Dorset Healthcare University NHS Foundation Trust

Quality Report

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Date of inspection visit: 1st February 2017
Date of publication: 12/04/2017

Core services inspected	CQC registered location	CQC location ID
Twyneham ward Forensic inpatient/secure ward.	St Ann's Hospital	RDY10

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We did not rate this service at this inspection.

The purpose of the inspection was to follow up the concerns raised at the Mental Health Act scheduled visit on the 23 January 2017 of Twyneham ward by Mental Health Act reviewers.

The concern raised from the Mental Health Act visit was patients who failed to attend the 9.00am meeting or groups held on the ward lost all or parts of their leave and that patients perceived the withholding of leave as punitive.

The concern about the restrictions on patients leave had been raised during a previous Mental Health Act visit in July 2015. Our concerns were thus known to the ward but no action had been taken to rectify this. On this previous visit the Mental Health Act reviewer had included references from the revised Code of Practice, which had introduced guidance on blanket restrictions.

The report in 2015 stated:

'All patients were restricted from entering their bedrooms by them being locked on weekdays during the working day, other than for an hour at lunchtime.

All patients were normally required to attend a full daily group programme, or they would not be permitted to go out on ground or community leave. On the day of our visit this consisted of four groups of approximately 45 minutes a day for most patients.'

Following this inspection the trust stated in their action statement :

'No service user who refuses to participate in their personalised group programme loses leave as a result of their non-participation or cooperation - .any such decision to rescind leave or restrict leave is based on factors other than the immediate presenting one of refusal to comply with their group programme. The decision is based on mental state examination, presence of identified relapse indicators or the presence of increased (known) risk factors.'

The Mental Health Act reviewers on their visit on 23 January 2017 found that those restrictions were still in place.

On this inspection (01 February 2017), we spoke with a range of staff and patients.

The four patients that we spoke with at this inspection and the four spoken with at the Mental Health Act reviewers' visit in January 2017, were all unclear about the link between attending the morning meeting, the group therapy sessions and the restrictions on their leave. They told us that if they did not go to the groups they lost all or part of their leave and viewed this as punitive. They said that there was a three-stage warning system relating to their behaviour in the group and that if they received three warnings then they lost their leave. They said that the staff member in the team that made the decision about them going on the leave often was not one of the staff who took part in the group. They were concerned about the lack of information they received from staff about the restrictions on their leave.

We looked at information given to patients about their attendance at the groups in the handbook and in rules of the group and there was no information about the link between non-attendance at the groups and leave restrictions.

Staff members we spoke with were not clear about the link between the attendance at groups and leave and the decision making process. They told us they completed risk assessments about a patient's current state of mental health if they did not attend groups. However, we could find no evidence in the care notes of risk assessments or rationale to rescind leave. Generally, risk assessments and care plans seen were not updated to reflect patients leave restrictions. Staff were unable to provide clear criteria for leave restrictions to ensure consistent working and decision making.

The consultant told us that he made decisions about leave and leave conditions and these were discussed at meetings of the multi-disciplinary team (MDT) following a review of the patient's current health. The consultant stated that these decisions should not be changed without further discussion by the multi-disciplinary team. We saw these were reflected in the MDT notes in patients' progress notes.

The consultant told us that he believed that there was a lack of communication within the wider team. Staff from

Summary of findings

a range of other professional groups also raised concerns about the management of the ward and the lack of effective working and communication within the staff team (across the range of professions).

On the 10 February 2017, we wrote to the trust detailing our concerns. We stated that patients and staff must have a clear shared understanding of the link between patient attendance at morning meetings and groups held on the ward and leave restrictions. We asked the trust to implement a policy that clearly identified how patients would be assessed and when and for what reasons leave would be rescinded. We stated that If there was any link between restricting leave and attendance at meetings, this must have a clear rationale and all staff and patients must understand this. All staff must receive training in how to apply the policy and who can make the decisions about restricting leave.

We asked the trust to forward the policy and provide assurance that all staff had an understanding of the policy and were applying it appropriately and assurance that all patients knew of the policy and had an understanding of how it would be applied and in what circumstances. We asked for this to be provided by the 24 February 2017.

The trust sent us an action plan to address our concerns on the 24 February 2017. The plan detailed how the ward manager had reviewed the policy and the plans in place to ensure clarity on rescindment of leave. A system was put in place whereby staff recorded when they had read the protocol and this was monitored by the manager.

On the 27 February 2017, staff and patients attended a training session about patients' leave and the new protocol. They told us this was to ensure that all patients understood and were clear on the leave protocol. A copy of the attendance at the event was forwarded to us.

The trust was also in the process of updating the section 17 policy in line with code of practice. The deadline for completion was the end of March 2017 and the trust stated they would then forward the document to us.

As the trust acted promptly to address our concerns, we have taken the decision to take no further action at this present time. We will use this information to inform our future inspections and will return to the ward if we have any additional concerns.

We will return to the ward in due course to ensure the actions identified have been implemented.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?
We did not look at this key question during this inspection.

Are services effective?
We did not look at this key question during this inspection.

Are services caring?
We did not look at this key question during this inspection.

Are services responsive to people's needs?
We did not look at this key question during this inspection.

Are services well-led?
We did not look at this key question during this inspection.

Summary of findings

Our inspection team

The team that inspected Twyneham ward (forensic services/secure ward) comprised Jacqueline Sullivan, lead inspector, a head of hospital inspection and a mental health reviewer.

Why we carried out this inspection

We inspected Twyneham ward as an unannounced, focussed inspection. The purpose of the inspection was to follow up the concerns raised at the Mental Health Act scheduled visit of Twyneham ward by Mental Health Act reviewers on 23 January 2017.

The concern raised from the MHA visit was that patients who failed to attend the 9.00 am meeting or groups held on the ward lost all or parts of their leave and that patients perceived the withholding of leave as punitive. Other concerns were about patients risk assessments and care plans not being up to date and not reflective of the plans for patients that staff described.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited Twyneham ward and spoke with four patients who were using the service
- spoke with the ward manager
- spoke with six other staff members; including lead consultant psychologist, the consultant, theactivities coordinator, two other staff members and the nurse consultant.
- observed a group for patients. and the staff handover
- observed the interactions between staff and patients and the care being provided.
- looked at three care records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about the provider

Twyneham ward is the low secure unit at St. Ann's Hospital. It is part of Dorset Healthcare University NHS Foundation Trust forensic service.

It has 12 beds for male patients, all of whom are detained under the Mental Health Act. At the time of inspection, the patients were detained under section 3, section 37 and section 37/41 of the Mental Health Act.

What people who use the provider's services say

The four patients spoken with at this inspection and the four spoken with at the Mental Health Act reviewers' visit were all unclear about the link between attending the morning meeting, the group therapy sessions and the restrictions on their leave.

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Detailed findings

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We did not look at this key question during this inspection.

Our findings

We did not look at this key question during this inspection.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We did not look at this key question during this inspection.

Our findings

We did not look at this key question during this inspection.

Are services caring?

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

Summary of findings

We did not look at this key question during this inspection.

Our findings

We did not look at this key question during this inspection.

Are services responsive to people's needs?

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

Summary of findings

We did not look at this key question during this inspection.

Our findings

We did not look at this key question during this inspection.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We did not look at this key question during this inspection.

Our findings

We did not look at this key question during this inspection.