Good

Dorset Healthcare University NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

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

This report describes our judgement of the quality of care provided within this core service by

Dorset Healthcare University NHS Foundation Trust

. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by

Dorset Healthcare University NHS Foundation Trust

and these are brought together to inform our overall judgement of

Dorset Healthcare University NHS Foundation Trust

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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

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Summary of findings

Overall summary

We rated Dorset Healthcare University NHS Foundation Trust as good because:

The ward did not have robust processes for reducing the risks to patients and staff. This included risks in the environment, gaps in policies for and implementation of procedural security, and the unsafe use of sharps bins. However, all patients had a risk assessment carried out which was reviewed regularly by the multidisciplinary team. Medication was administered and managed safely. Incidents were reported and investigated. Recruitment was ongoing, and bank staff were used to cover nursing and support worker vacancies. Staff had completed most of their mandatory training but there were gaps.

Patients had their needs assessed, and care plans developed in response to this. Patients had their physical healthcare reviewed every three months by a dedicated physical healthcare team in the hospital. Records were stored securely and could be shared with the community team. There was a structured activity programme five days a week. Staff received supervision, appraisal and training. Detained patients had their rights under the Mental Health Act explained to them, and had access to an independent Mental Health Act advocate (IMHA). The Mental Health Act was implemented correctly in most cases, and any errors were rectified. Patients who received a service from the Pathfinder service had regular psychological support. For other patients there was limited access to psychologists and occupational therapists on the ward.

Patients were mostly positive about the staff and the service, and said they felt safe on the ward. Patients had their care discussed with them. Patients had access to an advocacy service. Patients had been involved in deciding on the decoration of the refurbished ward, and an open day had been held for patients' relatives before it reopened. A patient on the ward was peer representative and attended ward and forensic service meetings, and was able to raise patients concerns. Although patients were mostly positive about their care, they were less certain about the blanket policy of locking doors during the day and what they saw as compulsory attendance at groups.

Patients had their own room, and a lockable draw and locker for valuable or contraband items. There was a kitchenette where patients could make their own drinks. There was a structured activity programme that ran five days a week. The service had a car to support patients to access services in the community. There were rooms on the ward for patient activities, and outdoor space. The service routinely reviewed the care, needs and risks of all inpatients. It also reviewed all referrals, people on its waiting list, and patients in services outside the trust team. With the exception of nursing staff and support workers all staff worked across both inpatient and community services. There were no delayed discharges at the time of our inspection. Patients were aware of the trust's complaints policy. The trust had no secure inpatient facilities for women, so any woman requiring this would have to be admitted out of area.

Staff were mostly positive about their managers and the staff they worked with. They felt able to speak out and voice their concerns. The ward had participated in the Royal College of Psychiatrists' quality network for forensic mental health services annual review cycle. The service had individual groups that focused on the three parts of the service: inpatient, community (which included referral and out of area patients) and the Pathfinder service. These fed into an overarching governance group that monitored the quality of the whole forensic service. All the groups included clinical and managerial staff. The inpatient group was attended by a peer representative, who was a patient on the ward. The forensic service used information from and fed into the governance systems within the trust.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The ward did not have robust processes for reducing the risks to patients and staff. This included risks in the environment, gaps in policies for and implementation of procedural security, and the unsafe use of sharps bins.

However,

- All patients had a risk assessment carried out which was reviewed regularly by the multidisciplinary team.
- Medication was administered and managed safely.
- Incidents were reported and investigated.
- Recruitment was ongoing, and bank staff were used to cover nursing and support worker vacancies.
- Staff had completed most of their mandatory training but there were gaps.

Are services effective?

Good

We rated effective as good because:

- Patients had their needs assessed, and care plans developed in response to this.
- Patients had their physical healthcare reviewed every three months by a dedicated physical healthcare team in the hospital.
- Records were stored securely and could be shared with the community team.
- There was a structured activity programme five days a week.
- Staff received supervision, appraisal and training.
- Detained patients had their rights under the Mental Health Act explained to them, and had access to an independent Mental Health Act advocate (IMHA).
- The Mental Health Act was implemented correctly in most cases, and any errors were rectified.
- Patients who received a care from the Pathfinder service had regular psychological support. For other patients there was limited access to psychologists and occupational therapists on the ward.

Are services caring?

Good

We rated caring as good because:

- Patients were mostly positive about the staff and the service, and said they felt safe on the ward.

Summary of findings

- Patients had their care discussed with them.
- Patients had access to an advocacy service.
- Patients had been involved in deciding on the decoration of the refurbished ward, and an open day had been held for patients' relatives before it reopened.
- A patient on the ward was peer representative and attended ward and forensic service meetings, and was able to raise patients concerns.
- Although patients were mostly positive about their care, they were less certain about the blanket policy of locking doors during the day and what they saw as compulsory attendance at groups.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients had their own room, and a lockable draw and locker for valuable or contraband items.
- There was a kitchenette where patients could make their own drinks.
- There was a structured activity programme that ran five days a week.
- The service had a car to support patients to access services in the community.
- There were rooms on the ward for patient activities, and outdoor space.
- The service routinely reviewed the care, needs and effective risks of all inpatients. It also reviewed all referrals, people on its waiting list, and patients in services outside the trust team. With the exception of nursing staff and support workers, all staff worked across both inpatient and community services.
- There were no delayed discharges at the time of our inspection.
- Patients were aware of the trust's complaints policy.
- However, the trust had no secure inpatient facilities for women, so any woman requiring this would have to be admitted out of area.

Are services well-led?

Good

We rated well-led as good because:

- Staff were mostly positive about their managers and the staff they worked with. They felt able to speak out and voice their concerns.
- The ward had participated in the Royal College of Psychiatrists' quality network for forensic mental health services annual review cycle.

Summary of findings

- The service had individual groups that focused on the three parts of the service: inpatient, community (which included referral and out of area patients) and the Pathfinder service. These fed into an overarching governance group that monitored the quality of the whole forensic service. All the groups included clinical and managerial staff. The inpatient group was attended by a peer representative, who was a patient on the ward.
- The forensic service used information from and fed into the governance systems within the trust.

Summary of findings

Information about the service

The trust's forensic service is made up of an inpatient low secure ward for men, a community forensic team, and a Pathfinder service.

Twynam ward is a low secure unit for up to 12 men. A major refurbishment had recently been carried out. The ward had been temporarily relocated but at the time of the inspection had just moved back in. Only 10 beds were available for use. There were eight patients on the ward at the time of the inspection.

The Pathfinder service provides psychologically-led services to men with a personality disorder and offending behaviour. At the time of our inspection it had a caseload of six patients; two were inpatients on Twynam ward, and the other four were living in the community.

We have inspected the services provided by Dorset Healthcare University NHS Foundation Trust

35 times between 2012 and 2015, across 18 locations.

Our inspection team

The inspection team was led by:

Chair: Neil Carr OBE, Chief Executive of South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Team Leader: Karen Wilson-Bennett, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team that inspected the forensic inpatient/secure wards comprised a CQC inspector, a Mental Health Act reviewer, and two specialist advisors who were mental health nurses specialising in forensic inpatients.

Why we carried out this inspection

We inspected this core 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?

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations to tell us what they knew;

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 5 patients
- spoke with the manager of the ward and forensic service manager
- spoke with 7 other staff members; including doctors, nurses, health care assistants, occupational therapists, psychologists and an activity assistant
- spoke with independent Mental Health Act advocates (IMHA)
- interviewed senior staff with responsibility for these services

Summary of findings

- attended and observed a hand-over meeting and activity groups
- looked at 5 treatment records of patients
- looked at all prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

All the patients we spoke with said they felt safe on the ward. They thought it was well managed, and said there wasn't a problem with violence or drugs on the ward.

Four of the patients we asked told us that they had had their care discussed with them, and there of these had a copy of their care plan. The care records showed that patients were involved in discussions about their care.

Patients were positive about the staff, and how they were treated by them. Some patients found the staff 'controlling', particularly when they were told what to do on the ward. Patients had mixed views about the groups they attended, but felt that they had to attend them as their bedrooms were locked and if they did not attend they would lose their leave. Even though they did not necessarily dislike the groups, they said they did not get a choice in what they participated in.

One of the patients on the ward was a peer representative, and attended the clinical strategy group where the development of the service was discussed.

Good practice

The ligature management plan included a description, photograph and barcode so that potential ligature points were easily identified. The plan rated the level of risk each ligature point presented, and any action that was to be taken.

Patients had their physical healthcare reviewed every three months by a dedicated physical healthcare team in the hospital.

A patient on the ward was peer representative and attended ward and forensic service meetings, and was able to raise patients' concerns.

Areas for improvement

Action the provider MUST take to improve

- The trust must identify environmental risks on the ward and implement risk management plans implemented to mitigate these risks.
- The ward must have clear written policies on procedural security on the ward which include management of barred items, use of emergency alarms, and security of keys.
- The service must ensure that sharps bins are used appropriately and the lids secured when in use.

Action the provider SHOULD take to improve

- The service should be assured that the resuscitation equipment is routinely checked.
- The seclusion room should be reviewed in accordance with the Mental Health Act Code of Practice.
- The service should consider the specific training needs of staff working within a low secure service.
- The service should review its blanket policy of locking all patients' bedrooms during the day, and perceived lack of choice by patients when attending groups.
- The service should review access to occupational therapy and psychology on the ward.
- The provider should, with its commissioners, review access to secure services for women.

Dorset Healthcare University NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

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

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.

All patients on the ward were detained under the Mental Health Act (MHA). The sample of section papers we looked at were completed correctly. They had their rights under the MHA explained to them, and this was repeated when necessary.

The patients we spoke with all aware that they could appeal against their detention. There was information in display about what patients could appeal against depending on which section they were on, which included if patients were subject to Ministry of Justice restrictions, or if they were on remand.

On occasions when patients had stopped being detained, they had been informed of their rights as informal patients, and appropriate arrangements made. Staff told us that they would not admit informal patients directly to the ward.

Section 17 leave forms were mostly completed correctly, and patients leave was taken in accordance with them. However, we identified a problem with how section 17 leave was recorded for patients who were detained under the MHA and subject to a Ministry of Justice (MoJ) restriction. It was unclear whether 'ground leave' was defined as within the ward garden (which was secure) or within the hospital (which was open). This was discussed with the ward staff, who contacted the MoJ and have subsequently clarified how they record this type of leave, and the permission required from the MoJ.

Patients confirmed that their medication and their rights with regards to this had been explained. We reviewed three files in relation to recording capacity to consent to treatment and there was evidence that the responsible clinician had recorded the patient's capacity to consent at first treatment for mental disorder. We reviewed the medication file and treatment was given under appropriate legal authority.

Detailed findings

Access to the independent Mental Health Act advocacy (IMHA) service was based on patient request and either staff or self-referral to the service. For Bournemouth and Poole residents this was provided by Rethink, and for Dorset by Dorset Mental Health Advocacy. Advocacy was a standard item on the weekly residents' meeting. The IMHA service told us that they usually only visited patients if they were referred, but they were occasionally invited to the ward meetings. Information was on display about the IMHA service.

Staff told us they could go to the trust's MHA office for advice about the Act. Staff had had training in the MHA, but were not aware of the revised code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

The manager told us that approximately half of the ward staff were trained in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They said that patients were usually detained under the Mental Health Act (MHA), so use of the MCA and the DoLS was rare. Most of the staff we spoke with had limited understanding of the MCA.

There had been no DoLS applications on the ward.

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

Summary of findings

We rated safe as requires improvement because:

- The ward did not have robust processes for reducing the risks to patients and staff. This included risks in the environment, gaps in policies for and implementation of procedural security, and the unsafe use of sharps bins.

However,

- All patients had a risk assessment carried out which was reviewed regularly by the multidisciplinary team.
- Medication was administered and managed safely.
- Incidents were reported and investigated.
- Recruitment was ongoing, and bank staff were used to cover nursing and support worker vacancies.
- Staff had completed most of their mandatory training but there were gaps.

Our findings

Twynam ward

Safe and clean environment

- The ward had been refurbished. The ward had moved back from temporary accomodation one week prior to the inspection. The refurbishment was not fully completed. Building work was still being carried out in the garden area, and two unfinished bedrooms were behind a locked partitioned area. There were a number of 'snagging' issues on the ward, which the manager acknowledged. This included an unsecure noticeboard, and screws hanging out of a wardrobe door.
- There were ligature points in some areas, which the manager told us were due to be removed. There was a blind spot near a potential ligature point in one area of the ward, which had only partially been addressed, but would again be removed when the building work was completed. A ligature management plan had been completed the week before patients and staff moved back into the ward. This clearly identified potential ligature points with a description, photograph and barcode. It rated the risks presented, any action that was to be taken, or if the risks were to be clinically managed by staff. The ligature audit was extensive and it identified, for example, that anti-ligature door handles should be fitted. New door handles were on order and were due for delivery after our inspection. However, although ligature points were identified there were other environmental risks that were not, so it was not clear how these risks were to be managed. This included items that patients could use to create a ligature or weapon, or otherwise harm themselves or others.
- Anti-ligature fittings were in the bedrooms and bathrooms, and bedrooms were finished with anti-tamper screws and anti-pick sealant.
- Most of the patients had their own televisions and other electrical equipment. There was no dedicated space to put these in their rooms, so they were unsecured with trailing cables. This could present a risk to patients and other people. Each patient was risk assessed to have the equipment in their rooms. However, as patients could not lock their own rooms, there was no management plan of how to stop other patients from entering each other's rooms.
- At the reception of St Ann's Hospital there was a notice stating that plastic bags were not allowed in the unit, and visitors should ask for alternatives (paper bags). However, on Twynam ward the communal rubbish bins were lined with plastic bags.
- There was a thumbprint operated key cupboard, but this was not working yet. There were no storage lockers for visitors to put their belongings, so that they did not take barred items onto the ward.
- There was close circuit television (CCTV) in the communal areas, which was monitored by the security nurse who was based at the entrance to the ward.
- There was a clean and appropriately equipped clinic room, which included emergency equipment. The resuscitation equipment appeared to be stocked and in date. However, there was no record of it being routinely checked, although staff told us they did this. There was an anaphylactic kit available, for use in the event of an extreme allergic reaction.

Requires improvement

Are services safe?

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

- The blood glucose monitoring machine was not working. This was used to monitor the blood sugar levels of patients with diabetes. Staff told us they had been waiting for a new machine since March 2015. There was no medication fridge on the ward as this was also on order. However, this was delivered during our inspection.
- A patient wore an oxygen mask at night. However, the plug was on the opposite wall to their bed, which meant they had to stretch the cable and have trailing leads across the room.
- The ward had a seclusion room which was adjacent to the de-escalation area. The seclusion room did not meet the recommendations of the Mental Health Act (MHA) code of practice in some areas. The windows were fixed so there was some ventilation in the room, but this was not controllable. There was a translucent tint on the windows, so daylight could enter but patients could not see outside. If it was very sunny the room could not be shaded. The radiator cover and windows did not have flush or soft edges. There was an ensuite shower and toilet, which did have anti-ligature fittings. There was a mirror to minimise blind spots, but there were still areas of the room that could not be seen from outside. Access to the ensuite could not be controlled from outside the room, so could only be opened if staff entered the seclusion room. The sink was not working, and the floor in the ensuite was dirty. There was a clock visible from inside the seclusion room, but it was not working. Electricity and water supplies in the room could be turned off from outside the suite, but these were not clearly labelled. There was a small wooden panel in the seclusion room – staff did not know what it was for, or if it could be easily damaged. The service later confirmed that there was pipework behind the panel, and that it could not easily be broken.
- Staff told us that the seclusion room was rarely used, and records showed that it had been used on three occasions over the last six months. The room could theoretically be used by other wards in the building, but we were told by staff that this this had not happened.
- There were two sharps bins in use in the clinic room, both of which had the lids resting unsecured on top. This presented a risk of needle stick injury to staff. We pointed this out twice to staff before the lids were secured. There was no blood spillage kit on the ward.
- Nurses and support workers carried emergency alarms, but the ward manager did not. The inspection team and other visitors (for example builders) were not provided with alarms. Staff could not tell us what the policy was on providing alarms to visitors. When activated, the location of the alarm was displayed on the two panels on the ward. Staff from elsewhere in the hospital responded to alarms on Twynam Ward. Staff on Twynam ward did not respond to other wards at the present time because of their relative isolation and risk levels.

Safe staffing

- The manager told us that staffing levels had been set for the ward several years ago, and were last reviewed and consequently increased in October 2014. Managers told us that there had been problems with maintaining adequate staffing levels, but although there were still vacancies this was improving. The ward employed the equivalent of 38.48 full time staff, and had nine staff vacancies, this was improving. Three of the 11 registered nurse posts were unfilled, and there were six mental health support worker vacancies. Agency nurses were not used on the ward, but bank staff were used to cover gaps.
- Patients told us that they usually saw the same staff on the ward. Staff and patients told us that leave and activities were rarely cancelled because there were not enough staff.
- Two experienced forensic consultant psychiatrists (one full time and one part time) worked across the inpatient and forensic community team. The service had a junior doctor but had a longstanding vacancy for a middle-grade doctor. This gap was covered by the two consultant psychiatrists. The consultant psychiatrists had their own caseloads, but shared information as part of team working, and provided cross cover for one another.
- There was no specific training for staff working in the forensic service. Staff told us that there was a forensic induction for staff working on the ward, but this was only provided once a year. There were staff on the ward who had started within the last year, and had limited previous experience of working in this setting.

Requires improvement

Are services safe?

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

- Training records were stored in several different areas on the computer system, so it was not easy to see where there were gaps. However, the manager told us that they received exception reports from the training department if staff had not completed the necessary training.
- Staff told us they were up to date with most of their mandatory training, which included physical interventions and life support. Training information up to the end of May 2015 showed that all staff had completed training in basic life support, equality and diversity, fire, health and safety for managers, information governance, and prevention and management of violence and aggression. However, less than 75% of staff were up to date with training in adult protection, child protection, enhanced life support, infection control, and moving and handling. The trust target was 85%.

Assessing and managing risk to patients and staff

- The ward had security procedures but there were gaps in these. The ward had moved within the previous two weeks, and staff told us they were still developing and familiarising themselves with the running of ward. There was an airlock and a security nurse who signed patients, staff and visitors into and out of the ward. However, there was no list of items not allowed onto the unit available. Staff told us mobile phones were not allowed on the unit. However, we observed a visitor using their mobile phone in the airlock and they were not challenged by staff and allowed to take the phone into the ward. When we pointed this out this was addressed. However, we observed that other staff and visitors came into the unit without being asked if they had any restricted items on them.
- There were procedures for managing keys, but not a standard means that ensured they were securely attached to staff.
- A security checklist was completed by staff during each of the three shifts. This included checking items were available, such as the ward mobile phone and ligature cutters, and checking all areas of the ward. Staff routinely carried out and recorded three random searches of patients each day, to ensure that contraband or dangerous items were not on the ward.
- The manager told us that all patients had a planned admission to the ward, and would have a risk assessment carried out before they came to the ward. Patients had a risk assessment completed on admission and this was reviewed routinely afterwards. This included the HCR-20 (version 3), which is a recognised risk assessment tool. Risk assessments were routinely reviewed as part of the care programme approach (CPA) process, or when there were changes to a patient's behaviour or situation.
- All patients' bedrooms were locked between 9am-12pm and 1.30-3.30pm each weekday. Staff told us that this was so patients would attend groups, which supported their rehabilitation. Patients had mixed views about this. Patients did not necessarily object to the groups. However, they had limited choice about what they attended, and were clear that if they didn't attend they would lose any leave they had. Staff said that this wasn't the case, but that attending the groups was about engaging with the rehabilitation process. Some leave may be conditional on patients engaging with the service.
- The ward carried out regularly drug screening on all patients.
- There was a policy for enhanced observations, which staff were familiar with. Staff told us that 1-1 observation was rarely used on the ward.
- Staff were trained in the use of de-escalation and physical interventions. The staff we spoke with described how they would attempt to calm down a patient who was agitated, so that physical intervention was usually not required. Restraint was not commonly used on the ward. We saw that there had been eight incidents of restraint over a six month period. Of these, six had included restraint in the prone position. Staff told us that their training included the use of prone restraint, with the proviso that it should only be used if necessary and for the shortest period of time. Staff told us it may be that a patient was initially restrained in the prone restraint, but were then turned over.
- Staff told us that rapid tranquillisation was rarely used on the ward.
- There was a safeguarding policy which staff were familiar with. Staff knew how to raise a safeguarding concern.

Requires improvement

Are services safe?

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

- Medication was managed appropriately on the ward. Medication was stored securely and medication charts were completed correctly. A trust pharmacist visited the ward weekly.

Track record on safety

- There had been a serious incident where a member of staff was assaulted within the last year. The manager described the positive action that had been taken as a result, and that it had also highlighted areas where improvements were required.

Reporting incidents and learning from when things go wrong

- The trust used an electronic system for recording incidents. Staff knew how to identify and record incidents. Any member of staff could submit an electronic incident form which would then be reviewed by the ward manager. It was then passed onto the risk management team, and anyone else who was relevant depending on the type of incident. For example, if there was a concern about the environment it may go to the facilities team. If an incident was patient related a copy of the form was attached to the patient's electronic care record in RIO.
- There was a staff debriefing following serious incidents.
- Feedback from incidents was discussed in the staff meetings.

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.

Summary of findings

We rated effective as good because:

- Patients had their needs assessed, and care plans developed in response to this.
- Patients had their physical healthcare reviewed every three months by a dedicated physical healthcare team in the hospital.
- Records were stored securely and could be shared with the community team.
- There was a structured activity programme five days a week.
- Staff received supervision, appraisal and training.
- Detained patients had their rights under the Mental Health Act explained to them, and had access to an independent Mental Health Act advocate (IMHA).
- The Mental Health Act was implemented correctly in most cases, and any errors were rectified.
- Patients who received a care from the Pathfinder service had regular psychological support. For other patients there was limited access to psychologists and occupational therapists on the ward.

Our findings

Twynam ward

Assessment of needs and planning of care

- Patients were assessed prior to admission, and their care plans had been reviewed within 24 hours of admission. The care plans reflected the assessment of the patient's needs and had been reviewed.
- St Ann's Hospital had a dedicated physical healthcare team, who reviewed each patient every three months. Most patients did not have a local GP, so medical problems would usually be reviewed initially by the junior doctor. Some of the medication patients were taking required them to have regular monitoring such as electrocardiograms (ECGs) and blood tests. The ward had an ECG machine, which was used for monitoring patients, and junior doctors and phlebotomists took patients' blood for tests when required.
- Patients' main care records were stored securely on RIO, a computer records system. Paper records were stored securely in the staff office. Records on RIO could be shared between the ward and community teams.

Best practice in treatment and care

- Staff told us that the ward followed the recovery model when caring for and working with patients. The ward aimed to provide structured meaningful activity for patients from 9-5 on weekdays. We saw that there was an activity programme throughout the week, and that all patients were expected to attend. There was no occupational therapist (OT) based on the ward, but there was limited OT input from the community team. There was a full time activity coordinator.
- All inpatients attended a three monthly health clinic which included taking of bloods and electrocardiograms (ECGs).
- There was limited access to psychological therapies on the ward, except for patients who received the Pathfinder service. However, the skill mix was being reviewed to consider a band 8a psychologist. Psychological advice was provided through the community team. There was an assistant psychologist who provided some groups on the ward, such as mindfulness.
- The service used outcome measures such as health of the nation outcome scales (HONOS).

Skilled staff to deliver care

- Care was provided by a multidisciplinary team of staff. This included nurses and support workers, consultant psychiatrists and a junior doctor, and an activity coordinator. Patients who received the Pathfinder service (two at the time of our inspection) had regular access to psychology support, but there was limited availability for other patients on the ward. An assistant psychologist provided some groups on the ward, and advice was available to the multidisciplinary team meetings. There were no occupational therapist or social workers employed on the ward, but there was limited access through the community team.
- Staff told us that they received supervision, though the time scales varied from once every month to every three months. The trust's incident management system also

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.

incorporated a staff management system which recorded supervision and appraisal. All staff who had been in the service for more than a year had had an appraisal.

Multi-disciplinary and inter-agency team work

- A multidisciplinary team (MDT) meeting was held every week, and each patient was seen and reviewed every two weeks. Many patients on the ward were also seen by staff from the community forensic team. Some of the patients were also working with the Pathfinder team. They were based within the community forensic team, but worked across this and the inpatient ward and provided specialist psychology led support to patients with offending behaviour and a personality disorder.
- There was a verbal and written handover between shifts. This provided detailed information about each patient and included their mental and physical health, and any action that was required.
- Staff routinely worked with external agencies. This was primarily through the community teams, but also with the Ministry of Justice (MoJ) and the police. For example, a patient had not returned to the ward, and staff communicated with MoJ and police until the patient was returned.

Adherence to the MHA and the MHA Code of Practice

- All patients on the ward were detained under the Mental Health Act (MHA). The sample of section papers we looked at were completed correctly. They had their rights under the MHA explained to them, and this was repeated when necessary.
- The patients we spoke with were all aware that they could appeal against their detention. There was information in display about what patients could appeal against depending on which section they were on, which included if patients were subject to MoJ restrictions, or if they were on remand.
- On occasions when patients had stopped being detained, they had been informed of their rights as informal patients, and appropriate arrangements made. Staff told us that they would not admit informal patients directly to the ward.
- Section 17 leave forms were mostly completed correctly, and patients leave was taken in accordance with them. However, we identified a problem with how section 17 leave was recorded for patients who were detained under the MHA and subject to a MoJ restriction. It was unclear whether 'ground leave' was defined as within the ward garden (which was secure) or within the hospital (which was open). This was discussed with the ward, who contacted the MoJ and have subsequently clarified how they record this type of leave, and the permission required from the MoJ.
- Patients confirmed that their medication and their rights with regards to this had been explained. We reviewed three files in relation to recording capacity to consent to treatment and there was evidence that the responsible clinician had recorded the patient's capacity to consent at first treatment for mental disorder. We reviewed the medication file and treatment was given under appropriate legal authority.
- Access to the independent Mental Health Act advocacy (IMHA) service was based on patient request and either staff or self-referral to the service. For Bournemouth and Poole residents this was provided by Rethink, and for Dorset by Dorset mental health advocacy. Advocacy was a standard item on the weekly residents' meeting. The IMHA service told us that they usually only visited patients if they were referred, but they were occasionally invited to the ward meetings. Information was on display about the IMHA service.
- Staff told us they could go to the trust's MHA office for advice about the Act. Staff had had training in the MHA, but were not aware of the revised code of practice.

Good practice in applying the MCA

- The manager told us that approximately half of the ward staff were trained in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They said that patients were usually detained under the Mental Health Act (MHA), so use of the MCA and the DoLS was rare. Most of the staff we spoke with had limited understanding of the MCA.
- There had been no DoLS applications on the ward.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Patients were mostly positive about the staff and the service, and said they felt safe on the ward.
- Patients had their care discussed with them.
- Patients had access to an advocacy service.
- Patients had been involved in deciding on the decoration of the refurbished ward, and an open day had been held for patients' relatives before it reopened.
- A patient on the ward was peer representative and attended ward and forensic service meetings, and was able to raise patients concerns.
- Although patients were mostly positive about their care, they were less certain about the blanket policy of locking doors during the day and what they saw as compulsory attendance at groups.

Our findings

Twynam ward

Kindness, dignity, respect and support

- The interactions we observed were positive, friendly and respectful. During our inspection the atmosphere on the ward was calm and relaxed.
- All the patients we spoke with said they felt safe on the ward. They thought it was well managed, and said there wasn't a problem with violence or drugs on the ward. They were positive about the staff, and how they were treated by them. Some patients found the staff 'controlling', particularly when they were told what to do on the ward.

The involvement of people in the care they receive

- Patients were shown around the ward when they were admitted, and this was included on the admission checklist. Staff also explained why the patient was on the ward and what they could expect. This included what medication they were taking, who was involved in their care, and that they would be expected to participate in groups as part of their care plan and what they were.
- Four of the patients we asked told us that they had had their care discussed with them, and there of these had a copy of their care plan. The care records showed that patients were involved in discussions about their care. Patients had mixed views about the groups they attended, but felt that they had to attend them as their bedrooms were locked and if they did not attend they would lose their leave. Even though they did not necessarily dislike the groups, they said they did not get a choice in what they participated in. Staff told us that the rationale for this was that it was important for patients to engage with groups as part of their rehabilitation plan, and that this was explained to patients. Staff said that bedrooms were locked to discourage patients from staying in bed all day, which would not support their recovery. Not all of the care plans we looked at referred to the groups that patients participated in.
- Patients had access to an advocacy service. Information about the service was displayed on the ward.
- The ward held an open day for relatives of current inpatients, which eight people attended. Visitors were not allowed onto the ward, so the open day was held shortly before the refurbished ward opened. This gave people a sense of where their relatives were staying. There was a strategy document for promoting involvement of carers, but this had yet to be fully implemented.
- A voluntary organisation worked with patients and staff to decide how the refurbished ward should be decorated.
- One of the patients on the ward was a peer representative, and attended the clinical strategy group where the development of the service was discussed. The manager told us that the peer representative was now able to email the ward manager directly on patients' behalf.
- There were residents' meetings during which patients raised their concerns, were updated on developments on the ward, and discussed the group timetable. We saw that patients views had been taken forward and changes made following the meeting. For example, changes to the times of some of the groups.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as good because:

- Patients had their own room, and a lockable draw and locker for valuable or contraband items.
- There was a kitchenette where patients could make their own drinks.
- There was a structured activity programme that ran five days a week.
- The service had a car to support patients to access services in the community.
- There were rooms on the ward for patient activities, and outdoor space.
- The service routinely reviewed the care, needs and effective risks of all inpatients. It also reviewed all referrals, people on its waiting list, and patients in services outside the trust team. With the exception of nursing staff and support workers, all staff worked across both inpatient and community services.
- There were no delayed discharges at the time of our inspection.
- Patients were aware of the trust's complaints policy.
- However, the trust had no secure inpatient facilities for women, so any woman requiring this would have to be admitted out of area.

Our findings

Twynam ward

Access and discharge

- At the time of our inspection there were eight patients on the ward, and there were 10 beds available that would be increased to 12 after the refurbishment. There were three male patients in other low secure hospitals. They were scheduled to return to the ward when the refurbishment of all the beds was completed. Senior managers told us that compared to the national specification for secure beds they should have 34 beds, but they were only commissioned for 12. This was part of an ongoing discussion with commissioners.
- There are no inpatient forensic facilities for women in the trust. The trust is currently not commissioned to provide these. Female patients were typically admitted to a unit in a neighbouring trust. Female community patients and their carers told us that there was a problem getting access to inpatient services for female patients. Staff told us that when women were placed in distant placements for extended periods of time, then arrangements could be made to ensure the care pathway was effective, and that families were involved. However, this was more difficult when women, particularly those with families, were in crisis and needed inpatient care at short notice. There were ongoing discussions with commissioners about the provision of forensic inpatient services for women.
- The waiting list for the service was managed by the Dorset forensic community team. The referrals went to the community team, and if suitable were admitted to the ward. Most patients were already in forensic mental health services. For example, they may have moved from a medium secure unit to a lower level of security, or may have been in the community and recalled to the unit by the Ministry of Justice for breaching their restrictions.
- The Dorset forensic community team remotely managed all forensic patients from the Dorset area. This included about 50 patients in different services outside the trust. A small number of patients were in male low secure beds, but most were in services not provided by the trust. This included learning disability and acquired brain injury, and some people were in prison. The trust had no female low secure, or male or female medium or high secure services so patients who needed this level of care and security could only be placed outside the trust. Medium secure services were usually provided by an NHS trust in Hampshire.
- For patients out of area staff aimed to attend every CPA and visit every three months. This included the consultants. Time constraints made this difficult, particularly as some patients were placed in the north of England.
- Staff told us that the average length of stay was 18 months. There was no one on the ward who had been an inpatient for longer than this at the time of our inspection.
- The ward had close links with the community forensic team. Most of the multidisciplinary team, except nursing staff and support workers, worked across both the inpatient and community service.

Are services responsive to people's needs?

Good

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

- There were no delayed discharges at the time of our inspection. Staff told us there could be delays caused by lack of suitable placements for patients in the community. Some patients were discharged to independent living or to live with their family, but many went into supported accommodation. There were three adult social care services in Dorset that the forensic community teams had close links with, and worked closely with as a number of their patients lived there. There were no specialist homes in the Poole area. Delays could be caused by delays in confirming funding, or more commonly by difficulties finding a suitable placement with bed availability. Placements were usually arranged by the community team.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own room. Patients' bedrooms had an inbuilt blind in the door window. Patients could adjust this from the inside if they wanted privacy, and staff could control it with a key from the outside if they needed to observe the patient. The manager pointed out that the blinds in one of the bedrooms had been fitted the wrong way, and they were waiting for this to be rectified.
- The ward had an open kitchenette area where patients made themselves drinks. Food was provided from the hospital kitchen, and patients had a choice of food.
- There was a structured activity programme on the ward, which ran five days a week. The ward had an eight-seater vehicle that was used to take patients out in the community. This included to the ward allotment. There was an onsite gym with a trained instructor. Other activities included mindfulness, arts and crafts, rambling, outdoor sports and watching DVDs. Staff told us that the aims of each group varied, but they aimed to promote structured healthy activity, group work, social inclusion, and learning new skills. The ward had a multi-use room which could be used for groups, and had projection display facilities, and kitchen facilities. There were no activities available at weekends, but patients told us there was always something to do.
- Patients did not have door keys, but had a lockable draw in their room. Patients also had lockers in a separate area that were used to store potential harmful items such as razor blades. Patients had the code to these lockers, but it could be overridden by the ward manager if necessary.
- Patients had personalised their rooms. This included with personal effects, and with their own entertainment such as televisions and DVDs.
- There was a payphone on the ward. Computer and internet access was provided in a room with the monitor secured behind a clear screen. We were advised that staff supervised patients when they used these facilities, and there were controls on the sites visited.
- There was an outdoor courtyard. This was currently in the process of refurbishment, so access was supervised. We saw that patients regularly used the space, which included for 'fresh air' or smoking breaks. There was a fixed table tennis table in the courtyard, and a gardening group planted and maintained raised beds.

Meeting the needs of all people who use the service

- There was information on display which included the activity programme, how to complain, and details of MHA solicitors and IMHAs.
- There was a multi-faith room in the hospital, which could be used by patients from Twynam ward. There was access to a hospital chaplain.
- Staff told us that there was no one on the ward at the moment required food that met their ethnic or religious dietary requirements, but this could be ordered when necessary.
- Staff told us that most of their patients were British and spoke English. However, if required Interpretation services were available through Language Line, a phone translation service.

Listening to and learning from concerns and complaints

- There had been four formal complaints in the year up to May 2015, two of which were upheld.
- There was a complaints policy. Patients raised complaints by talking to staff on the ward, making a formal complaint in writing, or raised issues at the residents' meeting. For example, patients had raised an

Are services responsive to people's needs?

Good

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

issue in the residents' meeting about the (then ongoing) refurbishment of the ward. They wanted aerial sockets in each of the patients' bedrooms, so that patients could have their own television. This had initially been turned down because of cost. However, the peer representative wrote to the chief executive about this, and a solution was found.

- There was information on display about how to make a complaint. This included telephone and email details to complain directly to the trust's complaints team, and a complaint webform that patients could complete online.

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.

Summary of findings

We rated well-led as good because:

- Staff were mostly positive about their managers and the staff they worked with. They felt able to speak out and voice their concerns.
- The ward had participated in the Royal College of Psychiatrists' quality network for forensic mental health services annual review cycle.
- The service had individual groups that focused on the three parts of the service: inpatient, community (which included referral and out of area patients) and the Pathfinder service. These fed into an overarching governance group that monitored the quality of the whole forensic service. All the groups included clinical and managerial staff. The inpatient group was attended by a peer representative, who was a patient on the ward.
- The forensic service used information from and fed into the governance systems within the trust.

Our findings

Twynam ward

Vision and values

- Staff reflected the trust's purpose to support patients' recovery by providing compassionate care, and team objectives aimed for excellence and expertise.

Good governance

- The forensic service had reviewed how it monitored the quality of its service, with the aim of improving the service, improving how the inpatient and community services worked together, and for monitoring of forensic services that were provided for Dorset patients outside the trust (out of area low secure for some men and all women, all medium secure services, and all high secure services).
- A monthly forensic service governance group had been established in May 2015, with an overview of the whole service. There were specific groups that fed into this from the inpatient service, the community team, and the Pathfinder service. A monthly forensic inpatient working group was due to start in July, as a predecessor meeting had not taken place during the refurbishment, as the focus had been on the new ward. There was a fortnightly Pathfinder review meeting, which discussed business and governance issues and caseload management. There was a weekly allocations meeting that discussed the Dorset forensic team community caseloads and management, and referrals, allocations and other issues within the team.
- These groups fed into one another so that service developments and concerns, specific patient care and risks, and the usual incidents and complaints could be reviewed by the team, and managed effectively. Some of the groups were new, or had developed from previous meetings, but we saw that they included detailed identification of issues, discussion, and actions which were followed up on.
- All the groups included clinical and managerial staff. The inpatient group was attended by a peer representative, who was a patient on the ward. The forensic service used information from and fed into the governance systems within the trust.
- The manager used several different tools for monitoring staff, performance, incidents and complaints. These were potentially confusing as information was not contained in an obvious place, but the manager was familiar with them.

Leadership, morale and staff engagement

- Staff generally felt supported by their managers, and were positive about the staff they worked with. There had been changes amongst the staff, which included new staff working on the ward, so not all staff had a lot of experience of working in a forensic setting.
- Staff told us they felt able to speak out and raise concerns. Most staff we spoke with were positive about the service, but were also able to be open about where they thought there were gaps. There were staff meetings, which included a peer representative who was a current patient on the ward. The group had recently been restarted so it was not possible to see how earlier issues had been addressed.
- The executive level lead for the service was the locality director for Dorset. The clinical lead was the consultant psychiatrist.

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.

Commitment to quality improvement and innovation

- The ward participated in the Royal College of Psychiatrists' quality network for forensic mental health services annual review cycle. This was part of the College Centre for Quality Improvement (CCQI) self and peer review against standards for medium secure services (2014) and low secure services: good practice commissioning guide (consultation draft) (2012). A peer review was carried out on the 29 May 2015. The ward fully met 82% of the low secure standards, and achieved 100% of the standards in physical healthcare, discharge, physical security and workforce. Areas that were partly met included admission, relational security, service environment, governance and equalities. The service had developed an action plan to address these areas, which took account of the then pending move back to the refurbished ward.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The ward did not have effective processes for reducing the risks to patients and staff. This included risks in the environment, gaps in policies for and implementation of procedural security, and the unsafe use of sharps bins.** This was a breach of Regulation 12(1)(2)(a)(b)(c)(d)(e)(h)