives.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. This was evident in care plans, as well as day to day interactions.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without any fear of consequences.

Staff always maintained the confidentiality of information about patients as expected.

Involvement in care

Staff used the admission process to inform and orient patients to the ward and to the hospital. A designated staff member showed each new patient around at the earliest opportunity and introduced them to staff and other patients. Staff gave information about the hospital, individual wards, mealtimes, activities, where to access food and drinks, and staffing. If possible, proposed admissions would be invited to view the hospital and spend some time there prior to transfer.

Staff involved patients in care planning and risk assessments. Each patient had the opportunity to attend their multi-disciplinary meetings. During these meetings, care and treatment was discussed. The team and the patient discussed progress, as well as any current challenges. Each patient had time to make any requests, offer suggestions, or voice any concerns. Patients were actively encouraged to work with the staff in the planning of their care, and in reviewing risk assessments.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients who had communication difficulties. The manager had access to an easy read tool, whereby information inputted could be changed into easy read format. The staff team worked together to ensure that patients who had limited vocabulary could communicate using pictorial aids. Information was available in large print for those who had visual difficulties.

Staff involved patients when appropriate in decisions about the hospital, their care and their treatment. Staff teams were open to ideas around different activities, recreational trips out, and menu planning. Patients felt that their opinions would be heard, considered and discussed. Some of these could be discussed in the regular community meetings held.

Staff enabled patients to give feedback on the service they received in a number of ways. Each ward had their own community meetings as well as a suggestion box. Patients were invited to attend a jointly run service user and carer forum at another St Matthews Healthcare hospital. Patients could give feedback about care and treatment during multi-disciplinary meetings and during one to one time with their nurse.

Staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Staff ensured that patients could access advocacy easily and assisted with this where appropriate.

Staff informed and involved families and carers appropriately and provided them with support when needed. Families and carers were invited to attend the service user and carer forum. Carers could ring the hospital and speak with staff if they had any concerns. Carers could also attend the patients multi-disciplinary meeting to discuss progress.

Staff enabled families and carers to give feedback on the service they received. The manager had an “open door policy”. Suggestion boxes were placed on both wards.

Long stay or rehabilitation mental health wards for working age adults

Good

Carers could place suggestions / comments in these. Carers were encouraged to voice any concerns to the staff for further exploration, through face to face visits, telephone calls or through meetings.

The hospital had sent out some feedback questionnaires to different stakeholders throughout 2019. These offered feedback for example around the environment, care delivery and staff support / intervention. Overall, the response was very positive. Themes rated as excellent included the level of respect and dignity patients in the hospital received; care delivery, and most stakeholders said that they would recommend this service to others.

Staff provided carers with information about how to access a carer's assessment if needed.

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

Good

Access and discharge

Between 01/05/2019 and 30/10/2019 the average bed occupancy across the hospital was 95%.

The average length of stay for patients in this service was 454 days.

Beds were available when needed for patients living locally. There was always a bed available when patients returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

Staff consistently ensured that any discharges were appropriately planned and occurred at a time which was convenient for the patient and the ongoing placement.

If there was an occasion where a patient required a more acute environment, the team worked with commissioners to try to transfer to a local hospital where possible. Staff reported that this was a rare occurrence.

Overall, discharges were timely and prompt. We reviewed two delayed discharges. The delays had been due to a lack of suitable accommodation for the patients to move into. We saw that staff were proactive in following these up. The hospital staff were working to achieve discharge for both patients at the earliest opportunity. Staff had kept patients and carers updated with difficulties encountered and had explained why there had been a delay. Managers had maintained contact with commissioners and continued to follow both discharges up.

Staff planned well for patients' discharge, with care co-ordinator's, external agencies, with patients and carers where possible. Staff supported patients during referrals and transfers between services. Where possible, staff facilitated viewing of the potential placement.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms with an en-suite toilet and shower. Patients were not expected to sleep in bed bays or dormitories. Patients were encouraged to personalise their bedrooms with photos, posters, own duvet covers and other personal effects to make it as comfortable as possible.

All patients had somewhere secure to store their possessions, either in their room, or in a secured place on the ward.

Staff and patients had access to a full range of rooms and equipment to support treatment and care. Each ward had a spacious lounge / dining area. The hospital garden was a good size and accessible to patients. Patients could sit outside if they wanted. In addition to this, the hospital had a "jolly cabin". This was accessed via the garden, and consisted of a large main activity room, a kitchen where patients could cook, supervised as appropriate. A toilet, a separate occupational therapy office, as well as a room which was primarily used for the visiting GP, or for physical health examinations or procedures – such as blood taking. We observed a number of activities taking place in the cabin over the course of the inspection. Patients from both wards attended scheduled sessions.

There were quieter areas on the ward and spaces within the hospital where patients could meet visitors. Patients were encouraged to go out with carers and friends where appropriate. Patients were able to make phone calls in private if they did not have a personal mobile phone.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients told us that the food was of a good quality. The hospital catered for a variety of dietary requirements, to include vegetarian, vegan, gluten free, and other intolerances. We noted that the hospital had achieved a five-star hygiene rating from the Local Authority. Patients were able to participate in "tasting sessions" and give feedback to kitchen staff.

Some patients told us that they liked the new "dining experience". Staff spoke positively about this, and gave an example whereby one patient, who had always chosen to eat in his room, was now attending the newly refurbished dining room for meals. Staff had put a lot of effort into making mealtimes more of an experience. Tablecloths "café style" had been purchased and laid. Condiments were placed on each table, along with daily menus. The staff bought the hot food up to the dining area, so that patients could physically view the food and make their choice "canteen style". Staff sat with patients at the tables. Both staff and patients had spoke of this initiative as being a success.

Patients could make hot drinks and snacks throughout the 24-hour period. All patients had access to hot and cold drinks, as well as snacks, such as fruit and biscuits. We saw staff regularly make and offer drinks to those patients who were unable to make their own. Staff supported patients to eat and drink where required. Some patients purchased their own preferred snacks and drinks, at local shops, supported by staff.

The hospital recognised that not all patients were able to go out of the hospital to purchase small items, such as newspapers, magazines, crisps and other snacks. They created their own "Dallingtons shop". Murals on the surrounding walls also offered the patients the sense of a grocery shop. This was located in The Lodge.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to work opportunities, through linking with different local charities and organisations.

Staff supported and encouraged patients to maintain contact with their families and carers. Patients were encouraged to maintain positive relationships with people that mattered to them, both within the hospital and in the wider community.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain, advocacy service, different health conditions and the role of the Care Quality Commission.

Information provided by staff was in a form accessible to the patient group. Easy read documentation was tailored to individual patients where needed. Pictorial communication aids were made available to patients who had difficulties in communicating verbally. Staff had made sure that the Lodge had clear signage to help patients who were living with dementia or had cognitive impairment.

If English was not a patient's first language, staff could source information leaflets in different languages. Staff had easy access to interpreters and / or signers.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Staff ensured that patients had access to appropriate spiritual support. Staff encouraged patients to attend a local place of worship, some of whom did. For those patients who could not leave the hospital, the manager arranged visits from the relevant individuals from the local community.

Listening to and learning from concerns and complaints

Over the past 12 months, the service had received four complaints. Of these, one was upheld, one partially upheld and two not substantiated. Three of the four complaints had been around care and treatment. The complaint which was upheld was around lack of staff support around the claiming of benefits. Appropriate action had since been taken to address this. No complaints had been referred to the Ombudsman.

Over the same time period the service had received 15 compliments around treatment and care from patients and carers.

Patients knew how to complain or raise concerns about the service and expressed no concerns about doing this. Patients told us that staff were easy to talk too. The staff satisfaction survey (2019) showed that 97% of staff who participated knew how to raise a complaint.

Long stay or rehabilitation mental health wards for working age adults

Good

When patients complained or raised concerns, staff acted upon these, and fed back to the individual as expected. The manager encouraged concerns or complaints around care and treatment, viewing these as an opportunity to improve and to learn. It was clear that any reported discrimination or harassment would be investigated. Whether this be by staff, patients or external persons.

Staff knew how to handle complaints appropriately and followed the hospital policy around the reporting of and responding to complaints. The manager kept a complaints log which clearly set out the stage of the complaint, as well as actions taken to address.

Staff received feedback on the outcome of any investigations of complaints where appropriate. The manager ensured that any actions or learning was taken forward, completed and cascaded to staff.

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

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The staff survey (2019) identified that 83% of respondents felt that the hospital was well led.

The hospital manager had a good understanding of the service they managed. They could explain clearly how the staff were working hard to provide high quality, dignified care.

Leaders were visible in the service and approachable for patients, staff and carers. There was clearly an “open door policy”. We saw numerous staff enter the manager's office throughout the inspection, with no pre-arranged appointments. Most staff confirmed that they could seek out leaders at any time as necessary.

Leadership development opportunities were available. The organisation had provided leadership training for the hospital manager, and also to qualified nursing staff. These opportunities were ongoing and were identified and discussed during individual staff appraisals.

Vision and strategy

Staff interviewed found it difficult to articulate the vision and values of the hospital. Five out of 19 staff were able to tell us what these were. Staff spoke about offering good, quality and compassionate care. We saw that staff did apply these values within the work of their teams. Senior staff had displayed the vision and values around the hospital. However, staff could not effectively relay these to inspectors at the time of inspection.

The organisation had in place it’s 2020 vision for what it wanted to achieve. This covered seven key areas to focus upon.

Staff were consulted about proposed new initiatives within the hospital, and their views were sought during staff meetings. The staff survey (2019) showed that 87% of respondents felt that they had the opportunity to share ideas within their teams.

The hospital was continuing to deliver good quality care within budgets available. Additional resources or equipment could be requested by the hospital manager and approved if justified. Financial restrictions did not impact upon patient care.

Culture

Staff working at the hospital felt respected, supported and valued. Staff morale appeared to be good. Staff felt positive and proud to be working at the hospital. The staff survey (2019) highlighted that 90% of respondents would recommend the organisation as a good place to work.

Staff told us that they felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and knew that they could raise concerns anonymously if they felt the need too, although spoke about managers and senior staff being approachable.

Managers dealt with poor staff performance when needed. Staff worked well together across the hospital as a team. Where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how the organisation could support this.

Staff reported that the provider promoted equality and diversity in its day to day work. Opportunities for career progression was indiscriminate.

Long stay or rehabilitation mental health wards for working age adults

Good

The service's staff sickness and absence rates were above the national average, at 6.6%. The hospital had appropriate policies and procedures in place to manage sickness and absence, and to support staff to work flexibly if needed.

Staffing turnover had been high at 51%. Some staff had emigrated, and others had been promoted internally within the organisation which had accounted for some of this figure. Managers conducted exit interviews where possible.

Staff had access to support for their own physical and emotional health needs through the organisational emphasis upon wellbeing. Staff could be referred to occupational health if needed.

The provider recognised staff success within the service. We saw that both staff and patients voted once a month for a recognition of "best practice award".

Governance

There was a clear framework of what must be discussed at ward, team and senior team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of incidents across the service. This was evident upon examination of individual patient records.

Staff participated in local clinical audits. Examples of these included medication; care records; infection control and Mental Health Act. The audits were sufficient to monitor the effectiveness of the service.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients.

Management of risk, issues and performance

The hospital manager had access to the local risk register. Staff at ward level could escalate concerns when required. Staff discussed any new perceived risks with leaders in the service. These were then added to the risk register where appropriate, along with mitigation of these risks. Staffs concerns matched those on the risk register.

Outcomes of investigations and complaints were shared with all staff regularly. Managers were visible and were aware of identified risks and mitigations of these risks. Staff received feedback individually, during staff meetings, hand overs, and through supervision.

Where cost improvements had taken place, they had not compromised patient care.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

The service used electronic systems to collect data from wards that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well.

Information governance systems included the importance of the confidentiality of patient records.

The hospital manager and the deputy ward managers had access to information to support them with their management roles. This included information around attendance and absence, supervision and mandatory training.

The hospital ensured all Information was in an accessible format, was timely, accurate and where necessary identified areas for improvement.

Staff made notifications to external bodies as required, such as the CQC, the local authority and clinical commissioning groups.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet and through bulletins and posters.

Patients and carers had opportunities to give feedback on the service they received via attending meetings, anonymously through suggestion boxes, or through satisfaction surveys the service circulated.

Managers and staff had access to the feedback from patients, carers and staff and used it to strive to make improvements, where possible.

Patients and staff could meet with members of the organisations senior leadership team if they wanted.

Learning, continuous improvement and innovation

Long stay or rehabilitation mental health wards for working age adults

Good

Staff were given the time and support to consider opportunities for improvements and innovation and this had led to changes. There was some evidence of ongoing innovations and initiatives.

Leaders had plans in place for career development. This included the introduction of apprenticeships, succession planning and bridging programmes to enable staff to access nurse training. Staff felt positive about opportunities to progress.

Staff were participating in different clinical audits. However, staff were not participating in any national audits relevant to the service, nor accreditation schemes at the time of inspection.

Outstanding practice and areas for improvement

Outstanding practice

The hospital recognised that not all patients were able to go out of the hospital to purchase small items, such as newspapers, magazines, crisps and other snacks. They created their own "Dallingtons shop". This also gave patients the opportunity to manage money. Murals on the surrounding walls also offered the patients the sense of a grocery shop.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all patients on high levels of medications have the appropriate monitoring forms in use.
- The provider should ensure that all staff undertake mandatory training and refresher training in the Mental Health Act.
- The provider should ensure that first aid kits and the fire evacuation bag are checked regularly to ensure contents are in date.
- The provider should ensure that all frontline staff are aware of the vision and the values of the organisation.
- The provider should ensure that staff turnover is monitored, and undertake exit interviews where appropriate.