Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Forston Clinic

Herrison Road, Charminster, Dorchester, DT2 9TB

Date of Inspections: 02 July 2013
10 June 2013
09 June 2013
08 June 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Standard	Result
Respecting and involving people who use services	✗ Action needed
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Action needed
Cleanliness and infection control	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Staffing	✗ Action needed
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Dorset Healthcare University NHS Foundation Trust
Overview of the service	Forston Clinic is registered to provide care and treatment for people detained under the Mental Health Act. It has a 13 bed in-patient unit called Waterston Assessment Unit which provides care within a protective environment for adults with mental health needs. It also has a ward known as Melstock House which is a self-contained unit set in the grounds of Forston Clinic. Melstock House has 12 single rooms for people over 65 years who need specialised care for mental illness.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Forston Clinic had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 June 2013, 9 June 2013, 10 June 2013 and 2 July 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information given to us by the provider and were accompanied by a pharmacist.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

We visited both Waterston Assessment Unit and Melstock House as part of our inspection of Forston Clinic. The main focus of this inspection, however, was to follow up concerns identified on Minterne ward (now Waterston Assessment Unit) at our last inspection in November and December 2012.

We found that the trust had made improvements to the service at Forston Clinic.

Patients' capacity to give consent to their care and treatment was now reviewed regularly.

The refurbishment of the premises meant that care was now provided in an environment that was comfortable, safe and well-maintained. Patients commented positively on the changes that had been made and told us that they liked the facilities available to them.

There were robust procedures in place to ensure the premises were clean and hygienic.

The trust had appropriate arrangements in place to manage medicines.

There was a less restrictive culture on Waterston Assessment Unit (formerly known as Minterne ward) so that patients had greater autonomy and choice. There were more activities available to patients.

However, there were some areas on Waterston Assessment Unit which required further improvement in order for the trust to demonstrate compliance with the regulations.

Care plans were not always in place to show how patients' needs would be met by the service and risks to their welfare were reduced.

Although there was some evidence of patients being consulted about their care, patients told us that they felt they could be involved and consulted more.

Patients told us that they did not always feel safe on the unit. Safeguarding procedures were not consistently followed to ensure that all concerns were reported and could be reviewed.

Staffing was not planned effectively to ensure there were always enough suitably qualified staff on duty at all times.

Although work was being carried out to ensure that all staff received regular supervision and appraisal, these processes had not been fully implemented at the time of our inspection.

Checks were being carried out to monitor the quality and safety of the service but did not always result in timely action to ensure shortfalls were addressed promptly.

You can see our judgements on the front page of this report.

What we have told the provider to do

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People were treated with respect and were enabled to access support from an advocate to ensure their rights were upheld. However, patients did not always feel that staff listened to them or involved them enough in their care. There was a lack of clear systems to ensure patients' views and experiences were recorded and acted upon by staff.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our last inspection of the service in November and December 2012, we found that patients were not treated with respect and their dignity was not promoted. Patients were not provided with information about their treatment and were not enabled to make decisions about their care. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulations.

During this inspection we found that the trust had made improvements. On our previous visit we had found that patients on Minterne ward (now called Waterston Assessment Unit) were subject to restrictions not related to individual risks. We found that these had now been reviewed and replaced by a less restrictive culture. For example, patients now had access to a choice of caffeinated or decaffeinated drinks and were able to use toiletries of their choice. We spoke with a member of staff who told us that these changes ensured that patients were not restricted unnecessarily.

We found that staff spoke with patients about the care they were receiving. We spoke with four members of staff on Waterston Assessment Unit who described how they promoted patients' involvement. They told us that they did this through regular one to one discussions with patients and community meetings where patients could, for example, make choices about the activities they wanted to do. We observed on the day of our inspection that some patients had chosen to go for a walk and were supported to do this.

Patients we spoke with on Waterston Assessment Unit had mixed views about whether staff involved them enough in their care. One informal patient we spoke with was fully aware of the care they were receiving and confirmed that they had been included in

discussions about their care, including contact with outside agencies. However, another patient who was detained under the Mental Health Act (1983), told us that staff did not listen to them or involve them enough in their care. Although we saw that systems were in place to ensure that patients had time to talk with staff on a daily basis if they wanted this, we also found that community meetings were not always recorded properly. This meant that it was not clear how patients had been enabled to make decisions about their day. It was also not always clear how issues raised by patients during the meetings had been followed up by staff as patients told us that they made suggestions in the meetings but did not always get a response.

Patients on Waterston Assessment Unit did not always receive copies of their care plans. We asked a member of staff about this. They explained that sometimes it could be detrimental for a patient who was acutely unwell to receive a copy of their care plan. This decision was not documented in patients' records. Therefore it was not clear that this decision was being reviewed regularly as patients' treatment progressed, or had been discussed with them.

Patients on Waterston Assessment Unit had access to information about the Independent Mental Health Advocacy Service (IMHA). This was important because the IMHA offers support to patients who are detained under the Mental Health Act (1983) and ensures their rights are upheld. We saw that information about the IMHA service was on display on a noticeboard on the unit and was included in a folder given to patients on admission. The information leaflet had also been adapted into an easy read format so that patients who had difficulties with reading could understand what it said. The ward manager told us that staff were good at encouraging patients to use the advocacy service and that since the unit reopened in April 2013, patients had used an advocate on at least twelve occasions. We spoke with two detained patients, both of whom were aware of the IMHA service, one confirming that an advocate had been present at their recent tribunal.

Most patients had received information about their rights soon after their admission to Waterston Assessment Unit. This ensured that they understood their detention and their rights of appeal. We looked at the records for four detained patients. Three records showed that patients had received information about their rights. One record showed that an attempt had been made to give this information to the patient but they had been unable to understand the information at the time. There was no evidence that a further attempt had been made to explain this information to them to ensure they were aware of their rights. Information about the appeals process was available for patients to read on a noticeboard on the unit.

During our inspection we saw evidence of positive interactions between staff and patients. For example, on Waterston Assessment Unit we saw staff talking respectfully to a patient who was unwell, offering to hold their hand when they asked for this but also respecting their wish when they asked not to be touched. Staff ensured that the patient was covered with a blanket to maintain their dignity when they had partially undressed themselves in a communal area. We also observed positive interactions between staff and patients at Melstock House. During our visit, a member of staff was supporting a group of patients in playing a game of Scrabble while engaging in light-hearted conversation with them. The member of staff and patients offered each other mutual encouragement with the game. We spoke with one patient about their experience at Melstock House. They told us that staff were "very respectful and patient...they are marvellous."

Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Patients' capacity to consent to their treatment was reviewed regularly.

Reasons for our judgement

At our last inspection of the service in November and December 2012, we found that the human rights of patients were not respected or taken into account in relation to their care and treatment. This was because patients' capacity to consent to their treatment had not been reviewed regularly on Minterne ward (now called the Waterston Assessment Unit). The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulations.

During this inspection we found that procedures were in place to review patients' capacity to consent to treatment on Waterston Assessment Unit. We looked at the records for four patients, all of which showed evidence that patients' capacity had been reviewed regularly and clearly documented on their notes. This helped ensure that patients' rights were promoted.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The trust had processes in place to ensure that patients received safe and appropriate care to meet their needs. However, there were shortfalls in some aspects of care planning and risk assessment on Waterston Assessment Unit which meant that arrangements to support patients, and ensure their needs were met, were not clear.

Patients had access to an improved range of activities as part of their care and treatment on the unit.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our last inspection of the service in November and December 2012 we found that the individual needs of patients had not been assessed. The planning and delivery of care was not individualised and activities were limited. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulations.

During this inspection we found some evidence that patients' needs were assessed and took account of risks to their welfare and safety. For example, on Waterston Assessment Unit patients who were identified as particularly vulnerable were being checked by staff throughout the day to ensure that they were safe. We saw that the level of observations needed by patients were reviewed regularly and increased or decreased depending on their changing needs.

Risks to female patients accommodated in the male area of Waterston Assessment Unit were not formally assessed in all cases. During our inspection we observed that two female patients were accommodated on the male side of the ward as there were not enough available beds on the female side of the ward. Staff told us that this happened on a regular basis. We saw that the female patients concerned were allocated bedrooms in a central part of the ward, opposite the nurses' office to promote their safety. The consultant psychiatrist and ward manager told us that where individual patients were deemed particularly vulnerable, their room allocation would be risk assessed. However, it was not clear that all females accommodated on the male side of the ward were risk assessed in the same way to ensure that dignity and safety issues were considered in all cases.

We found that staff on Waterston Assessment Unit had a good understanding of patients'

needs and preferences. However, it was not always clear how patients' needs were being met because there was a lack of formal care planning. For example, staff told us that three patients required support with their housing and money situation in preparation for their discharge from the unit. For one patient, we were able to see that arrangements had been made to support them in liaising with external agencies to address these issues. However, for the other two patients it was not clear how their support needs around discharge were being addressed. This was because there were no care plans to say what the arrangements were, what needed to happen and who would be involved in the plans. One patient told us that they felt they were not receiving the support they needed in this area which was making them feel anxious and upset. This was because the ward had not been able to establish contact with their community care co-ordinator.

We found that one patient, for reasons connected with their illness, was not prepared to consume food or drink supplied by the hospital. They told us that they had discussed this with the ward manager and were waiting for a response to see how the hospital could support them with their needs. Although staff told us that the patient currently purchased their own food and drink, there was no care plan about these arrangements to show how their eating and drinking needs would be met.

We looked at the care records for two patients who were prescribed medicines as required. Both of these medicines were prescribed to support patients' moods and behaviours. Their care plans stated that the medicines should be used when needed. However, they did not give any information about the circumstances in which they could be used or the escalation that may occur before they were needed. The absence of this information did not support staff in giving patients their medicines consistently when needed.

Patients' physical health care needs were met. Staff told us that there was a system for ensuring that the doctor was notified when a patient wanted to see them. They told us that they would write this in the diary which the doctor would check each day. We saw, for example, that one patient was experiencing pain. They had been able to consult a doctor about this, had been prescribed pain relief medicines and were referred to a hospital where they had attended appointments with support from staff. We saw that another patient had expressed concern about a skin condition. A member of staff confirmed that they had been prescribed a cream and, although they had declined to use it, their hands were healing.

Staff were clear about their responsibilities to seek emergency assistance in the event of a patient suddenly becoming unwell. They told us they would call an ambulance or take the patient to hospital if they required urgent care. We looked at an incident report which showed that appropriate action had been taken in a medical emergency.

Patients on Waterston Assessment Unit had access to activities during the day, in the evenings and at weekends. For example we saw that books and board games were available, patients were able to make use of the garden as they wished and there were facilities for patients to play badminton and pool. We observed that patients were able to go for walks with staff in the local area during our inspection. Electronic tablets were made available for patients following a risk assessment by staff and we saw these in use on the ward. One patient we spoke with valued this highly and told us that they enjoyed being able to surf the internet.

We spoke with the ward manager and the operational manager on 2 July 2013 about activities on the ward. They told us that the trust had increased the number of occupational

therapists on the ward to promote patients' access to activities on weekdays. They also told us that the unit's activity programme had been reviewed, based on feedback from patients, so that activity groups, run by nursing staff, were now scheduled to take place in the afternoons and evenings on seven days each week. The ward manager told us that patients were now able to use the gym facilities on the ward.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

The trust had procedures in place to report abuse. However, not all allegations made by patients on Waterston Assessment Unit were reported using these procedures to ensure their concerns were investigated appropriately.

There were procedures in place to help ensure that physical intervention was carried out safely and effectively.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our last inspection of the service in November and December 2012, we found that patients were not safeguarded against the risk of abuse. Patients were not protected against unlawful or excessive use of physical intervention. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulations.

During this inspection we found that procedures were in place on Waterston Assessment Unit to protect patients from abuse. The trust had a policy on safeguarding adults which was available to staff. We spoke with four members of staff, all of whom knew where to find the policy if they needed to refer to it. All four staff confirmed that they had received training in safeguarding adults.

Systems were in place to report abuse although it was not clear that all incidents were reported appropriately. For example, we saw that two incidents had been reported to relevant agencies such as the local authority and the police in line with local procedures. This ensured that the incidents were open to investigation by statutory agencies if appropriate. However, during our inspection, we became aware of allegations made by a patient following two incidents of restraint. Staff told us that they were aware of these allegations but there was no evidence that these had been recorded on the trust's incident reporting system or reported in line with safeguarding procedures. A member of staff explained that staff had used their judgement to decide that the allegations did not need to be reported because the patient's concerns were not substantiated by staff who had witnessed the incidents. However, this meant that the trust had not been able to respond to the patient's allegations and demonstrate that their concerns had been taken seriously.

Patients did not always feel safe on Waterston Assessment Unit. Information provided by

the trust indicated that, in a survey of eight patients between 23 April and 31 May 2013, six patients had said they did not felt safe on the unit. We spoke with three patients during our inspection about safety on the unit, two of whom told us they did not always feel safe. For example, one patient described how another patient, who had been in the garden, had thrown a hot drink through their bedroom window. They told us they had been shaken up by this incident and that, as a result, staff had supported them to move to a bedroom not adjoining the garden. Staff we spoke with were aware of this incident. There was no evidence that this incident had been reported through the trust's risk management system or action taken to minimise the risk of this type of incident happening again to other patients.

Procedures were in place to protect patients from unlawful or excessive restraint which included a trust policy on the use of physical intervention.

The trust told us in their action plan that all staff would receive training in the prevention and management of violence and aggression before the ward reopened in April 2013. We looked at the content of this training and saw that it included training on de-escalation, the appropriate use of seclusion, restraint and rapid tranquilisation as well as alternatives to these. The training programme also included a service user talking about their experience of restraint. The training was intended to support staff to develop skills in predicting potential aggression and use therapeutic tools to minimise it. We spoke with four members of staff employed to work on Waterston Assessment Unit, all of whom confirmed that they had completed this training. All the staff we spoke with told us that they would be expected to undertake refresher training each year to ensure their practice was safe.

Staff demonstrated awareness that the use of physical intervention was a last resort and told us that, as a team, they worked hard to diffuse potentially aggressive situations. Records we looked at supported this, demonstrating, for example, how staff had made repeated efforts to encourage patients who were detained, and therefore receiving treatment against their will, to take their medicines before administering medicines using physical intervention.

There were systems in place to ensure that incidents involving the use of physical intervention were reviewed by the trust's lead person for the prevention and management of violence and aggression. This was to ensure that physical intervention was being used safely and appropriately. We saw evidence that showed that incidents occurring since the ward reopened had been reviewed by them on 20 June 2013. They had sent confirmation to the ward manager that all incidents had been appropriately and professionally managed. They had made one recommendation as a result of their review which needed to be addressed by the ward to ensure patients' safety was maintained.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

Patients were protected from the risk of infection because appropriate guidance had been followed. Patients were cared for in a clean and hygienic environment.

Reasons for our judgement

At our last inspection of the service in November and December 2012, we found that the trust did not have systems in place to maintain appropriate standards of cleanliness and hygiene. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulations.

During this inspection, we found that Waterston Assessment Unit was clean. Action had been taken by the trust to ensure that patients, staff and visitors were protected from the risk of cross infection. Hand basins on the unit had touch free taps to minimise the risk of cross infection. There were soap dispensers and paper towels at hand basins to promote good hand hygiene. Pedal bins had been put in place so that people did not need to touch the bins to dispose of waste and therefore risks of cross infection were minimised. There was information about infection prevention and good hand hygiene on display on the ward for people to read.

We found that there were systems in place to maintain suitable standards of cleanliness and hygiene on Waterston Assessment Unit. We spoke with a cleaner and a cleaning supervisor who told us that the trust had increased their hours significantly to ensure the unit could be cleaned twice a day and standards of cleanliness and hygiene were maintained.

We observed that there was appropriate equipment and facilities available to ensure the unit could be cleaned effectively. This included a separate sluice for disposing of dirty water and colour coded mops and buckets for cleaning different areas of the unit. The cleaner was able to tell us how these were used and we saw they were stored appropriately. The cleaner told us that they were clear about the trust's expectations about maintaining a clean and hygienic environment including the tasks they were required to do and the frequency of those tasks.

Checks were carried out to monitor the cleanliness of the premises and infection control procedures. For example, we found that on Waterston Assessment Unit, the ward manager and a representative from the trust's hotel services department had carried out two audits in May and June 2013 where the unit had scored 95% and 98.3%. These checks helped ensure that housekeeping tasks were carried out to a suitable standard and

patients benefited from a clean and safe environment.

Patients we spoke with were satisfied with the cleanliness of the unit. For example, one patient told us, "It is spotless. The cleaners come every day". Another patient commented, "Hygiene levels are very good", while a third patient said, "The cleaners are brilliant!"

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the trust had appropriate arrangements in place to manage medicines.

Reasons for our judgement

At our last inspection in November 2012 we found concerns about the handling of medicines. During this visit we found that improvements had been made. We looked at medicines, medicines storage, records relating to people's medicines and talked to staff working on the two units.

Appropriate arrangements were in place in relation to the recording of medicines. We saw that, although printed labels were not always used on the front of prescriptions at Forston Clinic, the information was clear and accurate. We saw that records were completed accurately and that patients had received their medicines as prescribed. At Melstock House we saw some incidents of gaps in the recording of medicines administered. Staff we spoke with confirmed that people were not on the ward at the time and the administration record had not been correctly coded to show this. We saw that the administration of medicines for use 'when required' was recorded on the prescription chart and information about the use of these medicines and the incidents that prompted their use was recorded on the trust's electonic record system. This system also showed that appropriate decisions were taken and reviewed for patients to whom medicines were given covertly. The provider may find it useful to note that oxygen was not prescribed in accordance with current guidance (NPSA/2009/RRR006). Pharmacy staff visited the units regularly and we saw evidence of medicines reconciliation on admission and clinical interventions.

Appropriate arrangements were in place in relation to obtaining medicines. Medicines were supplied by a local hospital as stock or named patient supplies. We saw that medicines that were not held as stock were ordered for people promptly, although we noted that one person had not been able to receive their medicine for two days. Controlled drugs were ordered by nurses and countersigned by an appropriate doctor. Medicines for discharge were ordered from the hospital, or a local pharmacy when that suited the patient.

Medicines were kept safely, including controlled drugs. The temperatures of ambient and fridge storage were regularly monitored and shown to be suitable. However, the provider may find it useful to note that some of the cupboards used to store medicines on Waterston Assessment Unit may not comply with current safe storage guidance (The safe and secure handling of medicines : a team approach RPSGB 2005) and we found oxygen

cylinders not secured. In addition, the arrangements for ensuring the room in Melstock House remained cool were not subject to a suitable risk assessment.

Medicines were prescribed and given to people appropriately. A recent audit had shown that antipsychotic doses were within recommended limits. Nurses we spoke with told us that they had received training in rapid tranquilisation during induction and further updates during physical restraint training. We saw that there was now one policy for the trust, updated in December 2012 which covered people of all ages admitted by the clinic and specified that the doctor would administer the antidote if needed. This antidote was available on both units in addition to the more usual emergency drugs. This meant that patients were protected from the unsafe use of rapid tranquilisation medicines.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

Patients, staff and visitors were protected against the risks of unsafe or unsuitable premises. Care was provided in an environment that was suitably designed and adequately maintained.

Reasons for our judgement

At our last inspection of the service in November and December 2012, we found that the premises did not protect patients' rights to privacy, dignity, choice, autonomy and safety. The premises were not suitable for the assessment or medical treatment of people detained under the Mental Health Act (1983). The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulations.

During this inspection we found that the trust had carried out an extensive refurbishment of Waterston Assessment Unit. For example, window frames and glass had been replaced to ensure patients' safety. There was frosting on the lower half of bedroom windows to promote patients' privacy and dignity. Work had been carried out on pipes supplying water to the unit so that the water now ran clear instead of being an orange colour.

We found that the whole unit was in good decorative order and well-lit with new flooring throughout. New furniture and accessories, including chairs, coffee tables, pictures, cushions and plants, had been purchased to provide a more comfortable environment. New garden furniture had been purchased, including a shelter for patients who smoked. Staff spoke very positively about the changes, telling us that the refurbishment had resulted in a more therapeutic environment that promoted patients' safety, privacy and autonomy. Patients also spoke positively about the ward environment, one patient commenting that the unit was "Brilliant, peaceful, it has got everything I need", while another patient told us that it was a "massive improvement" on the previous facilities.

Action was being taken by the trust to ensure that the premises were maintained appropriately. On the first day of our inspection, staff told us that they had experienced problems with the door handles, some of which had fallen off and not been replaced. We were told that this was a manufacturer's fault and had been reported. This was confirmed by the ward manager when we visited the unit on 2 July 2013 who told us that new door handles had been ordered. We also observed that a window in a patient's bedroom was propped open by books and a milk carton as it would not stay open by itself. The ward manager confirmed that this had been repaired when we met with them on 2 July 2013.

We saw that a nurse call system had been installed in patients' bedrooms on Waterston Assessment Unit so that all patients could call for help if required. The provider may find it useful to note that staff were aware of the system but told us that it was not always audible unless they were in the nurses' office. We listened to the alarm and agreed with the staff's view. Not being able to hear the nurse call system had the potential to compromise patients' safety and welfare.

The trust told us in their action plan that they had hired an architect to carry out work on the seclusion room on Waterston Assessment Unit and ensure it was fit for purpose. At the time of our inspection, work undertaken on the seclusion room was not complete. Staff confirmed that the room had not been used since the unit reopened and that no situations had arisen where it was required.

At our last inspection of Melstock House, we found that there were domed shaped mirrors in patients' bedrooms which potentially compromised their privacy. During this inspection, staff told us that these mirrors had been removed. Staff told us that there had been some delays in the trust's estates department responding to requests for repairs on the ward. However, we saw that a member of staff had been allocated the responsibility of liaising with the estates department to ensure outstanding tasks were followed up and addressed.

On the second day of our inspection we found that the nurse call system that had been installed at Melstock House was not working in all areas of the ward. However, we spoke with the ward manager following the inspection who confirmed that this had now been fixed and the call system was fully operational.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

Staffing on Waterston Assessment Unit was not planned effectively to ensure that there were always enough suitably qualified staff on duty to carry out physical intervention if required and minimum staffing levels were met.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our last inspection of the service in November and December 2012 we found that patients were not safe because there were not sufficient numbers of staff with the right knowledge, experience, qualifications and skills to meet their needs. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements and comply with the regulation.

During this inspection we found that there were not always enough staff with the right skills and experience on duty at Waterston Assessment Unit. Before the inspection took place, the trust confirmed that staffing levels on the unit were set at five staff during the day and four staff at night. However, during our inspection, staff expressed concern that staffing was not planned appropriately to ensure there were always enough staff on duty with training in physical intervention should restraint be necessary.

The ward manager told us that a minimum of three staff were required to carry out physical intervention on Waterston Assessment Unit. We looked at the rota for the previous six days on the unit. We saw that on one night shift there were two staff on duty who had physical intervention training, the remaining two staff being from an agency who had not received this training. Incident reports provided by the trust also showed that there had been a further incident on 13 June where there had also been a lack of suitably trained staff on the ward to carry out physical intervention using three staff. This had resulted in staff adapting a physical intervention to ensure that the patient's medicine could be administered to them. A lack of suitably trained staff to carry out physical intervention potentially put patients and staff at risk of harm.

There were some arrangements in place to support Waterston Assessment Unit with staffing although these were not always effective. Staff told us that in the event of them requiring support on the ward to carry out physical intervention, they would ask a neighbouring ward, or the crisis home treatment team, to provide assistance. We spoke with staff from these areas who told us they could not always be relied upon to provide

additional staff to Waterston Assessment Unit for the purpose of physical intervention. This was due to the fact that they needed to maintain their own safe staffing levels and because staff working in these areas did not always have training in physical intervention. A member of staff also told us that, because they did not use physical intervention on a regular basis in their work environment, there was a risk that they would not be confident to use it on Waterston Assessment Unit if they were asked to provide assistance. The ward manager recognised this was an issue and told us that the trust was giving consideration to how they could ensure that staff remained competent to carry out physical intervention where they did not use it regularly.

Staffing on Waterston Assessment Unit was not always planned effectively to ensure minimum staffing levels were met. During our inspection, it was evident that there were four staff on duty during one afternoon when we had been told by the trust that the minimum staffing levels were five. A member of staff told us that the unit had not been able to secure an additional member of staff from the trust's staffing bank or from an agency on this occasion to ensure that the unit was fully staffed. We looked at information sent to us by the trust to see if this was a regular occurrence. We saw that during May 2013 there had been four staff, instead of five, on two morning shifts and three afternoon shifts. We spoke with the ward manager and operations manager who told us that the trust was working hard to recruit more staff by continued advertising and attending recruitment fairs. They acknowledged that, in the meantime, there were some shortfalls which were being carefully monitored by the trust to minimise the risks to patient safety.

Patients on Waterston Assessment Unit told us that most staff had suitable skills and experience to provide care for people. For example, one patient said, "They mostly know what they are doing", while another patient told us, "90% are spot on." They also told us that there were enough staff available to meet their needs. One patient commented that some agency staff seemed "lost" on the unit. We saw that the trust was implementing a system to ensure that agency staff were orientated to the ward on arrival and had the opportunity to go through procedures with a permanent member of staff. This was meant to be recorded by staff. However, when we talked with permanent staff on the ward it was not clear that this process had been carried out to date and there were no records to evidence that it had been carried out.

At Melstock House we found that staffing levels at night had been reviewed since our last inspection in line with the trust's action plan. There were now three staff on duty every night.

Supporting workers

✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Staff had received some training to be able to care for patients safely and effectively.

There were some arrangements in place to support staff on Waterston Assessment Unit but formal staff supervision and appraisal arrangements had not been fully implemented. This meant that there was a risk that not all staff were receiving the support they required.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our last inspection of the service in November and December 2012, we found that staff were not properly trained, supervised and appraised. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulation.

During this inspection, we found that staff on Waterston Assessment Unit had received some relevant training to support them in their role. The trust's action plan told us that all staff working on the unit would be undertaking a ten day training programme which included training on managing violence and aggression, mental capacity, mental health law, safeguarding and values. We looked at the training programme and saw that it also incorporated some specific training, for example, about working with patients with a learning disability and supporting patients who have psychosis. The ward manager told us that all staff had received this training which was confirmed by four members of staff we spoke with during our visit. It was not evident, however, that staff responsible for administering discretionary medicines had received specific training on this as outlined in the trust's policy.

A system was being developed on Waterston Assessment Unit to ensure that all staff received regular supervision, although this was not fully implemented at the time of our inspection. The ward manager told us that supervision should take place at least once a month for all staff. We looked at a supervision chart on the ward on our visit on 9 June 2013. This showed that five out of 25 staff had received clinical supervision since the ward reopened on 23 April. When we returned to the unit on 2 July we were shown another record which indicated that 12 out of 25 staff had received individual or peer group supervision. There was no record relating to the remaining 13 staff. The ward manager told us that the record was not up to date and therefore it was not an accurate reflection of the number of staff who had received supervision since the unit reopened. They told us

that they were in the process of updating the record. They also told us that a new process was being put in place to ensure that all staff received monthly supervision as it was recognised that this had not been achieved to date.

We spoke with five members of staff on Waterston Assessment Unit about the support they received. Most staff told us that they had received supervision since the unit had reopened and had found it useful. They also told us that they supported each other as a team, for example, by reflecting on their practice with peers to examine what they had done well and anything that could have been done better. For example, one member of staff told us, "Team work on the ward is good", while another staff member commented: "I feel really supported here. An awful lot of peer supervison goes on and we are constantly discussing interactions. I can talk to people about my practice. I find it refreshing." However, some comments we received from staff indicated that they would benefit from more support and leadership. The ward manager told us that they were increasing the number of Band 6 (nurse team leader) posts to ensure that there was greater support with decision-making available for staff and more effective leadership on a day to day basis.

Waterston Assessment Unit were making arrangements to ensure that all staff had an appraisal of their performance. The ward manager told us that most staff who worked on the ward had already set personal objectives for the year and most had already had a face to face appraisal. We saw records that supported this. The ward manager was in the process of reviewing staffing arrangements on the unit to ensure they had the capacity to carry out appraisals for all staff in a timely way. They told us that it was their intention that all staff would have an appraisal carried out by October.

There was an on-call system at Waterston Assessment Unit to support staff. We saw examples of how this had been used to obtain advice and support from senior nurses in relation to a safeguarding matter and a staffing issue when the ward manager was not on duty. The ward manager told us that it was anticipated that the appointment of night practitioners within the trust would also increase the support available to staff at night.

Regular staff meetings were held on Waterston Assessment Unit to support staff in their work and ensure that current issues and concerns were discussed as a team. We looked at a sample of records from these meetings and saw that topics discussed included safety issues, staffing, medicine administration procedures and care planning. Staff we spoke with were aware of these meetings and told us that they felt there was discussion at ward level about issues of concern. However, comments we received from staff indicated that they felt there was not enough communication from senior management about concerns they had raised. We spoke with the operational manager who told us that the trust were in the process of reviewing the way they communicated with staff to ensure staff always felt listened to and received a timely response to any issues they raised. They told us that, in the meantime, they had an open door policy and welcomed contact from staff who had issues they wanted to discuss.

The ward manager confirmed that they met with the operational manager regularly which helped ensure they were supported in their role and which promoted communication between the ward and the trust's senior management. They also told us that they attended regular meetings with managers from other inpatient mental health services across the trust so they were able to benefit from shared learning and experience.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The trust had systems in place to regularly assess and monitor the quality and safety of the service at Forston Clinic. This helped ensure that risks and areas for improvement were identified. However, systems on Waterston Assessment Unit were not fully embedded to ensure that monitoring resulted in timely action and shortfalls were addressed promptly.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our last inspection of the service in November and December 2013, we found that patients did not receive safe and quality care, treatment and support because systems to manage risks to their health, welfare and safety were not effective. The trust sent us an action plan in February 2013 telling us what they were doing to make improvements to the service and comply with the regulation.

During this inspection we found that the trust had systems in place to regularly assess and monitor the quality of the service at Forston Clinic. However, some systems were not fully embedded on Waterston Assessment Unit to ensure that monitoring always resulted in clear and timely action.

For example, we found that there were systems in place to seek feedback from patients about their experience so the trust could come to an informed view about the standard of care and treatment provided. On Waterston Assessment Unit, some patients had been asked to complete a survey before being discharged. Information from the surveys that had been carried out the previous month was on display in the reception area of the unit when we visited on 2 July 2013. However, at this time there was no information to tell patients, or their visitors, what the trust was doing in response to the feedback they had received. It was acknowledged that not all patients who had been discharged to date had been asked for their feedback on their experience due to staff forgetting to carry out this process with them.

The trust's action plan for Waterston Assessment Unit told us that patients' views would be sought during weekday community meetings and that records would be retained to reflect this. Staff told us that meetings took place but were not always recorded. We looked at a sample of records and found several gaps where there was no record of a meeting taking

place or patients' views being sought. Where meetings had been recorded, it was not always clear what had been discussed or how patients' suggestions were being addressed. There was no evidence of community meetings being monitored to ensure their effectiveness.

Processes were in place to ensure that incidents, accidents and potential risks to patients' safety and welfare could be reported and reviewed. The trust had an electronic risk management system which was accessible by all staff so that risks to patients' safety could be reported. We found that these incidents were escalated to the relevant department within the trust for review. For example, where physical intervention had taken place on Waterston Assessment Unit we saw that the lead person for the prevention of management and violence in the trust had reviewed incidents to ensure interventions had been carried out safely and effectively. The trust's patient safety advisor had also reviewed a safeguarding incident that had occurred at the Waterston Assessment Unit to ensure that appropriate action had been taken. At ward level, however, we identified that concerns on Waterston Assessment Unit were not always reported which meant they would not be reviewed by the trust.

The trust's action plan told us that a care plan audit would be carried out on Waterston Assessment Unit two weeks after the ward reopened. The operational manager confirmed that this had taken place and we saw a record that showed that some shortfalls had been identified in relation to care planning with a recommendation made about how this could be improved. We saw that care plans had been discussed with staff at ward safety meetings during May 2013 and staff had been instructed to ensure that patients had copies of their care plans. However, at our inspection it was not evident that this work had been carried out. The ward manager acknowledged that further work was required with regards to care planning to ensure that it was carried out effectively.

The trust had systems in place to identify, assess and manage risks relating to the health, welfare and safety of patients. For example, we saw that a safety trigger tool was completed on both Waterston Assessment Unit and at Melstock House on a monthly basis to enable the trust to anticipate any deterioration in standards and take action to prevent failures of care. We looked at the safety trigger tools that had been completed for Waterston Assessment Unit and Melstock House in May 2013. These looked at issues including staffing, patient feedback, cleanliness and incidents occurring on the ward to judge whether safe standards were being maintained. For example, the trigger tool for Waterston Assessment Unit had identified shortfalls in clinical supervision as a potential risk factor. The operations manager and ward manager were aware of the shortfall and described the action they were taking to improve the delivery of clinical supervision on the ward to ensure that it was effective.

The trust was identifying ways of working with people who use services and their representatives to monitor the quality and safety of the service. This included involving members of the Dorset Mental Health Forum, an independent peer led charity, which employs people with lived experience of mental health problems wherever possible, in a recent assessment of Waterston Assessment Unit. This process looked at standards around food, cleanliness, infection control and the ward environment. It was anticipated that the report from this assessment would help ensure that developments of the ward environment were based on the needs and wishes of people who use services. The ward manager told us they were planning to do further work with the Dorset Mental Health Forum, to include a review of staff's skills in working with patients in a kind and compassionate way.

At our last inspection of the service we found that the trust's governance processes were not up to date. This was demonstrated by the lack of integration of policies and procedures across the trust which meant that many policy documents in place at Forston Clinic were from a predecessor organisation. We were told that the trust had adopted the policies of the previous organisation before the merge took place and had a programme in place to review and integrate these. We saw that by February 2013, 190 policies had been integrated. By July 2013, 242 policies had been reviewed and integrated. Staff we spoke with at this inspection, were aware how to find relevant policies if they needed to refer to them to ensure that correct procedures were followed.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	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 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services** **How the regulation was not being met:** Patients on Waterston Assessment Unit did not always feel that staff listened to them or involved them enough in their care. There was a lack of clear systems to ensure patients' views and experiences were recorded and acted upon by staff. Regulation 17(1)(b).

Regulated activities	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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** There were shortfalls in some aspects of care planning and risk assessment which meant that arrangements to support patients, and ensure their needs were met, were not clear. Regulation 9(1)(b)(i)(ii).

This section is primarily information for the provider

Regulated activities	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 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse** **How the regulation was not being met:** The trust had procedures in place to report abuse. However, not all allegations made by patients were reported using these procedures to ensure their concerns were investigated appropriately. Regulation 11(1) (b).

Regulated activities	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 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** Staffing on Waterston Assessment Unit was not planned effectively to ensure that there were always enough suitably qualified staff on duty to carry out physical intervention if required and minimum staffing levels were met. Regulation 22.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers** **How the regulation was not being met:** There were some arrangements in place to support staff on Waterston Assessment Unit but formal staff supervision and

procedures Treatment of disease, disorder or injury	appraisal arrangements had not been fully implemented. Regulation 23(1)(a).
Regulated activities	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 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** Quality assurance systems on Waterston Assessment Unit were not fully embedded to ensure that monitoring resulted in timely action and shortfalls were addressed promptly. Regulation 10(1)(a).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✔ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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