Inspection Report

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

St Ann's Hospital

69 Haven Road, Canford Cliffs, Poole, BH13 7LN

Date of Inspections: 26 April 2013
25 April 2013

Date of Publication: June 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Dorset Healthcare University NHS Foundation Trust
Overview of the service	St Ann's Hospital provides assessment and treatment to adults with mental health needs. The hospital can accommodate up to 94 people. It has an acute admission ward for all newly admitted people and two wards (one male, one female) for people who need in-patient treatment. There is a ward for older people with functional mental health problems, a small intensive care unit and a low secure forensic unit.
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

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 25 April 2013 and 26 April 2013, checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

What people told us and what we found

We carried out our inspection of the hospital because anonymous information of concern had been posted on the Care Quality Commission's website.

We visited four of the hospital's six wards, two separate treatment wards for male and female patients, a mixed acute admission ward and a male low secure forensic ward.

We observed some of the day to day activities on the treatment wards.

We spoke with nine patients in order to hear what they thought about the service they received and a range of staff in order to obtain their views about the service the hospital provided. They told us staff were polite and treated them with respect. They told us they could make suggestions at ward meetings about how things could be improved.

Information about the hospital's services and facilities was readily available and accessible to patients.

Arrangements were in place that helped to promote patients dignity and privacy but sometimes this had been compromised.

The provider took steps that ensured as far as reasonably possible at all times there were sufficient numbers of suitably qualified, skilled and experienced persons on duty to meet patients' needs.

There were systems in place to monitor the quality of the service provided at the hospital and identify and manage risk to patients, visitors and staff.

Records we looked at were accurate and up to date which ensured patients were protected from unsafe care and treatment.

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

What we have told the provider to do

We have asked the provider to send us a report by 09 July 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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's rights,privacy, values and choices were respected but their dignity had sometimes been compromised.

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

People who used the service understood and were given appropriate information and support regarding their care or treatment.

The provider (Dorset Healthcare University NHS Foundation Trust) had a website with information about the hospital and a copy of the hospital's "Service User Information Booklet" which could be downloaded. The booklet set out what patients could expect at and from the hospital and included the following statement.

"We want to provide you with as much choice as possible throughout your care and treatment. By making different choices available, we hope your care is more designed to meet your needs and take account of your personal preferences. There may be dietary requirements, dress codes and cultural practices that are important to you and your family. Your key nurse will discuss your needs with you and will ensure the ward team are aware of your preferences and will aim to respect these …".

One patient we spoke with told us that they had looked at the website before they were admitted and consequently knew about all the facilities that were available to them before they had arrived.

We saw the information booklet was displayed throughout the hospital on wards. We also noted other important information on display throughout the hospital included details of the provider's complaints procedures and the patient advice and liaison service (PALS). We also noted that information was readily accessible about advocacy and advice services such as Independent Mental Health Act Advocates (IMHA), the Citizens Advice Bureau, Independent Mental Capacity Advocates (IMCA), Dorset Race Equality Council and the

Dorset Mental Health Forum. This meant that patients could obtain advice and help with upholding their rights.

Patients we spoke with told us they were treated with respect and their dignity was promoted. They said hospital routines, facilities and their legal rights were explained to them and their care and treatment was discussed with them.

This all showed that the hospital was committed to promoting patient's needs, choices and rights and their views and experiences were taken into account in the way the service was provided.

We saw that the hospital had some wards specifically for patients of the same gender and also wards that accommodate both male and female patients. On the latter wards facilities such as bedrooms and toilets and bathrooms were segregated and there were also lounge areas reserved for the use of female patients only.

On some wards there was mix of single and shared bedrooms. Patients who were accommodated in shared bedrooms told us that they had curtains around their beds that provided them with some privacy. Our observations on the wards confirmed this.

We were told by staff that when patients required assistance with their physical care that either staff of the same sex provided that help or a same sex chaperone was present.

One patient said, "The staff are polite. If I am doing something wrong they may not be quite so polite … They have explained my rights to me recently because my section was reviewed … At a ward round today they discussed my medication with me and I can discuss any concerns I have about my treatment at a ward round.

Another patient said, "I am getting all the help I need … we had a ward round yesterday and they told me that I could go home".

A third patient told us their belief system was very important to them. They said, "I am a Christian and I have been told about the multi-faith room they have here and that I can see a priest".

A concern was raised with CQC that a partially clothed female patient had been moved through the hospital to be cared for in the seclusion room on Twynham ward. This is the hospital's low secure forensic unit for male patients.

This was confirmed by staff we spoke with. They told us that if patients became agitated or were highly disturbed and were a high risk they sometimes had to be moved to the low stimulus unit or seclusion room on Twynham ward. This meant that on occasions female patients had to be taken through the hospital to that ward. We were told when this happened Twynham ward was normally informed but that this did not always happen. Consequently there had been an occasion when a partially clothed female patient had been taken to the ward.

We saw audits that had been carried out about the use of the low stimulus unit and seclusion room on Twynham ward between 23 September 2012 and 28 April 2013. These audits showed that on 21 occasions female patients were cared for in either the low stimulus unit or seclusion room on the ward.

This all showed that although generally patients' diversity, values and human rights were respected there were occasions when patients' dignity had been compromised.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Steps had been taken to ensure that at all times there were enough qualified, skilled and experienced staff employed to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

We spoke with the hospital manager, two consultant psychiatrists, seven registered nurses, two mental heath support workers and nine patients in order to obtain their respective views about staffing levels.

All the patients we spoke with thought that there were usually enough staff on duty although several commented that cigarette breaks could be curtailed if there were not enough staff available to provide the supervision needed.

Documents that we looked at included correspondence about and the outcome of a review of staffing levels at the hospital carried out in Autumn 2012. We noted that one of Dorset Healthcare University Foundation Trust's (the trust) directors stated a commitment to holding regular reviews of staffing levels and making a registered nurse avaialable on every shift on every ward at the hospital.

The outcome of the review set out the minimum number of registered nurses and mental health support workers on each shift and ward as agreed with consultant psychiatrists and ward mangers. It also showed that the number of registered nurses and mental health support workers had been increased on some shifts on some wards.

We saw that a senior member of the hospital's staff visited the wards each day. They recorded details about the numbers of staff on duty and information about any matters that could adversely affect staffing levels. A "nurse in charge" on duty each day was responsible for re-allocating staff among wards when there were absences that could not be covered by the hospital's own bank staff.

We noted a member of staff on each ward carried a pager so they could respond and attend emergencies on other wards. This meant that on occasions the staffing levels on every ward apart from the ward with the emergency could temporarily be below the agreed minimum.

There was evidence that there had been recent problems with maintaining staffing levels but these had been resolved.

For example we saw records that showed for three days in April (16, 17 and 18) the staffing level on one ward on the afternoon/late shifts had been below the agreed minimum. The ward manager said they had subsequently been told by one of the trust's directors that if bank staff were unavailable they could use agency staff to cover staff absences.

Staff we spoke with told us that the hospital's own bank of staff covered the vast majority of staff absences or vacancies. They said that agency staff were only used to cover absences of mental health support workers. No member of staff we spoke with could recall agency staff being used to cover the absence of a registered nurse. This showed that people with the relevant skills and knowledge provided cover in the absence of permanent staff.

Documents we looked at showed that from 5 January 2013 to 21 April 2013 on the specialist low secure forensic ward there had been staff shortages. We saw that on 107 occasions for periods of time ranging from one hour to complete shifts staff numbers fell below the agreed minimum level. This was because the ward provided staff to cover shortages elsewhere for tasks that included, monitoring patients in a seclusion unit on the hospital's psychiatric intensive care ward, monitoring patients brought to the low stimulus unit or seclusion room on the ward from other wards in the hospital or responding to emergencies in other parts of the hospital. They also included assisting with the admission of patients on the hospital's acute admission ward.

We also saw documentary evidence that on 9 March 2013 the re-allocation of two staff from the ward to other wards resulted in a patient's rights being denied. Planned escorted section 17 leave under the Mental Health Act 1983 was cancelled for one patient. It also resulted in the curtailment of activities important for the treatment of other patients.

On 29 April 2013 the modern matron responsible for Twynham ward told us the provider had agreed that in future no staff would routinely respond to emergencies on other wards. Staff would not be reallocated to other wards without the express permission of an associate director or an on-call out of hours manager. They said it had been agreed that the seclusion room on the ward would not be used as a resource for other wards without the express permission of the on-call consultant. This meant that it was less likely that the ward's agreed minimum staffing level would be reduced and patient's rights compromised.

At the time of our inspection there were five vacancies for nursing and support staff at the hospital. They comprised one clinical team leader, two registered nurses, two mental health support workers and one occupational therapist. They represented 6.25%, 11.86%, 5.06 and 16.66% of their respective complements. The vacancies had all been advertised.

We saw that an "Early Warning Trigger Tool" had been used to produce monthly reports for the trust's "quality, clinical governance and risk assurance committee. This was to alert senior managers to potential risks that could result in patient care being compromised and enable remedial action to be taken. Indicators included staff vacancy rates, unfilled shifts and staff sickness rates. A committee report of 2 April 2013 stated that for the three month period from December 2012 to February 2013 no wards reported a score that exceeded

the trigger threshold.

We also saw a copy of a report to the trust's quality directorate's "in-patient safety" meeting for April 2013. We noted there was comprehensive information about staffing levels including reasons for staffing shortages.

This all showed the provider had systems in place to enable steps to be taken if necessary that would ensure proper staffing levels and skill mixes were maintained.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 meeting this standard.

The provider had an effective system in place to regularly check and monitor the quality of the service and identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

We saw that patients' views about what they thought of the care they received were obtained in a number of ways. They included the use of questionnaires, regular community meetings held on the wards and the use of suggestion boxes located on every ward.

We looked a a copy of the report of the "St Ann's Hospital Experience Survey" carried out for the the third quarter of the year 2012/2013. Patients had been asked for their views about their hospital stays. Questionnaires or a hand-held device that was kept on each ward had been used to collect information. The report showed that 67 patients had taken part in the survey and several areas for improvement been identified as a result of the responses received from patients. They included improved privacy around bed spaces and more activities during the day and at weekends. We saw that an action plan had been implemented. It included the introduction of new activities on all the wards and the ordering of new furniture for one ward that would improve the security of patients personal items.

The hospital manager told us that a copy of the report was discussed at a monthly Inpatient Safety Group and by the Public and Patient Experience and Engagement Committee. This showed that suggestions and concerns raised by patients were acted on.

Patients we spoke with told us they went to community meetings and could raise issues. One patient said, "We have meetings most mornings and you can mention what you want".

Another patient said, "Every morning there is a meeting to talk about what we are going to do and to talk about things that worry us".

On all the wards we visited we saw notice boards with the outcomes of the discussions that took place in these meetings. For example on Dudsbury ward we saw the following statements. "You asked for more pamper nights. We provided one more pamper night a week with home made face masks".

On Branksome ward a member of staff told us therapeutic activities that were arranged were based on the interests of the group of patients and a recent suggestion had resulted in starting a movie club. They said that people who attended watched a film and then critiqued it. During our visit to the ward we saw this activity taking place.

This all showed that there was a commitment to obtaining the views of patients and wherever possible acting on them.

We saw that arrangements were in place to check the provider's procedures were followed and identify where if necessary improvements could be made.

We looked at records that showed the following procedures, practices and equipment were regularly checked: infection control procedures, care plans and patient records, obtaining consent to treatment, medical devices, medication administration records and the management of medication.

We also saw a report from an audit had been carried out at the end of 2012 on Merley ward the hospital's acute assessment unit. The audit was of the completion of initial physical examinations carried out on patients on admission to the ward. It showed that improvements had been made since a previous audit in February 2011. We also saw that recommendations had been made that would lead to further improvements to the standards of physical assessments of patients admitted to the ward.

Other documents we looked at showed the provider had systems in place to check that standards were maintained and identify where improvement may be needed. They included a clinical audit programme for 2012/13, a provider compliance assessments implementation plan dated January 2013 and recent copies of the "Mental Health Services Directorate Governance Reports".

There was evidence that learning from incidents/investigations took place and appropriate changes were implemented.

Documents that we looked at included one about lessons learnt. The hospital manager told us that it was produced annually and was compiled from records about complaints and incidents. The manager also said that as a result of incidents around the use of rapid tranquilisation new guidance about the use of restraint had been implemented. We saw this guidance was readily available on the wards we visited.

There was a system in place (Ulysses) for recording incidents. We were told that the information was collated and incidents were categorised and rated according to risk. One clinical team leader told us that certain incidents routinely required a root cause analysis to be carried out to see what lessons could be learnt from them. They also said that they often received requests from the head of patient safety and risk to do such analysis of other incidents.

At our last inspection of St Ann's Hospital in February 2013 we looked at the provider's complaints procedures. We found that the provider took account of complaints and comments in order to improve the service.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because information about them was kept securely and was complete and accurate.

Reasons for our judgement

We spoke with people who used the service but what they told us did not relate to this standard.

The provider's website included a number of their policies concerned with the management of information they held about people. They included the following.

Data Protection Act 1998: Access to Health and Social Care Records; Freedom of Information Act (2000): Trust Protocol; Guidance For Staff In Sharing Information With Carers: and Information Governance.

The information governance policy referred to among other things, staff training, the Common Law on confidentiality, password access protections and the Caldicott Committee recommendations on patient identifiable information.

This showed the provider was committed to managing sensitive information in accordance with the law.

People's personal records, including medical records, were accurate and fit for purpose.

With the assistance of staff we looked at the electronic records of the nine patients we spoke with during our inspection. We also looked at some paper records about patients that were held on wards. We saw that people's preferences and cultural needs were recorded. For example we saw that one patient's potential requirement for a Halal diet was recorded.

Records we looked at showed that patients' needs were identified and care plans were developed based on those assessments. We saw that care plans were routinely reviewed at least weekly in order to see what progress patients made with their treatment. Potential risk to patients were identified including self harm, harm to others, self neglect and accidents.

All the records that we looked at were up to date and accurate

Records were kept securely and could be located promptly when needed.

We saw that information about patients was accessed in staff offices on the wards that were locked when they were not occupied by staff. Records were kept in electronic and paper formats. We noted that access to electronic records was controlled by identity cards held by staff and passwords. Paper records were held in filing cabinets that could be locked.

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 activity	Regulation
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: Regulation 17(1)(a) The dignity of female patients was sometimes compromised when they were cared for on a ward that was meant to accommodate male patients.

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

The provider's report should be sent to us by 09 July 2013.

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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