Outstanding ☆

Dorset Healthcare University NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDY10	St Ann's Hospital	Seaview ward Harbour ward Dudsbury ward	BH13 7LN
RDY10	Linden unit	Linden unit	DT4 0QE
RDYEW	Waterstone assessment unit	Forston Clinic	DT2 9TB

This report describes our judgement of the quality of care provided within this core service by Dorset Healthcare University NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Dorset Healthcare University NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset Healthcare University NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
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 the acute wards for adults of working age and psychiatric intensive care unit at Dorset Healthcare University Foundation Trust as outstanding because:
- We found very caring, compassionate and motivated staff, and, saw good, professional and respectful interactions between staff and patients during our inspection. Patients commented positively about how kind the staff were towards them. We found that staff promoted egalitarian relationships with patients and showed empathy consistently. We saw evidence of initiatives implemented to involve patients in their care and treatment. We saw that all of the acute wards used the Safe wards interventions to ensure they provided a contained and therapeutic environment for patients.
- A service model and acute care pathway which optimised patients' recovery, comfort and dignity was in place. There was a varied, strong and recovery orientated programme of therapeutic activities, many of which were instigated at the suggestion of patients. People with lived experience of mental health conditions delivered a series of educational and skills based workshops and programmes, directly on the wards for patients in partnership with staff. We noted the service was responsive to listening to concerns or ideas made by patients and their relatives to improve services. Bed management processes were very effective and patients were able to access an acute and PICU bed when required.
- Wards were kept clean and well maintained and patients told us that they felt safe. There were enough, suitably qualified and trained staff to provide care to a good standard. We found that patients' risk assessments and formulations were robust and person centred and that the service had strong mechanisms in place to report incidents and we saw evidence that the service learnt from when things had gone wrong. However, the provider should review the description of the word seclusion while describing de-escalation on RIO in order that the intervention is accurately described and review availability of outside space on Seaview ward for non-smokers.
- The assessment of patients' needs and the planning of their care was individualised and had a strong focus on recovery. Most staff had a good understanding of the Mental Health Act 1983 (MHA), the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice. We saw throughout all of the wards that the multi-disciplinary teams were involved in assessing and delivering patient care. We found motivated and supportive ancillary staff on all of the wards. However, the provider should maximise use of the physical health teams, review input from psychology in order to offer patients a good selection of psychological therapies, review procedures for acquiring advance directives from patients and address training across all staff groups on the new Mental Health Act Code of Practice.
- Staff morale was good and they were well supported and engaged. There was visible and strong leadership team which included both clinicians and managers. Governancestructures were clear, well documented, adhered to by all of the wards and reported accurately. Managers and their teams were fully committed to making positive changes. Each manager had developed a ward business plan which included submissions to secure capital funds in order to develop and implement improvements to the service.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- We found that the wards were kept clean and well maintained and patients told us that they felt safe.
- There were enough, suitably qualified and trained staff to provide care to a good standard.
- Patients' risk assessments and formulations were robust and person centred.
- The service had strong mechanisms in place to report incidents and we saw evidence that the service learnt from when things had gone wrong.

However:

The provider should review the description of the word seclusion while describing de-escalation on RIO in order that the intervention is accurately described and review availability of outside space on Seaview ward for non-smokers.

Are services effective?

Good

We rated effective as good because:

- The assessment of patients' needs and the planning of their care was individualised and had a strong focus on recovery.
- Most staff had a good understanding of the Mental Health Act 1983 (MHA), the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice.
- Throughout all of the wards the multi-disciplinary teams were involved in assessing and delivering patient care.
- We found motivated and supportive ancillary staff on all of the wards.

However:

The provider should maximise use of the physical health teams, review input from psychology in order to offer patients a good selection of psychological therapies, review procedures for acquiring advance directives from patients and address training across all staff groups on the new Mental Health Act Code of Practice.

Are services caring?

Outstanding

We rated caring as outstanding because:

- We found very caring, compassionate and motivated staff, and, saw good, professional and respectful interactions between staff and patients during our inspection.

Summary of findings

- Patients commented positively about how kind the staff were towards them.
- Staff promoted egalitarian relationships with patients and showed empathy consistently.
- We saw evidence of initiatives implemented to involve patients in their care and treatment.
- All of the acute wards used the safe wards interventions to ensure they provided a contained and therapeutic environment for patients.

Are services responsive to people's needs?

Outstanding 

We rated responsive as outstanding because:

- We found a service model and acute care pathway which optimised patients' recovery, comfort and dignity.
- There was a varied, strong and recovery orientated programme of therapeutic activities, many of which were instigated at the suggestion of patients.
- People with lived experience of mental health conditions delivered a series of educational and skills based workshops and programmes, directly on the wards for patients in partnership with staff.
- We noted the service was responsive to listening to concerns or ideas made by patients and their relatives to improve services.
- Bed management processes were very effective despite the difficulties with high bed occupancy
- Patients were able to access an acute and PICU bed when required.

Are services well-led?

Good 

We rated well-led as good because:

- We found all staff to have good morale and that they felt well supported and engaged with a visible and strong leadership team which included both clinicians and managers.
- Governance structures were clear, well documented, adhered to by all of the wards and reported accurately.
- Managers and their teams were fully committed to making positive changes.
- Each manager had developed a ward business plan which included submissions to secure capital funds in order to develop and implement improvements to the service.

Summary of findings

Information about the service

The Acute wards provided by Dorset Healthcare University NHS Foundation Trust were provided at St.Ann's Hospital in East Dorset and at The Waterston assessment unit (within the Forston Clinic) in Dorchester and the Linden unit in Weymouth. At the time of our inspection the PICU unit at St.Ann's Hospital, Haven ward, was closed for refurbishment. Male and female PICU beds required across Dorset were being commissioned and provided by an independent mental health hospital provider.

St.Ann's Hospital in Poole has three wards. Seaview is the admission and assessment ward and has 14 mixed gender beds. Harbour ward is an acute treatment ward with 16 male beds. Dudsbury is an acute treatment ward with17 female beds. At the time of our inspection Dudsbury ward had been temporarily relocated to Mereley ward to enable the refurbishment of Dudsbury ward.

The Waterston acute assessment unit in Dorchester has one ward and has 13 mixed gender beds.

The Linden unit in Weymouth has one ward and has 16 mixed gender beds.

We have inspected the services provided by Dorset Healthcare University NHS Foundation Trust 35 times between 2012 and 2015, across 18 locations. At the time of the last inspections, the acute wards at St. Ann's Hospital were compliant with the essential standards inspected in December 2013. The Waterston assessment unit was compliant with the essential standards inspected in April 2015. The Linden unit were non-compliant against outcomes 13 (Staffing) and outcome 16 (Assessing and monitoring the quality of service provision), when essential standards were inspected in May 2013.

We have inspected three of the Acute wards provided by Dorset Healthcare University Foundation Trust from August 2014 to March 2015 via our Mental Health Act monitoring visits.

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 Disabilites and Substance Misuse, Care Quality Commission

The team that inspected the Acute wards consisted of 15 people, divided into two smaller teams;

- Two experts by experience and one supporter;
- Two inspectors;
- Two Mental Health Act reviewers;
- Four nurses with experience of working in acute settings;
- One social worker with experience of working in acute settings;
- One occupational therapist with experience of working in acute settings
- One pharmacist (for half a day); and
- One psychiatrist with experience of working in acute settings.

Why we carried out this inspection

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

Summary of findings

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, asked a range of other organisations for information and sought feedback from patients at focus groups. .

During the inspection visit, the inspection team:

- Visited all five of the wards at the three separate hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients;
- Spoke with 24 patients who were using the service; · Spoke with five carers of patients using the service;
- Spoke with the ward managers and team leaders, where available, for each of the wards; · Spoke with 61 staff members; including doctors, nurses, occupational therapists, support workers, ancillary staff, student nurses, student occupational therapists, volunteers and held two staff focus groups;
- Interviewed the senior management team with responsibility for these services, including the hospital manager and the service manager;
- Attended 13 patient meetings and groups; and
- Attended and observed eight multi-disciplinary clinical meetings.

We also:

- Looked at 32 treatment records of patients;
- Carried out a specific check of the medication management on Seaview ward; · Looked at 31 medication administration charts;
- Carried out a specific check of the Mental Health Act on Dudsbury ward;
- Looked at a range of policies, procedures and other documents relating to the running of the service;
- Collected feedback from eight patients using comment cards; and · Attended a meeting for carer's leads.

What people who use the provider's services say

- We spoke with patients and their relatives and the vast majority of comments were positive and complimentary about their experience of care in the acute wards. They told us that they found staff to be caring, kind, professional and supportive towards patients.
- Most patients felt that they were actively involved in looking at choices for and making decisions about their care and treatment.
- We were told that staff were particularly empathetic and developed egalitarian relationships with their patients that supported recovery.

Good practice

- We noted the acute wards were implementing the nationally recognised safe wards initiative which seeks to reduce conflict on a ward environment through a variety of strategies which are containing and therapeutic for patients. The initiative provides resources for wards to implement good practice which creates better and more positive relationships between patients and staff.
- We noted that each ward had either a sensory room or the availability of a calm box, or both. Staff and patients spoke positively about this initiative which provided a coping skills toolbox, full of aids to assist in calming distress, anxiety and agitation. Examples included something to touch, such as stress balls; some music to listen to; happy pictures to look at; herbal teas to taste and aroma therapy to smell. The initiative was part of the nationally recognised good

practice example of safe wards. We also noted that charitable funds had been raised to ensure the sensory rooms were furnished and equipped to a very high standard.

- We saw a variety of approaches used by staff to support holistic, occupation focussed, patient centred evidence based practice. We noted a plan to roll out dialectical behaviour therapy (DBT) training for nurses and we saw that at least one nurse on every ward was trained.
- We noted a particularly positive and successful initiative implemented called, "Getting to know us", part of the safe wards interventions. The aim of the intervention was to enhance therapeutic relationships between staff and patients through the sharing of personal information. All wards advertised posters, with pictures of all staff and described their likes, dislikes, preferences for music, hobbies, food, travel, aspirations and hopes for themselves. The information shared personal information about staff and showed an openness and trust to allow patients access to such information.
- We observed inter-agency working taking place. We attended one of the services' regular police liaison meetings, attended by the hospital manager, the head of patient safety and riks, the patient safety manager and the police neighbourhood liaison officer. We noted strong and firmly established relationships between the provider and the police which were conducive to positive outcomes. For example, we saw a sizable reduction in inappropriate telephone calls made to the police, by ward staff, following the introduction of clear guidance on the criteria. We also heard that all police received mental health training and that the police mental health co-ordinator spent time on the acute wards as part of their induction to the role.
- We noted a joint project between the trust and the Dorset Mental Health Forum across all of the acute wards. It was called the Wellbeing and Recovery Partnership (WaRP). We saw that peer specialists, people with lived experience of a mental health condition, provided a varied and rich programme of educational and recovery focussed sessions on the wards. In addition patients had access to the Recovery Education Centre which offered many courses to enable patients to understand their experiences, manage their recovery and also how to support others with their journey. We saw that peer specialists provided recovery coaching to patients and staff on the wards and provided patients with personal support plans.
- We saw that a number of support worker staff had attended training on phlebotomy. This enabled good monitoring of patients physical health needs and meant medication monitoring could be carried out in a timely manner.
- We noted that each of the acute wards had a carers lead staff member and that the leads meeting was proactive in engaging carers through of variety of initiatives. We saw that peer carer specialists were employed by the Dorset Mental Health Forum to work within the trust. These are people who have lived experience of being a carer for someone experiencing mental health problems. Examples were given of carer drop in sessions and carers, "high tea" events, picnics and peer specialists working with the staff carers leads to improve engagement with carers. We noted a carer resource pack was available electronically.
- We noted the co-ordinating chaplain was a member of the therapies team and provided picnic poetry appreciation sessions for patients in the grounds of the hospital. A number of patients told us how appreciative they were about these sessions and how much they had enjoyed them.
- We noted each ward had a permanent computer, housed in attractive home office furniture, in communal lounges for use by patients at any time. The computers had pre-loaded PDF documents on the desk top with information on the Mental health Act and the Code of practice.
- We spoke to staff about an initiative set up to support staff, called, "Hidden talents." This was an additional forum for staff who have had or have mental health issues. The support forum was an action group working with National guidelines promoting people in the workplace with lived experience of a mental health need.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review the description of the word seclusion while describing de-escalation on RIO in order that the intervention is accurately described.
- The provider should maximise use of the physical health teams.
- The provider should address training across all staff groups on the new Mental Health Act Code of Practice.
- The provider should review procedures for acquiring advance directives from patients.
- The provider should review availability of outside space on Seaview ward for non-smokers.
- The provider should review the bed manager roles and responsibilities as the post has multi-functions and is extremely busy.

Dorset Healthcare University NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Seaview ward Harbour ward Dudsbury ward	St. Ann's Hospital
Waterston assessment unit	Forston Clinic
The Linden unit	The Linden unit

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.

- We checked 15 files of people detained under the Mental Health Act. We did this by looking at three of the files of detained patients on each of the wards and carried out a specific Mental Health Act review on Dudsbury ward to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act and Code of Practice. In most cases this was correct. Where it was not the deficiencies were minor. The Mental Health Act documentation we looked at was in good order with one exception.
- Capacity and consent was regularly being considered and the consent to treatment requirements were being followed. We spoke to one of the independent Mental Health Act advocates who was regularly involved with patients from the acute wards. The advocate made positive comments about working with the wards and about the support received from staff. There was an effective process in place to scrutinise the legal documentation as errors with two patients had been

identified and dealt with. The trust could demonstrate that there is a systemic process in place to ensure that the operation of the Mental Health Act meets legal requirements. Weekly ward audits of Mental Health Act 1983 paperwork had been introduced and this enabled staff to ensure that the requirements of the act were being met.

- Good conditions of Section 17 leave were being recorded and reviews of risk carried out prior to leave. Capacity and consent was being assessed and recorded on admission and within the first three months prior to the statutory requirement to do this which was felt to be good practice and in line with the Mental Health Act 1983, accompanying Code of Practice.

Section 132 rights were found in most cases being given and recorded in line with the trust policy.

- Good signage was observed throughout all of the wards offering informative information for patients and carers including information regarding Independent Mental Health Advocacy Services (IMHAS). Notices were in place on exit doors for informal patients who wished to leave the ward.
- We noted each ward had a permanent computer, housed in attractive home office furniture, in communal lounges for use by patients at any time. The computers had pre-loaded PDF documents on the desk top with information on the Mental health Act and the Code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted that all clinical staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and that over 68% of eligible staff were up to date with refresher courses.
- No patients on any acute inpatient wards were being treated under Section 5 of the Mental Capacity Act.
- There were no current Dols applications and this was appropriate.

Good

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 good because:

- We found that the wards were kept clean and well maintained and patients told us that they felt safe.
- There were enough, suitably qualified and trained staff to provide care to a good standard.
- Patients' risk assessments and formulations were robust and person centred.
- The service had strong mechanisms in place to report incidents and we saw evidence that the service learnt from when things had gone wrong.

However:

The provider should review the description of the word seclusion while describing de-escalation on RIO in order that the intervention is accurately described and review availability of outside space on Seaview ward for non-smokers.

Our findings

Safe and clean environment

- The layouts of the wards enabled staff to observe the majority of the ward areas. Where observation was restricted we saw that risk mitigation plans had been put in place. We noted additional mirrors had been put in place in corridors, which improved visibility.
- We noted that Seaview and Harbour wards had an electronic door locking mechanism. Every patient had their own door fob to access their bedroom area and communal areas of the wards. Staff and patients commented positively on the system which enabled patients a good amount of independence to move freely around the wards. We saw that there had been a number of ongoing incidents where the door locking mechanism was faulty, which had led to doors locking or not locking, and sticking. We were told the contractor responsible for providing the system was reviewing the issues in order to provide a solution.
- We saw that all wards had ligature risk assessments. Specific action to be taken to mitigate the risks identified were detailed. We noted that where the trust had planned refurbishment work on wards that an anti-ligature capital works programme was implemented. At the time of our inspection refurbishment work was taking place on Dudsbury and Haven wards at St.Ann's Hospital.
- We saw that all of the wards had electric cigarette lighters provided on the walls in the smoking areas. This negated the need for patients to carry lighters, which in turn, lowered the risk of smoking in rooms and potentially fires.
- All wards, where services were for mixed gender patients, had separate male and female sleeping, lounge and bathing facilities.
- In all wards, emergency equipment was stored in well equipped clinical rooms. An automated external defibrillator and anaphylaxis pack were in place. All emergency equipment was checked weekly to ensure it was fit for purpose and could be used effectively in an emergency.
- None of the wards had a seclusion room. A seclusion room had been available at St.Ann's hospital, attached to the psychiatric intensive care unit , but was closed for refurbishment at the time of our inspection. All wards had de-escalation rooms and we noted a procedure for the use of the rooms was in place. We saw that the protocol contained flow charts describing the pathway for de-escalation and seclusion and the associated practices required. We also noted that the protocol had received an equality analysis to examine the potential impacts the procedure may have on staff and patients. We did however note, on two occasions, that staff had described the process of de-escalation as seclusion in the electronic care records and we brought this to the attention of senior managers. We noted that the trust had taken an annual report to the trust board in June 2015, reviewing its progress towards positive and proactive care which reduces the need for restrictive interventions.
- At the time of our inspection Dudsbury ward had temporarily de-canted to Mereley ward. The move had taken place one week before our Inspection. An extensive refurbishment had commenced on Dudsbury ward, due for completion in October 2015. We found Dudsbury ward (on Mereley ward) to be particularly

Good

Are services safe?

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

organised and ordered following the temporary move. We found that Mereley ward had three, four bedded, shared dormitory rooms. All but one patient we spoke to, spoke positively about their shared bedroom facility.

- All wards were well maintained and clean throughout. Furniture, fixtures and fittings were provided to a good standard. Staff conducted regular audits of infection control and prevention and staff hand hygiene to ensure that patients, visitors and staff were protected against the risks of infection.
- We were aware that the fire brigade had concerns about the fire safety on Dudsbury ward but were assured that the refurbishment would address these concerns.
- We noted that the patient-led assessments of the care environment (PLACE) for cleanliness across the acute wards averaged at 97% which was the same score as the average trust site and that of National hospital sites in mental health. The score for environmental upkeep and maintenance was 93% which was a higher score than the trust average at 92.5% and the National average of 91.5%.
- The staff carried out a range of environmental and health and safety audits and risk assessments, including checks on standards of cleanliness.
- Alarms were available in each room on the wards and all staff carried alarms. We were told by staff that alarms were responded to in a timely manner. We noted that the alarm system was a silent one, with appointed staff only, on each ward, receiving information via a pager about the activated alarm site. We found this assisted in the wards remaining calm and quiet with no disruption caused by alarms sounding, potentially, throughout the night and day.
- We saw evidence that all wards participated in regular health and safety meetings.

Safe staffing and key staffing indicators

- Most staff we spoke to said there were sufficient staff across all five wards to deliver care to a good standard. We found on the acute assessment and treatment wards a minimum staffing level of two qualified staff and three support workers. We noted that Dudsbury ward had enhanced staffing levels to mitigate the risks associated with the ward move and to enable use of a courtyard area. We reviewed available staff rotas and found that staffing levels provided were consistent with those planned. Where temporary staff were utilised we saw that managers attempted to use staff familiar with the wards.
- We saw vacancy levels across the trust were at 9% and were at 14% across the acute wards. We noted that Dudsbury ward had recently increased the nursing establishment by six posts which had been recruited into, staff due to start work within weeks, and that these vacancies had caused the high reported figure of 34% vacant posts on this ward. We saw that staff turnover across the trust was at 14.5% and that only Seaview ward had a higher turnover at 22%. Managers across the acute wards acknowledged that it was sometimes difficult to retain qualified nurses and that they were analysing reasons for this.
- We were told by ward managers that senior managers were flexible and responded well if the needs of the patient's increased and additional staff were required.
- We noted sickness absence rates for the year to January 2015 across the trust were 4.7% and for the acute wards this figure averaged at 6.8%. Managers acknowledged that the sickness and absence figures were too high and were analysing reasons for this.
- We saw that the majority of patients received a 1:1 time during the day, with staff, and that escorted leave or scheduled activities were rarely deferred or cancelled.
- Staff that had been trained in the use of physical interventions were identified on the rota to ensure there were sufficient staff available if required to assist.
- We saw evidence that the acute wards had access to a wider multi-disciplinary team which included psychiatrists, occupational therapists, a gym facilitator, activity workers, social workers and pharmacists. We noted that the acute wards did not have any psychology input.
- Medical staff told us that there were adequate doctors available over a 24 hour period, seven days each week who were available to respond quickly on the ward in an emergency.
- The trust, as of April 2015 had completed mandatory training for 91% of eligible staff, with a target of 85%. Most staff in the acute wards had received and were up to date with appropriate mandatory training and the average mandatory training rate of compliance across the acute wards was 87.25%. However Seaview and Harbour wards fell below 85% compliance with

enhanced life support training. All of the three wards at St.Anns fell below 85% compliance with child protection, level 2 training and Seaview ward fell below 85% compliance with adult protection, level 2 training.

Assessing and managing risk to patients and staff

- We sampled 32 electronic care records across all of the wards, including some for those patients who were detained under the Mental Health Act. The acute wards used an electronic care record system (RIO), which included the risk profile documentation. We noted all patients had received a comprehensive risk assessment on admission and that these were updated regularly and reviewed following any significant occurrence. We saw that all patients, where they had wanted to and had consented to, had been actively involved in the risk assessment process.
- We saw that risk formulations were good and that the regular reviews of risk took place in multi-disciplinary meetings and that the care programme approach (CPA) was used to assist risk management processes.
- We noted a recent acute ward audit that showed 100% of patients had an up to date risk assessment.
- We found that any blanket restrictions on the acute wards, such as contraband items and locked doors to access and exit the ward doors where justified. Clear notices were in place for patients explaining why these restrictions were being used. Informal patients were advised through signage that they were free to leave at will, and this information was also detailed in the ward information leaflets. We found all of the acute wards highlighted their approach to us and their patients, of applying least restrictive practices, to keep their patients safe while encouraging their independence and choice.
- Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was safely managed. We found that patients were individually risk assessed to determine their level of observation on the ward. For example, the level and frequency of observations of patients by staff were increased, if assessed as being required. Individual risk assessments we reviewed took account of patients previous risk history as well as their current mental state. We noted on Dudsbury ward that extra staff were used during the day to enable patients to safely use of a courtyard area, which was not directly visible from the ward area. Patients told us how important it was for them to be able to spend time in the courtyard area.
- We noted that staff actively promoted de-escalation techniques to avoid restraints and seclusion where possible. We saw evidence that all staff were trained in promoting safer and therapeutic services. We saw that staff were trained in two evidence based systems which were used across the acute wards, stress incident management and trauma incident management. Seaview and Dudsbury ward had the highest level of restraints and Linden and Harbour wards the lowest. 22% of all restraints took place using the prone position and of these, 78% resulted in the use of rapid tranquilisation.
- There were no long term segregation arrangements for any patient.
- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. We noted however that below 85% of staff had received updated refresher training in safeguarding vulnerable adults and children. Staff were aware of the trust's safeguarding policy. We noted that all safeguarding alerts were discussed in the regular police liaison meeting, which we attended. We tracked three of these cases through the RIO care records and found that all appropriate procedures had been followed and recorded, including the discussions with the police.
- Our pharmacy inspector carried out a specific and detailed medicines check on Seaview ward and we looked at the management of medicines across all of the acute wards which we found to be of a good standard. We found that most patients on Seaview ward were prescribed medicines for the management of challenging and overactive behaviour on a "when required basis" . The medication administration records indicated that these medicines were not used, at the maximum prescribed doses, on a continuous basis. The ward pharmacist told us that when patients were no longer overactive or at risk of harm associated with such behaviour, these medicines were then reviewed. They were reviewed on a regular basis from there on in to check if the medication was still required. Whilst the trolley for medicines and equipment required in an emergency was not tamper proof, it was kept in the treatment room which only staff had access to.
- For any patients wanting to see children from their family we found that processes and protocols had been

put in place to accommodate this. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. Separate and secure family rooms were available away from the ward areas.

Track record on safety

- We noted five recent serious incident occurrences across the acute wards which included two deaths, soon after discharge, from the wards and one inpatient death, currently being investigated. Other recent incidents reported from the acute wards included two violent incidents involving potential weapons and one self-harm incident. We saw that following reviews of the incidents changes to practice had been made to prevent any further occurences.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system (Ulysses). All incidents were reviewed by ward managers and forwarded to the service manager. All incidents were electronically forwarded to the patient's safety team. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. The patient safety team analysed recommendations from all serious incidents and reported these back to the acute services, for discussion in team and service wide meetings. All incidents were subject to root cause analysis, led by clinical staff.
- We were told by staff that they received feedback from investigations, in regular team meetings and that key themes and lessons learnt were discussed and action plans developed if change was needed. Staff we spoke with said there was always a de-brief session arranged, after a serious incident, and, that a facilitated, reflective session would take place to ensure, as well as learning lessons, that staff felt adequately supported. Staff told us that a daily supervision slot was held on every acute ward for half an hour, following every handover, and that the session was critical in providing support and a space to think reflectively on their practices and the needs of patients.
- We noted four written examples of staff de-briefing sessions, following serious incidents and we spoke to staff about these events. We saw that learning outcomes for teams had been highlighted and addressed in order to prevent a re-occurrence. Staff commented positively about the opportunity given to hold a de-brief meeting, receive support and also to put action plans in place to learn lessons from incidents.
- We noted that where capital works had taken place across the acute wards that lessons had been learnt on creating a conducive and high quality environment for patients and staff. For example ceiling heights and corridor widths had been maximised to ensure a feeling of space and to increase light into the ward areas.

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:

- The assessment of patients' needs and the planning of their care was individualised and had a strong focus on recovery.
- Most staff had a good understanding of the Mental Health Act 1983 (MHA), the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice.
- Throughout all of the wards the multi-disciplinary teams were involved in assessing and delivering patient care.
- We found motivated and supportive ancillary staff on all of the wards.

However:

The provider should maximise use of the physical health teams, review input from psychology in order to offer patients a good selection of psychological therapies, review procedures for acquiring advance directives from patients and address training across all staff groups on the new Mental Health Act Code of Practice.

Our findings

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans. Records showed that all patients received a physical health assessment on admission and regularly from there on in and that risks to physical health were identified and managed effectively. We noted care plans were available for patients with an identified risk associated with their physical health. We noted however that two patients did not have physical health care plans in place for identified physical health care needs and associated risks which our inspectors had identified.
- We noted that the acute wards had access to physical health care teams, one based at St. Ann's hospital and the other at the Linden unit. We noted that the teams, made up of qualified nurses, offered a weekly physical health clinic for patients, sexual health consultations, advice on nutrition, substance misuse, legal highs, as well as a consultancy function to ward staff.
- We noted that care plans were personalised, holistic and recovery focussed. All wards used the care programme approach (CPA) as the overarching method for planning and evaluating care and treatment. We noted that the care planning process focussed on a patient's strengths and goals. We spoke to patients about the care planning process and most agreed that their plans were recovery orientated and that they were encouraged to be fully involved in planning and evaluating care and treatment. We saw evidence of comprehensive, acute care pathway paperwork completed.

Best practice in treatment and care

- We saw evidence that NICE guidance was followed when prescribing medication. For example we saw that lower doses of antipsychotic medication were used where possible, and, that when high doses of antipsychotic medication was used, it was clinically indicated and appropriate.
- Patients had access to psychological therapies either on a one to one basis or in a group setting, as part of their treatment. We saw that this was delivered by a variety of practitioners, including staff from the therapies team and nursing and support worker staff on the wards. We noted, however, that the acute wards service did not have any psychology input. Having psychology input into the multi-disciplinary team is a standard that an accredited ward would be expected to meet. We saw from the acute and crisis care pathway action plan that the wards planned to apply for accreditation for inpatient mental health services (AIMS) which is accredited by the royal college of psychiatrists.
- We saw that patients had good access to physical healthcare and that the physical healthcare team kept an overview of the physical health needs of patients and ensured physical health care plans were kept up to date. Regular physical health checks were taking place where needed.
- All patients were assessed using the health of the nation outcome scales (HoNOS). These covered twelve health and social domains and enabled clinicians to build up a picture overtime of their patients' responses to interventions.

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- We noted the acute wards were implementing the nationally recognised safe wards initiative which seeks to reduce conflict on a ward environment through a variety of strategies which are containing and therapeutic for patients.
- We noted that each ward had either a sensory room or the availability of a calm box, or both. Staff and patients spoke positively about this initiative which provided a coping skills toolbox, full of aids to assist in calming distress, anxiety and agitation. Examples included something to touch, such as stress balls; some music to listen to; happy pictures to look at; herbal teas to taste and aroma therapy to smell. The initiative was part of the nationally recognised good practice example of safe wards. We also noted that charitable funds had been raised to ensure the sensory rooms were furnished and equipped to a very high standard.
- We saw a variety of approaches used by staff to support holistic, occupation focussed, patient centred evidence based practice. We noted a plan to roll out dialectical behaviour therapy (DBT) training for nurses and we saw that at least one nurse on every ward was trained.
- We saw that staff were appointed as leads in certain critical areas and that these were known as, "task forces". This ensured that key areas such as, dual diagnosis, the Mental Health Act, carers, medication, physical health and learning disabilities were given high priority and prominence, to ensure best practice was achieved and delivered to patients.
- Staff participated in range of clinical audit to monitor the effectiveness of services provided. One example of this was an audit to check how focussed care plans were on goal setting, with the active involvement of patients. We saw that all staff participated, at least weekly, in reflective practice sessions to also evaluate the effectiveness of their interventions.
- Several patients commented on how effective they felt their treatment had been and that their mental health problems had reduced markedly.

Skilled staff to deliver care

- The staff on all of the wards came from a variety of professional backgrounds, with the exception of psychology, including medical, nursing, occupational therapy, pharmacy and social work and were all fully integrated into the service.
- We noted all of the wards were supported by strong and committed ancillary staff, several of whom we met and spoke to in a focus group. Comments made were very positive about the service provision and support offered to ancillary staff.
- We saw that several of the nursing staff had received training in dialectical behavioural therapy.
- Staff received appropriate training, supervision and professional development. We found that over 87.25% of all staff had updated mandatory training refresher courses recorded. We saw that staff were also encouraged to attend longer internal and external training courses and secondments into professional training. For example we saw that a number of support worker staff had attended training on phlebotomy.
- All staff we spoke to said they received individual and group supervision on a regular basis as well as an annual appraisal. We noted that all staff received both managerial and clinical supervision separately. We saw that over 80% of staff had received an appraisal and had a professional development plan. All staff participated in regular reflective practice sessions, where they were able to reflect on their practice and incidents that had occurred on the ward.
- All wards had a regular team meeting and all staff described morale as very good, with their team leaders being highly visible, approachable and supportive. We noted that some staff had commented that morale had been poor on Dudsbury ward.We spoke with the manager about an action plan which had been put in place to address this. We were told that Dudsbury ward had experienced a period of unsettled morale over the last year. Additional resources had been sourced, to actively address these issues, including external team building and leadership support for the team leader. Staff from this unit told us morale was much improved as a result. The implementation tool used to address the problem of poor staff morale was the nationally recognised team recovery plan recommended by the Implementing Recovery for Organisational Change (ImROC) Programme, originally developed and researched in Nottingham.
- We noted that all wards had multi-disciplinary team away days.
- Senior managers told us they were performance managing a small number of staff with capability and disciplinary issues at the time of our inspection.

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Multi-disciplinary and inter-agency team work

- We found fully integrated and adequately staffed multi-disciplinary teams throughout the acute ward service . Regular and fully inclusive team meetings took place. We observed care reviews and clinical hand over meetings on most wards and found these to be effective and involved the whole multi-disciplinary team.
- We observed that all members of the multi-disciplinary team were given space and time to feedback and add to discussions in meetings. We noted that everyone's contribution was valued equally by the team and whoever was chairing at any given meeting.
- We observed inter-agency working taking place. We attended one of the services' regular police liaison meetings, attended by the hospital manager, the head of patient safety and risk, the patient safety manager and the police neighbourhood liaison officer. We noted strong and firmly established relationships between the provider and the police which were conducive to positive outcomes. For example we saw a marked reduction in inappropriate telephone calls made to the police, by ward staff, following the introduction of clear guidance on the criteria. We also heard that all police received mental health training and that the police mental health co-ordinator spent time on the acute wards as part of their induction to the role. We also noted the regular strategic mental health legislation multi-agency group which was held with the trust, police and ambulance service. We looked at a series of minutes from the meeting which addressed issues arising across the organisations relating to mental health.

Adherence to the MHA and the MHA Code of Practice

- We checked 15 files of people detained under the Mental Health Act. We did this by looking at three of the files of detained patients on each of the wards and carried out a specific Mental Health Act review on Dudsbury ward. This was to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act and Code of Practice, and in most cases this was correct. Where it was not, the deficiencies were minor. The Mental Health Act documentation we looked at was in good order with one exception. One patient who was detained on a section 3 had a delay of five days before they were given their rights. Capacity and consent was regularly being considered and the consent to treatment requirements were being followed. We spoke to one of the independent Mental Health Act advocates who was regularly involved with patients from the acute wards.The advocate made positive comments about working with the wards and about the support received from staff. There was an effective process in place to scrutinise the legal documentation, as errors with two patients had been identified and dealt with. The trust could demonstrate that there is a systemic process in place to ensure that the operation of the Mental Health Act meets legal requirements. Weekly ward audits of Mental Health Act 1983 paperwork had been introduced and this enabled staff to ensure that the requirements of the act were being met.
- Conditions of Section 17 leave were being recorded and reviews of risk carried out prior to leave. Capacity and consent was being assessed and recorded on admission and within the first three months prior to the statutory requirement to do this.We felt this to be good practice and in line with the Mental Health Act 1983, accompanying Code of Practice. Section 132 rights were found in most cases being given and recorded in line with the trust policy.
- Good signage was observed throughout all of the wards offering informative information for patients and carers including information regarding Independent Mental Health Advocacy Services (IMHAS). Notices were in place on exit doors for informal patients who wished to leave the ward.
- We noted each ward had a permanent computer, housed in attractive home office furniture, in communal lounges for use by patients at any time. The computers had pre-loaded PDF documents on the desk top with information on the Mental health Act and the Code of practice.
- We did note that not all staff we spoke to were confident in discussing the new Mental Health Act Code of Practice.

Good practice in applying the MCA

- We noted that all clinical staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and that over 68% of eligible staff were up to date with refresher courses.
- No patients on any acute inpatient wards were being treated under the Mental Capacity Act.

Are services effective?

Good

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- There were no current Dols applications and this was appropriate.

Outstanding ☆

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 outstanding because:

- We found very caring, compassionate and motivated staff, and, saw good, professional and respectful interactions between staff and patients during our inspection.
- Patients commented positively about how kind the staff were towards them.
- Staff promoted egalitarian relationships with patients and showed empathy consistently.
- We saw evidence of initiatives implemented to involve patients in their care and treatment.
- All of the acute wards used the safe wards interventions to ensure they provided a contained and therapeutic environment for patients.

Our findings

Kindness, dignity, respect and support

- Patients we spoke to overwhelmingly said how caring and compassionate the staff on the acute wards were.
- We observed interactions between staff and patients and saw how responsive, professional and respectful the staff were towards patients at all times. We noted several occasions when staff discreetly intervened to alleviate patient's distress and agitation.
- Despite the complex, and, at times challenging needs of the patients using the service, the atmosphere on all of the wards was mostly calm and relaxed.
- Patients were complimentary about the staff providing their care and support. One patient said, "The staff are very caring and they treat us as equals." Another patient said, "The staff are very focussed on our recovery and they are creative in what they provide. We are always encouraged to come up with new ideas, of things we'd like to see on the ward and generally these are responded to well." Another patient said, "The nurses are fantastic and they work so hard."
- We also saw spontaneous engagement between staff and patients. For example we observed a senior clinician walking past a football game with patients and staff and joining in spontaneously. This demonstrated the high level of human engagement that we saw throughout our visits and the dignity which patients were treated with by staff.
- We were impressed that throughout our inspection of the acute wards we saw that staff maintained highly positive and egalitarian relationships with patients. We saw many examples of staff participating in therapeutic endeavours with patients.
- We noted a particularly positive and successful initiative implemented called, "getting to know us", part of the safe wards interventions. The aim of the intervention was to enhance therapeutic relationships between staff and patients through the sharing of personal information. All wards advertised posters with pictures of all staff which described their likes, dislikes, preferences for music, hobbies, food, travel, aspirations and hopes for themselves. The information shared personal information about staff and showed an openness and trust to allow patients access to such information. Staff were very positive about the initiative and patients told us how helpful they found the information.
- Staff we spoke with were able to confidently describe the individual and unique needs of their patients. Staff were familiar with patients' likes, dislikes and preferences.
- The PLACE score for the acute wards on privacy and dignity averaged at 87% which was slightly higher than both the trust and the National average of 86%.
- We saw a particularly positive initiative in which staff and patients had together developed a set of statements to create a mutual expectations charter. The charter included mutually respectful statements developed between staff and patients about treating one another with kindness, compassion and with empathy.

The involvement of people in the care they receive

- We saw that patients received a variety of information about the acute wards they were admitted to and that this was included in written format in the ward reception pack. This had been codeveloped with patients to ensure it was relevant.
- We noted that wards allocated one staff member to receive all patients onto the ward and to carry out an induction interview. We saw a reception interview

Are services caring?

Outstanding ☆

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checklist was used and scanned onto the patient's electronic care record. We saw that information was shared about the role of the ward, what to do in an emergency, general housekeeping such as where to make a drink, checking the patient had everything they needed for comfort and introductions to patients and staff. We saw that every new patient received a welcome pack.

- We saw evidence in the electronic care records that patients had been involved with and participated in their care planning and risk assessments. There was, however, some inconsistency between the wards as to the level of involvement and the attention given to highlighting the recovery approach.
- We saw several pamphlets and posters advertised prominently across the wards, explaining about care plans, what a care plan is and how it could help patients and how patients are encouraged to fully participate. We also saw a written document available on all of the wards highlighting what a good care plan should look like and emphasising the importance of patient involvement.
- We noted that a number of patients had been actively involved in their planning of care and we saw co-produced safety plans and positive behaviour support plans. The plans were developed following the publication of the Department of Health Guidance, "Positive and Proactive: Reducing the use of restrictive interventions." We saw that the plans considered individual patients' trigger points for agitation and distress. The plans considered patients' preferred de-escalation interventions, use of the sensory or de-escalation rooms, use of the calm boxes and advance directives on the use of restraint, seclusion and medication.
- We noted all staff had under gone training on the recovery approach and this was evident in the practice we observed and the way staff worked in partnership with the patients.
- We saw that the acute wards encouraged patients to choose what activities were available from an activities menu for them to participate in. This was not a timetabled activity list, but rather an innovative way to ensure patient choice in the activities they chose to do.
- We saw that patients had access to an advocacy service on request and that this service was widely advertised. We also saw that the Citizens Advice Bureau visited the wards weekly.
- We noted on all wards that a briefing meeting was held every morning, between staff and patients, to run through and agree the daily schedules and routines. We noted that they were generally called, "plan your day coffee morning." We were invited to join a number of these meetings and found them inclusive, egalitarian and a positive and proactive start to the day for both patients and staff. We noted on some of the wards that staff were allocated specifically to the role of the daily planning co-coordinator to ensure that priority was given to daily routines, including the delivery of activities and therapeutic groups.
- We saw several variations, on all wards, of an initiative called, "you said and we did". Patients and their friends and relatives were encouraged to make suggestions about how the quality of care and/or the environment could be improved. Each ward had developed their own template and brand for this initiative. For example one ward used, "a bucket list" to put ideas on a post it note into the bucket, for patients and staff to use. Another ward had an, "ideas tree" where ideas could be posted onto the tree, again for use by both patients and staff. Another ward used a, "wish list." Examples of where the service had listened and made changes to improve included; patients saying they wanted access to hairdryers, patients wanted more information on their medication, patients wanted access to bikes to ride out on locally, information on legal highs and drugs, individual appointment times for ward rounds, and access to mobile phones and laptops.
- We noted that all of the wards had comment boxes which were regularly checked for responses.
- We looked at the trusts' carers strategy and were invited to join the carers lead meeting, which we did. We noted that each of the acute wards had a carers lead staff member and that the leads meeting was proactive in engaging carers through of variety of initiatives. We saw that peer carer specialists were employed by the Dorset Mental Health Forum to work within the trust. These are people who have lived experience of being a carer for someone experiencing mental health problems. Examples were given of carer drop in sessions and carers, "high tea" events, picnics and peer specialists working with the staff carers leads to improve engagement with carers. We noted a carer resource pack was available electronically.

Outstanding ☆

Are services caring?

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

- Carers we spoke to were mainly complimentary about the service provided by the acute wards. Adverse comments included poor discharge planning and communication due to bed management pressures and provision of community services.
- We noted that only Waterston ward received feedback from the family and friends audit of carers in February 2015.

Are services responsive to people's needs?

Outstanding ☆

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

Summary of findings

We rated responsive as outstanding because:

- We found a service model and acute care pathway which optimised patients' recovery, comfort and dignity.
- There was a varied, strong and recovery orientated programme of therapeutic activities, many of which were instigated at the suggestion of patients.
- People with lived experience of mental health conditions delivered a series of educational and skills based workshops and programmes, directly on the wards for patients in partnership with staff.
- We noted the service was responsive to listening to concerns or ideas made by patients and their relatives to improve services.
- Bed management processes were very effective despite the difficulties with high bed occupancy
- Patients were able to access an acute and PICU bed when required.

Our findings

Access and discharge

- Although all of the wards were at full capacity when we inspected, we saw that there were good bed management processes in place to access beds, with appropriate lengths of stay, ensuring patients moved on when it was appropriate for them to do so.
- We noted bed occupancy for the preceding six months averaged at 97% for the acute wards.
- The average length of stay on the admission wards was 17 days and between four and nine weeks on the treatment wards.
- At the time of our inspection two acute beds were being used by the trust which were out of area and one was for a specific and justified clinical reason. Five PICU beds were being commissioned in the independent mental health sector during the refurbishment of the male PICU, Haven ward. Seven additional PICU beds were being provided by an independent mental health provider, of which six beds were for female patients.
- We noted that the bed manager was overseeing the care pathways for the women in external PICU placements, and that the PICU ward manager was overseeing the male PICU pathways.
- We saw that a business case was awaiting trust board approval to develop an in-house PICU facility for women.
- The male PICU refurbishment of Haven ward was due for completion in September 2015.
- Between September 2014 and February 2015 the acute wards experienced a total of 11 days of delayed discharges, which equated to 12% of the overall trust delayed discharge days. We were told the trust had a County wide delayed discharge co-ordinator.
- We noted that St. Ann's Hospital had a bed manager overseeing access into the admission and assessment wards, the treatment wards and PICU beds, across Dorset. We did note the bed manager role also covered admissions to the Section 136 place of safety, and a generic bleep holder role to any queries arising from any of the acute wards. We found the post to be exceedingly busy and noted in the inpatient action plan that this role was under review.
- Most of the staff we spoke to said that the wards were under pressure to find beds for patients awaiting admission and to discharge patients swiftly. In some cases staff commented that discharge was instigated too quickly into a patients treatment and care plan. We noted that information given to us and seen by us was inconsistent. For example on the day we spoke to the bed manager we received data on beds which differed from the information we received by the crisis team. This meant that there were communication issues between the two service areas leading to incorrect information on bed availability.
- We attended one of the twice weekly bed management meetings which was led by the East Dorset crisis team. We noted that the bed manager was not a member of this meeting. We saw that challenges were made to the inpatient representatives about their bed usage and possible discharges that could be made. We did not find the meeting conducive to good joint working as we found some of the challenges unjustifiable. We also found inequitable relationships between the inpatient and crisis teams at the meeting. We drew our experience

Are services responsive to people's needs?

Outstanding ☆

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of this meeting to the attention of a senior manager. We raised concerns about the effective functioning of crisis provision in East Dorset. This is detailed in a separate inspection report on crisis services.

- We received three adverse comments from patients and one from a carer about poor communication around discharge planning from the acute wards. This related to the community provision not the ward and was in the context of the poor relationship between the East Dorset crisis team and the locality community mental health team. This is detailed in our report on crisis services. We also received one comment from a staff member that a patient had been moved, at night, to a rehabilitation ward, in order to relinquish their bed for an acute admission.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust had invested in the building of a purpose built new inpatient unit of Seaview and Harbour wards and had completed a full refurbishment of Waterston ward, all of which had been completed to a very high standard and were very conducive to patients having a positive experience in a safe and comfortable environment. Patients commented to us on how wonderful the environments were.
- At the time of our visit the psychiatric intensive care unit, Haven ward, was closed for refurbishment and we saw the plans for the refurbishment were to a similar to high standard. One of the other acute wards, Dudsbury, had temporarily relocated whilst that ward was also being refurbished.
- Patients and staff were both extremely positive in the wards that had been refurbished and were confident that the projects underway would result in the same high quality environments.
- All of the wards had a full range of rooms and equipment to support care and treatment delivery. With the exception of Dudsbury work, which was temporarily re-located, the remaining four wards had an exceptionally high standard of environment and provision. Quite spaces to utilise, therapy rooms, de-escalation rooms, sensory rooms and visitor rooms. We noted two limitations with the ward environments of a minor concern which was the location of the Seaview manager's office which was not on the ward and that some of the dining areas could not sit all of the patients at the same time. The new build and refurbished wards were provided to an excellent design and standard.
- Each ward had access to a private telephone and patients also had access to their mobile phones on request.
- Each ward had access to outside space. Seaview and Dudsbury wards' courtyard areas were however the only outside spaces and were used by both smoking and non-smoking patients, which one patient raised as an issue. We were invited to see the new courtyard on Dudsbury ward which had been built to enable patient's access to outside space whilst on the temporary ward. We saw that staff and patients were decorating the area together and that they had planned a series of murals to enhance the environment. Patients spoke very positively to us about this initiative, undertaken jointly with staff.
- All of the patients we spoke to commented positively about the quality and variety of food served. We were told that if patients had specific dietary requirements or preferences that a chef would visit the ward to speak directly with the patient.
- We noted that the patient-led assessments of the care environment (PLACE) score for food quality averaged at 88% which was marginally higher than the trust average of 87%, however was slightly lower than the National average score of 90%.
- Facilities were available on all of the wards for patients to make hot drinks and to have snacks throughout the night and day.
- Patients were encouraged to personalise their bedrooms and the communal areas of the wards. We were shown around some bedrooms by patients and could see that they had created a homely environment, if they wanted to. All of the wards had enhanced the environment with the use of soft furnishings and pictures.
- All patients had an electronic wrist fob to gain access to and lock their bedrooms and could gain access at any time. We noted patients were all able to securely store their possessions.
- Daily and weekly activities were advertised and available on and off all wards. We noted an excellent range of activities and groups available to patients on all of the wards. The activities were varied, recovery focussed and aimed to motivate patients. We saw that

Are services responsive to people's needs?

Outstanding ☆

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

the activities programme covered evenings and the weekend periods. We saw that patients were actively encouraged to make suggests for activities they would like through the activities menu. We saw workshops were available on a wide variety of skills based learning and included how to manage emotions, how to manage distress and gaining recovery skills.

- We noted a joint project between the trust and the Dorset Mental Health Forum across all of the acute wards. It was called the Wellbeing and Recovery Partnership (WaRP). We saw that peer specialists, people with lived experience of a mental health condition, provided a varied and rich programme of educational and recovery focussed sessions on the wards. In addition patients had access to the Recovery Education Centre which offered many courses to enable patients to understand their experiences, manage their recovery and also how to support others with their journey. We saw that peer specialists provided recovery coaching to patients and staff on the wards, and provided patients with personal support plans.
- We were impressed by the way the peer specialists worked in partnership with patients and staff to ensure good outcomes.
- Occupational therapy was available across all wards and a variety of therapy sessions were also available on all wards. We saw they operated a model which focussed on a holistic, person centred and recovery based approach.
- We noted the acute wards had a dedicated gym instructor who provided a wide variety of activities on both a group and individual basis. We saw the well equipped gym and heard that patients all received an induction and personalised plan. We saw that bikes had been provided on each of the wards, following requests made by patients. We heard that initiatives surrounding good physical health were generally attached to a National or International sporting activity. For example table tennis championship tournaments would be held on the hospital site over the Wimbledon tennis tournament, and events have been planned to coincide with the 2015 rugby world cup.
- We saw examples of activities undertaken by patients and we discussed these with them. Examples included; beach fun, cycling challenges, walks around the hospital and beach, attending college, gardening projects, computer courses, cookery classes, Tai-Chi, movie nights, relaxation, boxercise, mindfulness courses, music appreciation, art and poetry and much more. Many activities involved ward staff and we found all staff motivated and driven to embrace the recovery based approach. We noted at least one staff member on every shift, on each ward, was allocated as the activity nurse which highlighted the importance that the wards attached to this role and function.
- We were told the acute wards would, in the near future, be offering younger patients the chance to participate in the Duke of Edinburgh Awards.

Meeting the needs of all people who use the service

- All of the acute wards had full disability access.
- The staff respected patients' diversity and human rights. Attempts were made to meet people's individual needs including cultural, language and religious needs through thorough enquiry on a patients admission. Contact details for the chaplaincy service were on display in the wards and in all communal areas. Local faith representatives were available to be contacted by the chaplaincy team when required. We noted the co-ordinating chaplain was a member of the therapies team and provided picnic poetry appreciation sessions for patients in the grounds of the hospital. A number of patients told us how appreciative they were about these sessions and how much they had enjoyed them.
- Interpreters were available to staff and were used, when required, to help assess patients' needs and explain their rights, as well as their care and treatment. Leaflets were available explaining patients' rights under the Mental Health Act.
- We saw up to date and relevant information on the wards and in communal areas detailing information which included: contact details and information on healthwatch Dorset, contact details and information on local mental health charities, information on mental health problems and available treatment options, local services for example on benefits advice, information on legal and illegal drugs,help-lines, legal advice, advocacy services, live well Dorset physical health care initiative and how to raise a concern or make a complaint.
- We noted each ward had a permanent computer, housed in attractive home office furniture, in communal lounges for use by patients at any time. The computers had pre-loaded PDF documents on the desk top with information on the Mental health Act and the Code of practice.

Are services responsive to people's needs?

Outstanding ☆

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

- We noted that most of the wards had a full range of musical equipment, key boards, guitars, stereos, headphones and electronic gadgets, all provided in response to patients' suggestions. We were told that the equipment was used often and that jazz evenings were particularly enjoyable.
- We saw that all wards had an extensive variety of books, games, puzzles, CDs and DVDs, all on show and available to patients at any time.
- A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to eat appropriate meals. We noted that a chef was readily available to speak individually to any patient with specific dietary requests or preferences.

Listening to and learning from concerns and complaints

- Copies of the complaints process were displayed in the wards and in all communal areas.
- We saw that each ward had a daily briefing meeting and a weekly community meeting where patients were encouraged to raise any concerns that they had. We noted that all wards advertised changes that had been made in response to patient's feedback.
- All patients we spoke to knew how to make a complaint and felt confident in raising any concerns with the ward managers or staff in charge of shifts.
- Staff were able to describe the complaints process confidently and how they would handle any complaints. Staff told us they regularly discuss any concerns or complaints raised in their meetings and at a variety of practice and governance meetings for the acute care services.

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:

- We found all staff to have good morale and that they felt well supported and engaged with a visible and strong leadership team which included both clinicians and managers.
- Governance structures were clear, well documented, adhered to by all of the wards and reported accurately.
- Managers and their teams were fully committed to making positive changes.
- Each manager had developed a ward business plan which included submissions to secure capital funds in order to develop and implement improvements to the service.

Our findings

Vision and values

- The trusts' vision, values and strategies for the service were evident and on display in all of the wards. Not all staff we spoke to on the wards understood the vision and direction of the trust. A number of staff commented that they felt the very senior management team of the trust were remote and detached. Other staff however said that front line staff needed to be more proactive in engaging senior managers and that staff could at times be too passive in this respect. We were given one example when a ward manager invited the trusts 'communications team to assist in a launch of the newly refurbished ward. We were told that the Chief Executive Officer and several other Board members attended, together with nationally known people who had been invited, responsible for innovative practices in mental health.
- We noted some of the wards had profiles of the trust Board members, in communal areas so that both staff and patients knew who they were.
- The ward managers had regular contact with the hospital manager and service manager. The senior management and clinical team were highly visible and we were told by all staff that they often visited the wards.
- Managers and their teams were fully committed to making positive changes. We saw that each manager had developed a ward business plan which included submissions to secure capital funds in order to develop and implement improvements to the service.
- We noted that a nurse consultant had been recruited and was due to start working with the acute wards in the near future. We were told this post would strengthen the acute care wards leadership team.
- We spoke to staff about an initiative set up to support staff, called, "Hidden talents." This was an additional forum for staff who have had or have mental health issues. The support forum was an action group working with National guidelines promoting people in the workplace with lived experience of a mental health need.

Good governance

- We noted that the wards had good access to robust governancesystems which enabled them to monitor and manage the wards effectively, and provide information to senior staff in a timely manner. One example of this was the risk registers for each ward, on display in all offices. We saw that the top acute ward risks were listed. We saw similar dashboards on display concerning performance and learning from incidents.
- We looked at the acute wards performance management framework and saw that data was collected regularly. This was presented in a dashboard format, monthly, and we saw that a performance meeting was held to scrutinise the dashboards. Where performance did not meet the expected standard action plans were put in place. Managers could compare their performance with that of other wards and this provided a further incentive for improvement. We saw evidence of all wards meeting their key performance indicators and that the information provided was accessible and well advertised. We were able to see from tracking the dashboards that there had been a strong and continuous improvement in performance in many areas on all wards.
- All ward managers told us that they were encouraged by their managers to operate autonomously in managing their wards and received, "excellent" support from the hospital manager and service manager.
- All ward managers we spoke to were familiar with and actively participated in the formulation of the acute ward risk register which we viewed.

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.

Leadership, morale and staff engagement

- We found all of the wards were well-led and had all ward managers in position.The ward managers were visible on the wards during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. Staff told us that the culture on the wards was open and encouraged them to bring forward ideas for improving care which we sampled.
- Most of the ward staff we spoke to, were enthusiastic and engaged with developments on the wards. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to ward practice. We did hear a minority of feedback that said managers were not supportive, particularly after serious incidents. We fed this back to senior managers at the time of our inspection.
- Staff told us that staff morale was, “very good”. We noted there had been some concerns on Dudsbury ward about staff morale which had been actively addressed with support from senior managers and externally facilitated team building.
- We noted all wards took time out to attend multi-disciplinary away days.
- Sickness and absence rates were 6.8% and we noted these rates were higher than the trust average of 4.7%. We spoke to managers about work underway to analyse this and develop strategies to reduce levels of absence.
- Staff were aware of the whistleblowing process if they needed to use it. We received feedback from one staff member who said that whistleblowing processes within the trust were not effective.

Commitment to quality improvement and innovation

- Implementation of the ten safe wards interventions across all acute wards to reduce conflict on wards. The initiative provides resources for wards to implement good practice which creates better and more positive relationships between patients and staff.