Agenda Item:

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 November 2014
Officer	Director for Adult and Community Services
Subject of Report	**Dorset HealthCare University NHS Foundation Trust – Recent Care Quality Commission (CQC) inspection of mental health services at Waterston, AAU Forston Clinic, CQC Mental Health Act Inspections of other mental health units in Dorset and compliance inspection of Bridport Community Hospital**
Executive Summary	Dorset HealthCare University NHS Foundation Trust (DHC) has been asked to submit a report to Dorset Health Scrutiny Committee on the outcome of recent CQC inspections and CQC Mental Health Act visits to mental health in-patient units in Dorset. In addition, a compliance inspection has been carried out at Bridport Community Hospital. The Care Quality Commission carries out announced and unannounced visits to inspect providers of health care services against the Essential Standards of Quality and Safety. The inspectors make a judgement as to whether the service is meeting the outcomes inspected or not. In the event of improvement actions being identified, the Trust is required to submit an action plan to address the shortfalls. As well as inspecting against the Essential Standards of Quality and Safety, the CQC also inspect services where patients' rights are restricted under the Mental Health Act 1983. These inspections assess whether the requirements of the Act are being met and patients' rights are protected. Since 1st April 2014 DHC has received two compliance inspections

	and three Mental Health Act visits. It is important to note that Mental Health Act visits are currently separate to CQC compliance inspections and do not directly impact on a provider's registration with CQC. However, if there are concerns identified these may be shared with compliance inspectors who may carry out a compliance inspection
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset HealthCare University NHS Foundation Trust.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate) Residual Risk ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate)
	Other Implications: None.
Recommendation	That the Dorset Health Scrutiny Committee consider and comment on the report.
Reason for Recommendation	The work of the Committee contributes to the County Council's aims to protect and enrich the health and wellbeing of Dorset's most vulnerable adults and children.
Appendices	1 Care Quality Commission inspection report: Forston Clinic, 4-5 August 2014 2 Care Quality Commission inspection report: Bridport Community Hospital, 27 August 2014
Background Papers	None.
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Dorset HealthCare NHS
University NHS Foundation Trust

CARE QUALITY COMMISSION (CQC) COMPLIANCE AND MENTAL HEALTH ACT (MHA) INSPECTIONS OF MENTAL HEALTH IN-PATIENT UNITS AND BRIDPORT COMMUNITY HOSPITAL

1.0 INTRODUCTION

1.1 Dorset HealthCare University NHS Foundation Trust (DHC) have been asked to submit a report to Dorset Health Scrutiny Committee on the outcome of recent CQC inspections and Mental Health Act visits.

1.2 The Care Quality Commission carries out announced and unannounced visits to inspect providers of health care services against the Essential Standards of Quality and Safety.

1.3 The inspectors make a judgement as to whether the service is meeting the outcomes inspected. In the event that the standards are not being met in full the Trust is required to submit an action plan to address the shortfalls identified.

1.4 As well as inspecting against the Essential Standards of Quality and Safety, the CQC also inspect services where patient's rights are restricted under the Mental Health Act 1983. These inspections assess whether the requirements of the Act are being met and patients' rights are protected.

1.5 Since 1st April 2014 DHC has received two compliance inspections and three Mental Health Act visits for the Dorset area.

1.6 It is important to note that Mental Health Act visits are currently separate to CQC compliance inspections and do not directly impact on a provider's registration with CQC. However, if there are concerns identified these may be shared with compliance inspectors who may carry out a compliance inspection.

2. MENTAL HEALTH ACT (MHA) VISITS

2.1 The following services in Dorset have received a Mental Health Act monitoring visit this reporting year (1st April 2014 – 31st March 2015)

Date	Service
30 May 2014	Melstock Unit, Forston Clinic
30 June 2014	Glendinning Unit, Maiden Castle, Dorchester
9 September 2014	Chalbury Ward, Weymouth Community Hospital

2.2 The CQC inspected Waterston Acute Assessment Unit at Forston Clinic on 4th and 5th August. It was believed to be a joint MHA and compliance inspection. To date the Trust has received the draft compliance report and is awaiting the final report.

3. KEY FINDINGS FROM MENTAL HEALTH ACT MONITORING VISITS

3.1 Key findings identified as a result of MHA visits to the units are:

Care Plans

3.2 Care planning was noted on two of the reports. The issues identified were that care plans were not always up to date and they did not all reflect the action which should be taken to deal with identified risks. There was a lack of evidence that patients were involved in planning their care.

Actions

- The Trust has recognised that work is needed to improve care plans and one of the Trust's Quality Priorities for 2014/15 is *to demonstrate integrated personal care plans for patients*. The Trust has a detailed action plan to achieve this which includes: achieving greater involvement of patients and service users, carrying out clinical audits, and sharing best practice.

- The Mental Health Team is implementing a competency based framework assessment tool for front line staff from 6th October 2014, which will include a domain relating to care planning, crisis and contingency plans. This is due to be completed in December 2014.

- Support and training will be provided to ensure that staff meet the required competency standards through a 6-8 week programme, following which they will repeat the competency assessment framework.

Activities / Therapies

3.3 A lack of activities was noted on one unit on the day of the visit.

Actions

- All the wards have a programme of activities structured around therapeutic engagement and social inclusion. This is augmented by the weekly community meeting which all units have where service users and staff discuss any other activities they may wish to participate in outside of the structured timetabled activity.

- Wards have designated Occupational Therapy time as well as nurses and support workers who engage the service users in a number of activities.

- Staff will ensure that support is given to help service users identify additional activities they wish to undertake, which will be in the form of a personalised timetable for specific activities identified to support their recovery.

- Staff will continue to encourage and support service users to access the range of activities available in the community.

Opinion of Second Opinion Appointed doctors

3.4 For some patients detained under the Mental Health Act, there are requirements to seek a second opinion, for example, when a person refuses the treatment prescribed to them or if a person is deemed incapable of consenting. Whilst this process was in place, there were times when the view of the second opinion doctor had not been recorded or had not been discussed with the patient.

Action

- Relevant staff have been reminded of the requirements and this will be monitored to ensure that the requirements are being met.

3.5 The Trust monitors all the CQC MHA inspections through a Non-Executive Director led Mental Health Act Assurance Committee. This Committee oversees the action tracker of the implementation of the improvements to achieve the standards and assures that there is robust evidence in place that supports the improvement.

4. COMPLIANCE INSPECTIONS

4.1 Dorset HealthCare has received two compliance inspections this reporting year. One of these was a community hospital. Both inspections have been to services which when inspected last year were found to need action to meet certain outcomes. The services inspected are Waterston Acute Assessment Unit at Forston Clinic and Bridport Community Hospital.

Waterston Unit

4.2 Waterston Acute Assessment Unit was inspected on 4-5 August and the Trust has received the draft report. The inspection identified the following areas for improvement in order to meet the outcomes inspected:

Outcome	CQC Finding	Potential Impact on service users
Outcome 4 – care and welfare of people who use services	Action needed	Moderate
Outcome 7 – safeguarding people who use services from abuse	Action needed	Moderate
Outcome 13 – staffing	Action needed	Moderate
Outcome 16 – assessing and monitoring the quality of service provision	Action needed	Moderate

4.3 In keeping with the CQC process, the provider has the opportunity to make representations against any factual inaccuracies when a draft report is produced. DHC have made representations against some factual inaccuracies and submitted evidence to support this. CQC have confirmed they are considering our representations and a final report is yet to be received.

5. ACTIONS BEING IMPLEMENTED TO ADDRESS COMPLIANCE

5.1 The Trust has been monitoring the essential standards at Waterston Unit. At the time of the CQC inspection in August, the Trust was aware of a number of issues impacting on the standards, predominantly related to staffing of the Unit.

5.2 These areas were being addressed at the time of the visit but have not yet been fully resolved. A formal action plan is not yet in place to address the findings of the draft report. In line with the CQC processes, this will be agreed and sent to the CQC after the final report has been agreed.

5.3 The following information highlights the action already underway to address compliance. Where appropriate, service wide training is being implemented to ensure

that actions/learning identified from one unit is spread across similar services. This will help to ensure standards are raised and maintained across the County.

Staffing

5.4 The CQC's draft report raised concern about the staffing levels on the ward.

Actions

- The Trust identified a lack of Clinical Leadership at Waterston brought about by a change in Ward Manager. To rectify this position a Clinical Lead was redeployed from another part of the Trust to support the Unit. This was implemented in mid-August. The Clinical Lead post provides support and direction to staff across Waterston AAU and Linden Unit and is developing an appropriate framework to manage the units.

- At the time of the inspection the Ward Manager was being covered via a manager who was acting up into the post. In August an interim Ward Manager with extensive experience of managing challenging units was commissioned to work with the ward until the end of the year. Recruitment for a permanent replacement is in progress.

- As a result of the lack of effective leadership, there were some anomalies with how staff/shift rotas were being developed. The Clinical Lead has reviewed the rotas to ensure there is critical mass within the units across all shifts. The revised rota in place covers up to November 2014 and this principle will be followed when the next rota is developed.

- In addition to the Interim Ward Manager, the Trust has procured fixed-term placement nurses to cover unfilled shifts. These placements have been secured for a period of 3-4 months and are part of the unit rotas. The time period will enable the recruitment process to be taken forward to fill substantive posts. All interim nursing arrangements have an induction to the Unit and full access to the patient electronic record. We have however not been able to recruit to the vacancies due to applicants withdrawing at the last minute following recruitment because they have taken employment elsewhere. The interim cover will be extended and interviews have been set for the new adverts during the first and second week of November 2014.

- Organisationally there have been significant difficulties recruiting to posts due to the geographical location and associated living costs within Dorset. The Human Resource Department has implemented a number of recruitment and retention strategies to address this across the Trust such as the introduction of relocation packages. This is being monitored as it continues to be a challenge within the national context. All vacancies continue to be advertised.

- The Trust is committed to ongoing investment in the training and development of managerial and leadership competencies of ward managers and charge nurses. This is to be monitored via meaningful supervision with clear performance objectives.

Clinical Care

5.5 The CQC raised concern about the seclusion room and keeping patients safe whist in this environment.

Actions

- In July 2014, the Trust identified that the environment of the seclusion room at Waterston did not meet national standards. As a result a programme of work was commissioned to rectify the issues; however at the time of the visit the work had not yet brought the room in line with national standards. A schedule of work for the seclusion room is currently being agreed between the Estates and Facilities Department and the Ward.

- In the interim, whilst the work to the seclusion room is undertaken the Trust has taken the room out of commission.

- All staff on Waterston are fully trained in de-escalation skills and are using the quiet area to de-escalate any situation that may lead to seclusion. De-escalation is the practice of calming or diffusing a volatile or potentially volatile situation. Should seclusion be indicated service users will be transferred to St. Ann's Hospital where they have appropriate facilities as well as a Psychiatric Intensive Support Unit to support service users' needs.

- It is important to note that during the past 18 months there have only been 6 incidents which have resulted in the use of seclusion at Waterston. This would suggest that there is appropriate management and de-escalation of incidents involving services users in the unit.

- Whilst the seclusion room is undergoing repairs, the bed management process has been modified, as an interim measure, to take into account how acutely unwell a person is the before being admitted to Waterson.

Care Plans and Risk Assessments

5.6 The CQC identified that care plans and risk assessments were not always up to date.

5.7 The Trust has been focussing on ensuring that service users have a care plan and a risk assessment; however it has recognised that further work was needed in terms of ensuring that the contents reflect service users' needs and are regularly kept up to date (see point 3.2).

Actions

- The Trust has developed a framework of core competencies to be rolled out to staff within mental health inpatient services. This will be accompanied by a training programme to support staff who may not meet the required level.

- The Mental Health Inpatient Core Competency Training Programme will focus on:
  - Staff skills and competencies:
  - Care Plans
  - Risk Assessments
  - Safeguarding
  - Respect and Dignity of patients
  - Relational Security (the knowledge and understanding staff have of a patient and of the environment; and the translation of that information into appropriate responses and care).
  - De-escalation skills (calming or diffusing a volatile or potentially volatile situation)

Review of restraint incidents

5.8 At the time of the inspection the assessors identified that there wasn't always evidence that incidents of restraint had been reviewed in line with the Mental Health Act code of practice.

5.9 The Prevention and Management of Violence and Aggression Trainer reviews every incident that has resulted in a restraint. These reviews identify any themes which are used to inform the training delivered. The Trainer also goes to the units to de-brief the staff and reflect if the incident could have been managed differently. Any training needs identified are incorporated into the training programme.

Action

- There will be a focus on systems in place to ensure that when a restraint has taken place, post-incident support and review are available and are delivered. This will include:
  - Staff involved in the incident
  - Patients
  - Carers and Family
  - Other patients who witnessed the incident
  - Visitors who witnessed the incident

Bridport Community Hospital

5.10 Bridport Community Hospital was inspected on 27th August, with five Essential Standards of Quality and Safety re-assessed. The final report has been published with the outcome of the inspection that all five standards were being met.

Outcomes	CQC Finding
Outcome 4 – care and welfare of people who use services	Met this standard
Outcome 7 – safeguarding people who use services from abuse	Met this standard
Outcome 13 – staffing	Met this standard
Outcome 16 – assessing and monitoring the quality of service provision	Met this standard
Outcome 21 – records	Met this standard

5.11 The Trust monitors the progress of the implementation of actions from CQC Compliance inspections in the Non-Executive Director chaired Quality Assurance Committee. This is a sub-committee of the Board and a monthly report is submitted to this Committee to review progress and to consider the systems and processes in place that can demonstrate assurance and evidence of the improvements made.

6. CONCLUSION

6.1 The Trust takes the findings of all CQC / MHA inspections and visits very seriously and takes all the necessary steps to implement appropriate actions to improve and maintain the high quality standards of care and welfare of patients and service users that we aspire to deliver.

6.2 The Trust assures progress of improvement through two Trust Board sub committees, the Mental Health Act Assurance Committee and the Quality Assurance Committee. Issues are escalated to the Board as appropriate.

6.3 The Trust disseminates learning so that improvements can also be made, where necessary. This benefits other services as well as those inspected.

6.4 A process of peer review within the Trust is in place. This means that staff review services which they are not responsible for against the CQC's essential standards. At a recent workshop of peer-reviewers the process has been found to be very well received and beneficial in helping to share good practice across the organisation.

Fiona Haughey
Director of Nursing and Quality, Dorset HealthCare NHS University Foundation Trust
October 2014

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: 05 August 2014
04 August 2014

Date of Publication: October 2014

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

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Staffing	✖ 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

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 looked at the personal care or treatment records of people who use the service, carried out a visit on 4 August 2014 and 5 August 2014, observed how people were being cared for and spoke with one or more advocates for people who use services. We talked with people who use the service and talked with staff.

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 had previously carried out an inspection between 8 June 2013 and 2 July 2013. At this inspection we identified concerns with care and welfare, safeguarding, staffing, support of staff and the monitoring of quality of the service. We identified what actions the trust should take in order that we were reassured that people were in receipt of safe and adequate care. The trust provided an action plan and then an update on their actions in September 2013. They told us they would be compliant in every area by December 2013. We inspected on 4 and 5 August 2014 to review the progress the trust had made and because we had received information of concern regarding people's care on the unit.

Waterston Assessment Unit provides an acute admission service. Since our visit in 2013, there had been a change in management arrangements. The previous ward manager had been seconded to another post and an acting manager was covering the ward.

On the day of our inspection there were 13 people on the unit with only one qualified nurse who did not usually work on this ward. In addition there were three regular support workers, a bank support worker and two occupational therapists.

We observed staff were respectful, and asked people if they needed support and assisting when asked to do so.

We found that the provider had taken some steps to improve the reporting of safeguarding and the support of staff. However, although most of the care plans were individualised for mental health needs, they had not been updated to reflect the care each person required. Records such as risk assessments had not been updated to reflect the information we saw in meeting notes and progress records.

We were told by the staff working that staffing levels were below the requirements of the

unit, which had been assessed as requiring two qualified nursing staff and four support workers during the day and two nurses and three support workers at night. Records we reviewed showed there had regularly been only one nurse on duty.

On this occasion we identified concerns with care and welfare, safeguarding, and staffing. Whilst there were audits in place we found issues on the ward during our inspection. We saw that the quality assurance monitoring of the service had not led to action to manage these concerns.

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 24 October 2014, 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

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 care plans and risk assessments did not show that people's care and treatment was planned and delivered in a way that ensured people's safety and welfare.

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

The care plans and risk assessments did not show that care and treatment was planned and delivered in a way that ensured people's safety and welfare.

At our last visit between 8 June 2013 and 2 July 2013 we found 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.

The provider wrote to us and told us what action they were going to take and they sent us an update on their actions in September 2013. Part of that action was regular auditing of the care plans and risk assessments by the ward manager.

We looked at three care plans and they did not always reflect specific needs that patients and staff had told us about. The care plans we looked at had information regarding: mental health needs, physical health, daily living skills and social needs and personal hygiene. However, although the regular members of staff were aware of the needs and support needed by the patients, the care plans and other records we saw had not been updated to show what was needed. This meant that any new members of staff or bank/agency staff would not know what support to offer.

We saw that the patient's views were not included in the care plans although most of the care plans were individualised for each person. We saw that care plans had not been signed by the patient/relative/representative and there was no indication as to whether people had been offered the opportunity to sign and why they had declined. Two patients we spoke with were not aware of their care plan. One showed us their care plan and staff had recorded they were asleep in the 'patient's view' section. There was no evidence to show that staff had gone back at a later time to speak with the patient. This meant there

was a lack of involvement of the patient in the planning of their care.

For one patient there was evidence of an advance directive in the historical information. However, this information had not been used to plan the care of the current admission of the patient.

The care plans and associated records were maintained in two ways; electronically and on paper with some patients being given a copy of their care plan. The electronic records allowed staff who had access to view, historical information for example previous risk assessments and admissions. We were told that not all bank/agency staff did not have access to these electronic records and relied on regular staff to inform them of patients' needs.

The care plans included risk assessments. However, care plans and risk assessments did not always reflect each other and did not appear to inform or drive care and had not been regularly updated. For example, one patients risk summary was dated 30 May 2014 and was dated for review on 18 July 2104. This had not been carried out. They had been readmitted to the unit on 10 July 2014 and the assessment stated they were 'warm and pleasant'. The records did not truly reflect the behaviours of the person on the current admission to the unit. Staff had not updated the records to show what was relevant at that time. Our observations of this patient on the day were very different to the records and this was confirmed in the progress records which showed that there were behavioural issues with the patient.

Other parts of this patient's care plan also had not been reviewed recently; their core assessment was dated 16 April 2014, the physical health assessment was dated 17 February 2014 and their 24hr physical monitoring assessment was dated 6 July 2014.

The doctor's meeting with the patient on 18 July 2014 was recorded in the progress records and was detailed referring to their risk profile and capacity assessment. It noted their capacity to understand and make choices regarding treatment and medicines varied. Nursing staff had not used this information to inform the care plan or update the risk assessments.

A second patient's risk assessment had last been updated on the 29 June 2014. The care plans stated they had been reviewed on 1 August 2014 but there was no evidence on what had been reviewed or changed. The progress records for the patient made reference to their discharge. However there was no care plan in place for their moving from Waterston.

The third patient had been admitted the weekend before our visit. We found an advance directive from the patient on how they wished to be treated should their health needs meet a certain criteria. Staff spoken with knew the patient and their views but the advanced directive was not referred to in their care plans. The care plans did not make reference to this directive and in the 'patients view' part of the care plan; it stated the person was asleep. We were able to speak with the patient on the day of our visit and they had a copy of the care plan which said they were asleep, they said 'I am not asleep now am I'.

We discussed these with the ward manager and gave them the opportunity to find the information. They agreed that the three care plans and risk assessments we looked at had not been reviewed and updated and did not reflect the current needs of these patients.

Daily progress records were completed for each person. These records detailed the

support given by nursing and care staff. Staff told us daily meetings were held with the staff on duty, where the multi-disciplinary team discussed the care needs and treatment for the patients. However, this information was not used to update care records which means that new or agency staff, if not told verbally, would not have access to the most up to date information.
Staff members we spoke with told us that they did not always have the opportunity to read care plans although there was a handover before each shift. The handover was led by a senior staff member of staff so that all staff could be briefed on how patients had been over the previous 24 hours. However the senior member of staff (nurse) was sometimes an agency nurse who did not know the patients. This did not always enable regular staff or those who may be working on the ward for the first time, to have the most up-to-date information they needed to provide a consistent service.

The comments from the patients were varied. Some spoke positively about their experience on the ward, whereas others were less positive. With comments made to staff for example "You don't know me". This was directed at a member of staff who was working on the ward for the first time. Patients were complimentary about the staff although we did observe one interaction when the patient made very negative comments about the staff member concerned.

Patients told us about their arrangements for leave and seemed happy with the arrangements. They told us that the food was good. Some patients expressed concern about the activities available on the ward. We were told that one particular patient liked being taken out for a ride in the ward car every day and staff usually managed to facilitate this. Some patients expressed concern about the impact that one particular patient was having on them. Staff were aware of this situation.

One patient, who had regularly been admitted to the ward when it was it known as Minterne, spoke positively about the changes to the building and the environment.

However, we looked at the seclusion records. Since April 2014 the seclusion room had been used on six occasions. Of the six episodes, three related to one patient over a short period of time. We noted that with two of the episodes the decision had been reached to end seclusion even though the patient was asleep. This happened with one particular patient who, within a very short space of time, was secluded again after they had woken up.

Another example we saw was where a secluded patient had been released from the seclusion room and allowed into the garden area. They enjoyed this experience and there were no major problems however, at the end of the time in the garden the patient was returned to the seclusion room.

We found that some of the seclusion reviews were not always fully completed and did not show how the assessment had concluded that seclusion was the appropriate action. Or why someone had been returned there although their behaviour did not seem to indicate they needed to continue to be secluded. This placed people at risk of being placed in seclusion without adequate assessment.

This means there was a lack of assessment and planning regarding the care of the patients and the use of the seclusion area. With a lack of regular trained staff working on the ward there was potential for the seclusion area to be used inappropriately.

We identified concerns with the seclusion room:
a) In the room there were "blind spots" where the patient could not be seen from the observation panels.
b) Patients could access the electrical devices in the ceiling area.
c) There was a piece of wood attached to the wall. The lock of the toilet door fitted into a fixing on the wood. A patient could rip this off the wall and use it as an offensive weapon.
d) There was no clock visible when the seclusion door was closed.

We were given information showing that the trust had also identified in April 2014 that the area had defects. This meant that the seclusion area was being used when it had been assessed as being unsafe by the trust. No planning had taken place on how behaviours and patients welfare could be managed without using an area that had many faults.

There were a variety of notices on the ward. On admission, patients were given an information folder containing details of their detention and care plan. There were daily community meetings, providing patients with an opportunity to be made aware of activities available. We looked at the notes of the community meeting, however they did not show that feedback was given to patients about issues or concerns that had been raised.

There was a separate room which contained gym equipment, although we were told that its use was limited because there were no staff with the necessary level of skills. A member of staff had been appointed and they were due to take up the post shortly. There were four occupational therapy staff attached to the ward, one of whom only worked one day a week. There was a useful activities room, but throughout our two day visit, we did not observe the room being used. There were some activities taking place for example escorted leave from the unit. We did observe one patient approaching one of the occupational therapists to seek a one to one discussion which took place.

There was regular contact between the ward and the independent mental health advocate (IMHA) service.

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 registered person did not have suitable arrangements in place to safeguard people against the risk of control or restraint being excessive.

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 between 8 June 2013 and 2 July 2013 people using the service 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. The provider wrote to us and told us what action they were going to take and they sent us an update on their actions in September 2013.

The action requested at the last inspection was with regard to the reporting of safeguarding .

At this inspection patients told us care plans had been developed without their involvement which is against the principles of the Mental Health Act code of practice. There were some patients who had significant risk issues. However the risks had not always been addressed in the risk assessment documentation and most of these were out of date. This meant that patients were not safeguarded against risks to their health and well-being.

Staff from the ward were able to escort patients to the local shop which patients benefited from. Risk assessments were carried out prior to leave being granted.

From the paper and electronic records we saw that patients were regularly being restrained. We looked at incident records, which included details of how the person was restrained and which part of their body was held. The Mental Health Code of Practice says:

"15.29 Hospitals should have in place a system of post-incident support and review which allows the organisation to learn from the experience of using physical restraint and which caters for the needs of the patient who has been restrained, any other patients in the area where the restraint occurred, the staff involved in any incident, the restrained patient's carers and family (where appropriate) and any visitors who witnessed the incident."

15.30 After physical restraint has been used, staff should reassess the patient's care plan

and help them reintegrate into the ward environment. They should also give the patient an opportunity to write their account of the episode, which will be filed in their notes."

However, the records showed that there was a situation where there had been a debriefing for the patient but the requirements of the code of practice had not always been adhered to.

Staff were aware of safeguarding procedures. We asked about the use of restraint and staff were able to tell us when restraint had been used in the recent past. We were able to confirm these with the incident records although they had not always been reviewed.

This meant that patients were not safeguarded against inappropriate and unsafe use of restraint.

We identified concerns with the seclusion room and we were given information showing that the trust had also identified in April 2014 that the area had defects. This meant that the seclusion area was being used when it had been assessed as being unsafe by the trust. No planning had taken place on how behaviours and patients welfare could be managed without using an area that had many faults.

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.

People were at risk of not having their needs met and for this to be done safely as there were not enough qualified, skilled and experienced staff available.

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 visit between 8 June 2013 and 2 July 2013 staffing was not planned effectively to ensure there were always enough suitably qualified staff on duty at all times.

During this inspection we found that there were not always enough staff with the right skills and experience on duty at Waterston Assessment Unit. We were told that staffing levels on the unit were set at six staff during the day and five staff at night. This decision had been made following an incident on the ward. However, during our inspection, staff expressed concern that staffing was not planned appropriately to ensure there were enough staff on duty with skills and experience to care for patient's needs. We were informed after the inspection that there were five day staff and four night staff.

At our last inspection we also raised concerns about the skills and experience of staff in the prevention and management of violence and aggression. We were given information at this inspection which showed a list of 20 members of staff available to work on the unit. We saw that three were due to update their training later in the year.

When we arrived on the unit, there was one qualified nurse, acting as the clinical team leader, supported by four support workers. It was the first shift that this nurse had undertaken on the unit. Later during the visit, the acting ward manager came on duty, which meant that there was two qualified staff on duty, together with the four support staff. However, the clinical team leader nurse was committed to attending a mental health review tribunal with a patient from the ward and the acting ward manager was involved in interviews for staff. This meant there was no qualified staff member actively working the shift.

We looked at the staff rotas for the period of 20 July 2014 to 16 August 2014. We saw that, including the ward manager, there were seven nursing staff on the rota available to work. However, on the week of our visit three of these nurses were on leave and one was working day shifts off the ward. This left four to cover the week including night duty. The unit could not meet its staffing level of two nursing staff per shift. We saw that on the day

before our visit Sunday 3 August 2014 that an agency nurse had been on duty all day. Staff told us that whilst they were 'good' they had not been to the ward before. Staff told us they were covering where they could but there was regular use of agency/bank staff. The rota showed that some shifts had not yet been covered with qualified staff.

For the 28 days of the rota we saw, 84 shifts that needed to be covered by two nursing staff, only 18 had two nurses, 5 had no staff and on 61 occasions there was only one nurse on duty. Of these 84 occasions 13 had been covered by agency staff.

We were told and saw on the rota that there should be four health care support workers on duty during the day and three at night. We saw that on 9 occasions there were the numbers of support staff needed, on duty. The remaining 75 occasions were supplemented by agency/bank staff but these additions did not raise the staffing levels to those that should have been in place.

We were told that there were three nurse vacancies on the unit which they were interviewing for.

Staff made a number of comments about the situation on the ward. Comments were:
"We are chronically understaffed."
"There is only so much that we can do."
"We are all stressed out by the staffing situation."
"Things have taken a definite dive staffing wise."
"Things are slipping away because of the staffing situation."
"Management do not listen."

Staff appeared to be committed to their work and this was reflected in their comments. One member of staff said that "It was nice working on the ward" and that "staff are patient centred".

We were told that hotel service staff were in the dining room to assist in the delivery of food at meal times. The hotel service staff were not left alone with the patients as nursing staff were always available. The only exception was where a patient was late for breakfast and was the last patient in the dining room. From time to time, the patients would be left with the hotel service staff but only with the hotel service staff agreement.

The ward was using monitoring tools to record when staffing did not meet the assessed requirements, which was sent to senior staff at the trust. However, shift vacancies were continuing not to be filled on a regular basis.

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 providers system used to identify, assess and manage risks to the health, safety and welfare of people who use the service and others did not adequately ensure that the service provided was safe and offering quality care.

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 between 8 June 2013 and 2 July 2013 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.

Some of the concerns highlighted last year were identified again during this inspection. The most significant of these were around care planning and risk assessments not being up to date, and the lack of planning and monitoring of the service.

We saw that legal documentation for four patients we looked at was in good order. We looked at the reports from the approved mental health professionals (AMHP). The quality of these varied. Patients had been given their rights and on the day of our visit an independent mental health advocate (IMHA) was visiting the ward. The mental health records were monitored by a member of staff from the trust and specialists from the Commission.

People using the service had the opportunity through the daily community meeting to express their views on a wide range of issues. We did see the community meeting minutes. However, patients were not able to tell us about the meetings. Paperwork used to record meetings had an area to record previous information to be shared, this was not used..

We were told last year that care plans would be monitored by the ward manager. However, the care plans were not up to date and we could find no evidence of involvement by the manager. Records and the lack of involvement of patient's nearest relatives were raised as a concern at the last inspection, as were concerns about the use of restraint and the need to adhere to the Mental Health Act code of practice.

The environment of the seclusion room was not appropriate. In the room there were "blind

spots" where the patient could not be seen from the observation panels. Patients could access the electrical devices in the ceiling area. There was a piece of wood attached to the wall. The lock of the toilet door fitted into a fixing on the wood. A patient could rip this off the wall and use it as an offensive weapon. There was no clock visible when the seclusion door was closed. We were given information showing that the trust had also identified in April 2014 that the area had defects. This meant that the seclusion area was being used when it had been assessed as being unsafe by the trust.

From our visit we saw that there were continued areas of concern that had not been addressed. We did not see that the issues had been raised with senior staff or that action had been taken to address the issues around care plans and risk assessments, staffing and safety of patients.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The care plans and risk assessments had not been reviewed and updated and did not reflect the current needs of these patients. Regulation 9 1 (a) (b) (i) (ii)
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	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The registered person did not have suitable arrangements in place to safeguard people against the risk of control or restraint being excessive. Regulation 11(2)(b)

This section is primarily information for the provider

injury	
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: There were insufficient nursing and support staff to ensure that people's needs could be met and that this was done safely. Regulation 22
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: The providers system used to identify, assess and manage risks to the health, safety and welfare of people who use the service and others did not adequately ensure that the service provided was safe and offering quality care. Regulation 10 - (1) (a)(b)(2)(b)(iii)(iv)

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 24 October 2014.

This section is primarily information for the provider

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.

Contact us

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Inspection Report

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

Bridport Community Hospital

Hospital Lane, West Allington, Bridport, DT6 5DR

Date of Inspection: 27 August 2014

Date of Publication: October 2014

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

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
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	Bridport Community Hospital has two inpatient wards and an outpatients department. The hospital also has a minor injuries unit and offers some surgical procedures.
Type of services	Acute services with overnight beds Acute services without overnight beds / listed acute services with or without overnight beds Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical 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 to check whether Bridport Community Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Staffing
- Assessing and monitoring the quality of service provision
- Records

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 27 August 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, reviewed information given to us by the provider and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We inspected Langdon and Ryeberry inpatient wards at the hospital. This inspection was to follow up concerns found at the previous inspection in April 2013 and to check that regulations were being met.

Patients told us they received excellent and compassionate care, and that staff delivered care in a timely manner. Patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs.

Patients were fully protected from the risk of abuse, as staff demonstrated full understanding of the safeguarding of Vulnerable Adults guidelines, and Deprivation of Liberty Standards.

There were sufficient staff to meet patient needs in a timely manner.

The hospital had systems to identify, assess and manage risks to the health, safety and welfare of patients using the service and others. Monitoring had identified issues requiring further investigation, and appropriate actions had been taken where necessary.

Records were mostly complete and accurate, and stored appropriately.

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

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

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

During the previous inspection in April 2013, we found that although patient risks were assessed, their future care was not planned in a way that ensured their needs were met safely. Staff did not always demonstrate understanding of some patient needs, and patients did not have the opportunity to participate in activities.

At this follow up inspection, we found that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Staff were aware of individual care requirements and ensured these were carried out appropriately and in a timely manner. Patients now had access to some activities. We observed many episodes of individualised care, including a personal timeline being written with a patient. This was evidence of good practice.

The care plans had detailed requirements listed, and this translated into observable practice. For example, one person had to be helped to walk in a specific manner, and checked regularly to ensure their safety. This was done during our visit.

People's care and treatment reflected relevant research and guidance. Some patients required specialist input from other healthcare professionals such as physiotherapy. Clear guidelines and treatment plans had been written by these professionals, to ensure that the correct treatment was in place. This meant that nursing staff could, for example, check the correct way people should be safely moved .

There were arrangements in place to deal with foreseeable emergencies. Fire training had been undertaken at appropriate intervals and emergency equipment had been checked and maintained correctly.

We checked the documentation for people who used services. They were only deprived of their liberty when this had been authorised by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

During the previous inspection in April 2013, we found that although patients felt safe within the hospital, staff did not always know how to report safeguarding matters externally. This meant that people were not as safe as they should have been.

At this follow up inspection, we found that people who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We spoke with patients on both wards. They told us they felt safe. One person said "If I saw or heard something I thought was wrong, I'd tell my carer."

All staff, including non clinical staff, had undergone training to understand the different types and mechanisms of abuse. Each member of staff we asked could describe these, and were aware of their responsibilities to report any suspected abuse.

The Trust had policies and procedures in place to ensure patient's safety. Staff on the wards, and at senior level, all knew how to report safeguarding or abuse issues, and how to follow these up in a timely manner. One person had the correct Deprivation of Liberty documentation in place, and staff were aware of what this meant for the patient.

The specialist advisor who joined us on this inspection sat in on a multidisciplinary meeting. A major focus of this meeting was on the capacity of individuals to make the correct decisions for themselves. This was good practice and highlighted the Trust's commitment to ensuring that people were protected from abuse or the potential of abuse.

The provider responded appropriately to any allegation of abuse.

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.

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

Reasons for our judgement

During the previous inspection, we found that on some occasions the number of staff did not meet the ward's set minimum levels. This meant that there had not always been sufficient staff to meet the needs of the patients.

At this follow up inspection we found that there were enough qualified, skilled and experienced staff to meet people's needs. Patients on both Langdon and Ryeberry ward told us there were sufficient staff to meet their needs. They said they did not have to wait long if they required help. We observed there was a timer in place recording how long buzzers rang. The vast majority of these were answered promptly, despite a busy shift.

We observed that people were helped to wash and dress according to their individual requirements. If a person needed two members of staff to help them, the staffing was sufficient to allow the care to be delivered according to the care plan. Staff took time to enjoy social moments with patients they were caring for. For example,one member of staff took considerable time to have a long conversation with a patient about his concerns. Another promised to take a patient outside for a walk later in the shift.

During the inspection, staff were busy, but worked in a purposeful and co-operative manner with each other. A transport co-ordinator came to Langdon Ward, and the staff nurse took time to ensure the patient was securely and comfortably seated before they left for their appointment. Another member of ward staff accompanied them to the appointment so the patient would feel safe and secure. These were examples of staffing where patient personal requirements had been taken into account. It also indicated that staffing had flexed depending upon specific circumstances, and to reflect people's dependency needs.

We reviewed the staff rotas and discussed these with the unit Matron. A small number of bank staff were used during the holiday periods, and the hospital tried to keep agency staffing to a minimum.

Rotas indicated where people were away on training days. Training had not been delayed and this is another indicator of sufficient staffing being in place.

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

Reasons for our judgement

At the inspection in April 2013, we found that although there were systems in place to identify risks and provide suitable action plans, these had not consistently identified appropriate risks. For example, although cleaning audits had been undertaken, they had not identified that the bed spaces were not completely clean.

At this follow up inspection we found that regular audits were made of a variety of clinical and non-clinical issues. These included infection control checks, emergency equipment audits, training record reviews and the use of pressure mattresses and other specialist equipment. Any issues arising from these audits now had a robust follow up action plan. Equipment such as hoists had been serviced as required, with the next check due in January 2015.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Boxes were kept on the nurses' stations to enable easy access for patients to fill in questionnaires if they wished. Relatives who spoke with us said that personal preferences and individual needs were taken into consideration when planning treatment and discharge arrangements. This meant that the staff had taken note of the patients and relatives' points of view.

All patients were offered the opportunity to complete the Friends and Family survey shortly before discharge, using either a paper copy or a hand-held tablet. This data was collated and fed back to all staff. An example of a change made was an alteration to visiting times to enable more families to visit their relatives.

The views of staff were sought via a variety of methods. This included team meetings, supervision sessions and appraisals, and attendance at patient review meetings.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. This was particularly noticeable at the multidisciplinary team meetings which were held regularly. Individual capacity was discussed at length prior to any decisions being

made by staff.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. For example, incident forms had been submitted for instances of falls. Post fall protocols were in place and feedback given to staff in order to further enhance practice. Some staff had raised the issue that agency staff were not always aware of incident reporting, but this had been raised correctly with the Matron.

The provider took account of complaints and comments to improve the service. The Trust issued "Have your say" leaflets to ensure families and patients knew how to raise an issue or leave comments and complaints. This leaflet included an outline of the complaints procedure, and details of other organisations such as Dorset Advocacy and the Parliamentary Health Service Ombudsman.

We observed many letters and cards offering compliments to the staff on their attitude and care of their patients. These were discussed at team meetings to ensure staff were fully aware of patients and families comments.

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 accurate and appropriate records were maintained.

Reasons for our judgement

During the inspection in April 2013, we found that patient records did not always contain sufficient information to ensure patients were protected from the risks of inappropriate or unsafe treatment.

At this follow up inspection we found that person specific information such as physiotherapy interventions and physical support were clearly documented. We also saw this translated into practice where a patient with specific mobility needs was appropriately supported.

Records were kept securely and could be located promptly when needed. People's medical records were paper and electronic, and were accurate and fit for purpose. Electronic records were password-protected ensuring that access was traceable and available only to those staff who had the right to view them. There was a new electronic system in place. Although this was not yet fully embedded, staff were beginning to integrate it more into their daily practice. All staff we spoke with were fully aware of the necessity to keep their log-in cards secure at all times. This was also observed in practice during our inspection.

Paper records were, in part, records from another Trust; these were filed but not always fully secured in a locked trolley. However, this was immediately dealt with when addressed with senior staff.

Documentation showing patients consent to share information was available and had been signed by the people whose permission had been requested. This documentation ensured that the patient had given written consent for their medical records to be shared with other appropriate staff.

On occasions, details of specific patient care could not always be easily located within the nursing care plans. However, all staff were aware of the care required, and had written the information elsewhere within the care plan. A particular example of this was the use of specified body slings, relating to the person's physical ability and body shape. This information had been recorded in different places in two patients' care plans. It had not

impacted on the delivery of care, but there was an inconsistency to this practice which the provider may wish to note.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. We asked for a training matrix; this was immediately available and up to date. When we spoke with staff, they confirmed their attendance at the training sessions indicated.

Records were kept of team and unit meetings. These were cascaded to staff via noticeboards, and were available on request.

Records were kept for the appropriate period of time and then destroyed securely.

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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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