Devon Partnership NHS Trust

Torbay Hospital

Quality Report

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Date of publication: 17/04/2014
Date of inspection visit: 4-7 February 2014

This report describes our judgement of the quality of care at this location. 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.

Summary of findings

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Summary of findings

Overall summary

Torbay Hospital is in Torquay. The hospital has both acute and mental health services on site provided by two different NHS trusts. This inspection looked at the mental health services only, which are run by Devon Partnership NHS Trust.

The mental health services provided by Devon Partnership Trust consist of one acute admission ward for adults of working age, Haytor Ward which has 17 acute beds and 2 detox beds. Haytor Ward provides assessment, care and treatment for men and women with mental health needs. Also based on this site is Beech ward currently providing care and treatment for 14 older patients. The ward provides assessment and treatment for older people with mental health needs, such as depression, anxiety and psychosis.

We found areas of good practice and many positive findings across adult and older inpatient services in Torbay. Patients were mostly positive about staff and told us they were compassionate and caring. Patients confirmed there was a recovery approach to care and support, which they found responsive to their needs and experienced at all stages of their hospital stay. On the ward for older people, potential risks associated with ageing, such as falls, were well managed and meant that people's health was promoted.

Patients confirmed the accommodation was comfortable. The hospital environment offered people privacy. All areas of the hospital were clean and staff followed good infection control practice.

Staff morale was generally positive and multi-disciplinary teams worked well together. There was an open culture on both wards and staff were confident about raising concerns. Governance arrangements were in place and monitored the performance of the services. Both ward managers demonstrated they had a good knowledge and understanding about their services and wanted them to succeed.

There were a number of improvements needed in the services, specifically for people using the acute services on Haytor Ward. Too many patients in crisis are being taken to police stations or the local emergency department rather than to the trust's own 136 suites (which are the designated health-based places of safety). In the year ending November 2013 in South Devon, 47 patients used the trust's own place of safety suite and 134 went to police custody.

For the past six months, 44% of adult patients from South and West Devon needing an acute admission had to go to Exeter and a few to North Devon. This means they are a long way from relatives, carers and their community care professionals. At the time of our inspection the acute older adult ward in Torbay was occupied by 40% of working age adults although many were over the age of fifty. The staff of the older people's mental health community service in Torbay expressed difficulties in finding beds for older adults who required admission.

We were also concerned about the safety of patients who may need restraint or seclusion. In Torbay there is one seclusion room which is in a potentially unsuitable location on a suspended ward and different floor to Haytor Ward. We found that some recording of the use of seclusion is poor impacting on the effective monitoring of its use across the trust. In addition 21% of staff on Haytor Ward had not received up-to-date training to manage incidents where physical restraint might be required. We also found that some patients were staying in seclusion for long periods of time based on their clinical need while a bed in a Psychiatric Intensive Care Unit was found.

We found patients were lawfully detained; however there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of risk plans associated with section 17 leave.

Patients and staff told us that engagement with patients does not occur as frequently as they would like. This was attributed to periods of high activity and being busy with office duties. Some patients on the older people's ward told us there was not enough to keep them occupied. Beech Ward had less occupational therapy input and access to activities.

In Torbay engagement with staff was variable. The trust has been running a 'Listening into Action' programme with mixed feedback about these events. In Torbay some staff felt the trust was not really listening or acting on

what staff had said. Some staff on Haytor were negative about the trust's performance management. They said the trust had its priorities wrong and focussed too much on "targets rather than quality of care".

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Systems were in place to capture and report incidents and notify external bodies. However, incident reports did not always contain detailed information explaining exactly what had occurred. For example, they did not detail what constituted as 'threatening behaviour' or exactly what occurred during the process of escorting a patient to seclusion. Teams were learning from incidents to improve the standards of safety for patients.

The ward environment on Haytor did present a number of ligature risks of which the staff were aware. These had been risk assessed and management plans were in place.

Staff understood and followed safeguarding procedures.

Are services effective?

Patients experienced care and support based on the recovery model of care. This was supported by our observations of the use of appropriate clinical guidance, standards and best practice.

There were good examples of collaborative working between the ward teams, with people using the services and with external professionals.

Quality audits were used to guide and improve patient care. Care plans and risk assessments were not always person-centred or evidence based. It was not clear from some care plans if patients had been involved with writing them. Two patients on Haytor told us that they had not been involved with their care plans but would have liked to have been involved.

Are services caring?

The majority of the patients spoke positively about the staff and many patients were full of praise and said that staff were kind, caring and mostly met their needs. Patients consistently raised concerns about not being able to access staff when they needed to. Staff confirmed they were not always able to speak with or engage with patients when they had requested as they were busy.

We observed that staff communicated with patients in a respectful way, listening and acting upon their wishes. Patients' privacy and dignity was maintained.

People who use the service, and carers, felt able to make choices and be involved in review meetings. Staff were aware of carers needs and involved them as far as possible. We observed that staff provided support to relatives without breaching confidentiality.

Are services responsive to people's needs?

Major improvements are needed to the responsiveness of services so they meet the needs of people who use them, especially for adults accessing acute services. One of the wards at Torbay is currently suspended.

Patients knew how to make complaints if they wanted to. Staff told us how they would support patients to make complaints and how the ward would learn from any complaints made.

Are services well-led?

There was an open culture within both ward teams. Staff told us that they felt supported by their clinical team leader and the wider multi-disciplinary team.

Summary of findings

Both clinical team leaders were knowledgeable about the wards and the needs of the patients and how to deliver good practice in their area.

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The Senior Nurse Manager told us that they felt senior managers in the Trust listened to concerns that they raised and acted on them. However some staff told us that they felt the trust was not really listening or acting on what staff had said and that it was focussed too much on “targets rather than quality of care”.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We found that patients were lawfully detained; however there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of risk plans associated with section 17 leave.

Care planning and risk assessments were not always fully completed or inclusive of the patient's views.

We found for two patients that they had been receiving medication without the appropriate authority to treat in place.

We heard about difficulties in accessing psychiatric intensive care facilities which are not commissioned from the trust and that this could mean patients being secluded for periods based on clinical need to manage this risk.

The use of seclusion is not being recorded appropriately and this affects the quality of the monitoring. We found that there were difficulties in accessing the seclusion facility due to this being sited on a different floor within a separate unit.

We found that there was a programme of audit in place to consider how well the Mental Health Act is being implemented at the hospital. Audits undertaken included recording of consent to treatment, information on rights, section 17 leave arrangements, discharge arrangements and use of the place of safety.

Acute admission wards

We found areas of good practice in the acute adult inpatient ward in Torbay. Patients were mostly positive about staff and told us that they were compassionate and caring. Patients confirmed there was a recovery approach to care and support, which they found responsive to their needs and experienced at all stages of their hospital stay. This was supported by good occupational therapy services.

Patients said the accommodation was comfortable. The ward offered people privacy. All areas of the ward were clean.

Staff morale was generally positive and they worked together well in multi-disciplinary teams. There was an open culture and staff were confident in raising concerns. Governance arrangements were in place and monitored the performance of the services. The ward manager demonstrated a good knowledge and understanding about their service and wanted it to succeed.

There were a number of improvements needed in the services. Too many patients in crisis are being taken to police stations or to the local emergency department rather than to the trust's own 136 suites (which are the designated health-based places of safety). In the year ending November 2013 in South Devon 47 patients used the trust's own place of safety suite and 134 went to police custody.

For the past six months, 44% of adult patients from South and West Devon needing an acute admission have had to go to Exeter and a few to North Devon. This has meant they are a long way from relatives, carers and their community care professionals.

We were also concerned about the safety of patients who may need restraint or seclusion. In Torbay there is one seclusion room which is in a potentially unsuitable location on a suspended ward on a different floor to Haytor ward. We found that some recording of the use of seclusion is poor and this affects the effectiveness of monitoring of use across the trust. In addition 21% of staff on Haytor ward had not received up-to-date training to manage incidents where physical interventions might be required.

Patients and staff told us that engagement with patients does not occur as frequently as they would like. This was attributed to periods of high activity and being busy with office duties.

Summary of findings

Engagement with staff was variable. Some staff on Haytor were negative about the trust's performance management. They said that the trust had its priorities wrong and focused too much on "targets rather than quality of care".

Services for older people

Beech ward provided a high standard of care to people using the service. It was a safe and secure place for patients to stay, where staff cared for them in the least restrictive way.

Patients told us that they felt safe and well cared for. However, two patients told us that there was not always a lot to do and they sometimes got bored.

Carers were full of praise about the service provided to their relatives. Where patients did not have mental capacity, appropriate steps were taken to promote their rights through best interest and involvement of carers. However, one capacity assessment we saw, which deemed the patient not to have capacity, was only partially completed. It was not evident from this assessment that the principles of the Mental Capacity Act had been followed.

Patients had thorough assessments, which considered appropriate risks and health issues related to the ageing process. Patients were involved in discussions about treatment options available and alternatives to inpatient care, such as adult social care providers in the community.

Management of risks and care planning was done on an individual basis. Good quality information was given to carers and individuals throughout their stay at the ward.

Collaborative working across all sectors and services was evident to ensure patients had the right support and experienced seamless care.

The manager on Beech was passionate and promoted best practice. Staff worked well together as a multi-disciplinary team. There was an open culture on the ward and staff were confident in raising concerns. Morale was positive on Beech ward.

The governance of the hospital was monitored at both local and Trustwide levels by senior managers.

Summary of findings

What people who use the location say

As part of our inspection we held listening events across Devon to enable people who used the service and their friends and relatives to tell us about their experience of services. With the support of the trust's carer and user involvement team we held two events for carers in the south of Devon: one in Torbay and the other in Paignton. While there were positive comments from a person who had been an inpatient at the Haytor unit the majority of people were less positive.

We heard about a number of occasions were people had not been able to get any support in a crisis. We were told about times when the police station had been used to manage someone in crisis due to their being no beds available across the area. People told us of their loved ones being sent to Exeter, North Devon or Plymouth to access beds and of the impact this had on their ability to visit. People told us that ward staff at Haytor did not have time to speak with patients and that they were too focused on paperwork. Two people also told us that they had tried to complain to the trust and had felt that they were not listened to or that their complaint was not managed appropriately. A large number of carers told us that the trust's carer and user involvement team were very good and that the model should be rolled out in other parts of Devon.

Areas for improvement

Action the provider MUST take to improve

- There must be systems in place especially for adults of working age that need acute inpatient care, with effective bed management that reduces the need for patients to be admitted long distances from their homes. This must ensure that valuable nursing time is not taken up with searching for a bed.
- Access to the hospital's own place of safety must be reviewed to ensure it is being used as the preferred place of safety.
- The use of seclusion and restraint must be correctly recorded to ensure effective monitoring. The use of the seclusion room in its current location must be reviewed. Acute admission wards must meet the trust target in terms of the numbers of staff having up to date training in restraint.

Action the provider SHOULD take to improve

- Recording of procedures required under the Mental Health Act should be improved – especially in relation to risk plans associated with section 17 leave. Forms confirming the appropriate authority to treat must be in place before patients receive medication.
- Potential risks to patients caused by the environment should continue to be reviewed to ensure safety measures are being implemented while building improvements take place.
- Staff knowledge of the whistleblowing process should be refreshed.
- Further work should take place to support staff working in the Torbay services to be engaged with the work of the trust. This includes access to professional as well as managerial support especially for nursing staff.
- Patients on Haytor ward should be supported to have care plans that reflect their individual needs, to be involved in preparing their care plan and have a copy of their care plan.
- The amount of therapeutic activity available for patients on Beech ward should be reviewed to ensure it supports the recovery model.
- Capacity assessments and decisions should be recorded fully.

Summary of findings

Good practice

On both Haytor Ward (Acute working age adult) and Beech ward (Acute older adult) we observed staff supporting patients with care and compassion and a high level of commitment to providing a good quality service. Work with patients on Haytor Ward around wellness and recovery was very positive offering a range of activities including a well used onsite gym and access to large garden areas. There was good occupational therapy support.

Medication management across the location was of an acceptable standard and initiatives such as a medication information helpline provided support to patients and staff. The location had access to expert pharmacists. People using the inpatient services received good physical healthcare input.

Records, assessments and care plans about physical health were in place. Most patients had a detailed risk history recorded. There was clear understanding and emphasis on the importance of reporting and recording incidents and complaints.

The staff were provided with a comprehensive induction, ongoing mandatory training and additional training to support them to undertake their roles. People had access to Independent Mental Health Advocates (IMHAs) and staff were proactively referring people for this support.

Torbay Hospital

Detailed findings

Services we looked at:
Mental Health Act responsibilities; Acute admission wards; Services for older people

Our inspection team

Our inspection team was led by:

Chair:, Professor Tim Kendall, Medical Director, Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Jane Ray - Care Quality Commission

Our inspection team at Torbay District Hospital was led by a CQC inspector and included two Mental Health Act Commissioners and a senior nurse specialist with executive NHS management experience.

Background to Torbay Hospital

The mental health services provided by Devon Partnership Trust consist of one acute admission ward for adults from the ages of 17 up to 65, Haytor ward which has 17 acute beds and 2 detox beds. Haytor ward provides assessment, care and treatment for men and women with mental health needs. Also based on this site is Beech ward providing care and treatment for 14 older patients. The ward provides assessment and treatment for older people with mental health needs, such as depression, anxiety and psychosis.

Devon Partnership NHS Trust which is a Mental Health and Learning Disability Trust was established in 2001 and has six hospital sites across Devon and Torbay. The trust employs approximately 2,500 staff and also has 100 staff assigned from Devon County Council and Torbay Unitary Authority, including social workers and support workers. Devon Partnership Trust serves a large geographical areas with a population of more than 890,000 people and has an annual budget of around £130 million.

The trust services fall into three areas of care:

- **Mental Wellbeing and Access** – for people experiencing a common mental health problem for the first time who need more help than their GP can provide.
- **Recovery and Independent Living** – for people with longer-term and more complex needs.
- **Urgent and Inpatient Care** – for people with severe mental health difficulties, in crisis or experiencing distress and who may require a stay in hospital.

At any one time, the trust provides care for around 19,000 people in Devon and Torbay. The vast majority of these people receive care and treatment in the community. A small number may need a short spell of hospital care to support their recovery if they become very unwell and an even smaller number will have severe and enduring needs that require long-term care. Teams include psychiatrists, psychologists, specialist nurses, social workers, physiotherapists, occupational therapists and support workers.

This report describes our judgement of whether Torbay Hospital delivers safe, effective, caring, responsive and well

Detailed findings

led services. 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 patients, the public and other organisations.

Our inspection team included a CQC inspector, two Mental Health Act Commissioners and a senior nurse specialist with executive NHS management experience. We spent three days visiting the hospital. We spoke with patients and their relatives, carers and friends, and hospital staff.

Why we carried out this inspection

We inspected this provider as part of our in-depth mental health inspection programme. One reason for choosing this provider is because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the services and asked other organisations to share what they knew about the location. We spoke with people about their experiences of using the mental health services in their area. We carried out an announced visit to the mental health units at Torbay Hospital on 4, 5, 6, and 7 February 2014.

During our visit we spoke with a range of staff, such as nurses, doctors and therapists. We talked with people who use the services and staff from both wards. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use the services.

We attended two carer groups that were held in Torbay.

To get to the heart of people who use services' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Mental Health Act responsibilities
- Acute admission wards
- Services for older people
- Community-based crisis services

Mental Health Act responsibilities

Information about the service

During our inspection we looked at how the Mental Health Act was operated at the Haytor unit. The mental health services provided consist of one acute admission ward for working age adults, Haytor Ward, which has 17 acute beds and 2 detox beds. Haytor Ward provides assessment, care and treatment for men and women with mental health needs. Also based on this site is Beech ward providing care and treatment for 14 older patients. The ward provides assessment and treatment for older people with mental health needs, such as depression, anxiety and psychosis.

Summary of findings

We found that patients were lawfully detained; however there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of risk plans associated with section 17 leave.

Care planning and risk assessments were not always fully completed or inclusive of the patient's views.

We found for two patients that they had been receiving medication without the appropriate authority to treat in place.

We heard about difficulties in accessing psychiatric intensive care facilities which are not commissioned from the trust and that this could mean patients being secluded for periods based on clinical need to manage this risk.

The use of seclusion is not being recorded appropriately and this affects the quality of the monitoring. We found that there were difficulties in accessing the seclusion facility due to this being sited on a different floor within a separate unit.

We found that there was a programme of audits in place to consider how well the Mental Health Act is being implemented at the hospital. Audits undertaken included recording of consent to treatment, information on rights, section 17 leave arrangements, discharge arrangements and use of the place of safety.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

During the inspection we observed the wards that we visited to be calm and feel safe. However we were told by staff about occasions were demands from the use of the seclusion room or the "place of safety" facility can mean that the staffing levels on Haytor ward are reduced.

We found that Haytor ward was operating a locked door policy which the manager told us was reviewed three times daily. This review was not recorded. We noted information for informal patients confirming arrangements for leaving the ward.

We found that the systems for managing section 17 leave could be improved. Staff explained that the leave is authorised and conditions are set by the responsible clinician through a care plan on the electronic record system. Patients are then able to request leave on a daily basis at the ward meeting. Staff then attempt to facilitate all requested leave within the authorised allowance. Ahead of leave commencing they are required to complete an assessment and record this, along with a post leave evaluation, on the progress notes. It was not always possible to find entries referring to leave within the progress notes.

Generally we found that risk assessments were in place for patients and usually indicated relevant areas of risk. However we did find some cases where risk assessments had not been updated regularly, or following incidents, and where the assessments did not adequately address the risk issues. In one example a patient had gone absent without leave on three occasions without the assessment being updated to reflect this risk. We also noticed that some information relating to this case had been recorded in the patient's care plan but only included information about what to do if the patient went missing, it did not address how to prevent the patient going missing.

One patient told us she had been assaulted by another female patient and her hand and arm were hurt. She confirmed that she was examined by the doctor and she was happy with her medical examination and the team's response. At the time of the inspection there was an ongoing safeguarding referral for one person who had sustained bruising allegedly as a consequence of being restrained in order to be escorted to the seclusion room.

Are Mental Health Act responsibilities effective?
(for example, treatment is effective)

We examined legal documentation and care records for a number of patients detained under the Mental Health Act. We noted that the application for detention documents were usually of a high standard and that all patients appeared legally detained.

We found that discussions between the responsible clinician and the patient regarding capacity to consent to treatment and actual consent were usually recorded in the notes. However we found for two patients that they had been receiving medication without the appropriate authority to treat in place. It was not possible to locate the required certificate of treatment or alternatively records of emergency treatment for these two patients. For a third patient it was not immediately possible to locate the required certificate. When this was eventually located it was noted that it had been completed approximately two weeks after the date it was due to be authorised.

All three of these patients had moved between different units either inside the trust or beyond, as a result of the extreme pressure on beds within adults of working age and older people's services. It appeared that the process for alerting the responsible clinician and the ward of the need to assess for capacity and consent, and if necessary, request a second opinion appointed doctor, may have been disrupted by these transfers.

One informal patient had started on a course of electro-convulsive therapy (ECT). At the time of our visit the patient was stated to be consenting to this treatment however there were conflicting records available regarding this patient's ability to give informed consent. On the electronic system it was noted that the patient was viewed as not having capacity to consent just a few days prior to the commencement of treatment however within the ECT paperwork there were records stating that the patient did have capacity and had consented. We met with this patient who confirmed he had given consent for the treatment but that he did not hold out hope of the treatment working. We noted that there had been no second opinion sought before the ECT commenced, and that would be considered best practice given this patient's fluctuating presentation.

Mental Health Act responsibilities

Are Mental Health Act responsibilities caring?

The teams on both inpatient wards were generally caring and committed to patient care. Patients told us that most of the staff were very good and they got on well with them.

The explaining of a patient's rights appeared to have been done promptly and recorded appropriately. At the same time information would be given about the independent mental health advocacy service. Many patients told us they understood their rights and also knew who their consultant and named nurse were.

We were told by both patients and staff that nurses do not always get time to meet with the patient's in their care to discuss their specific needs. This was reflected in the care plans examined that did not evidence the patient's views and wishes and had not been signed by the patients. A number of patients were unaware of their care plans.

The seclusion room at the unit is on the floor below the acute unit in a suspended ward. When someone requires seclusion this means them being transferred via lift or staircase, possibly while being restrained.

Are Mental Health Act responsibilities responsive to people's needs? (for example, to feedback?)

We were informed of some good practice where the service was generally responsive to people's needs. One patient on Haytor had a discharge meeting involving a multi-disciplinary and multi-agency team, including a member of staff from the hostel he was going to move to, a link worker from the crisis team to the hostel and a housing worker, as well as his care co-ordinator. An interpreter came to meetings on Beech Ward to enable a family member to be involved in discussions about a patient's care and treatment.

We were however informed of a number of situations where patients were being treated in different hospitals, both within and outside the trust, and the impact this had on effective care and contact with families and friends.

We heard that many patients in crisis are being taken to police stations or to the local emergency department rather than to the unit's own place of safety suite. The suite was not always available for use, for example the seclusion room is based in the same area and shares a toilet with the place of safety suite. Staff told us "I have had to turn people away from the suite while we have a person in seclusion." They told us that this was to protect the dignity of the person who was in seclusion.

During our visit we observed the police attempting to access the suite for a patient, who was not accepted as he was considered as too threatening and to be under the influence of drugs. As a result the patient was returned to police custody.

Are Mental Health Act responsibilities well-led?

We found that there was a programme of audits in place to consider how well the Mental Health Act was being implemented at the hospital. Audits undertaken included recording of consent to treatment, information on rights, section 17 leave arrangements, discharge arrangements and use of the place of safety.

We spoke with the manager with lead responsibility for Mental Health Act administration across the trust. She confirmed that the trust had a governance process in place for looking at the use of the Mental Health Act. Inpatient audits undertaken at hospital level are aggregated and presented at the Hospital Managers meeting along with information about how frequently different sections of the Mental Health Act are used. Through this meeting the hospital managers also look at any findings from Care Quality Commission inspections and other external reviews about how the Mental Health Act is operated. Any areas of concern are referred to the trust's quality and safety group and to directorate management groups for taking forward at hospital level.

Acute admission wards

Information about the service

The mental health services provided by Devon Partnership Trust at Torbay Hospital consists of one acute admission ward for adults from the ages of 17 up to 65, Haytor Ward which has 17 acute beds and 2 detox beds. Haytor ward provides assessment, care and treatment for men and women with mental health needs.

Summary of findings

We found areas of good practice in the acute adult inpatient ward in Torbay. Patients were mostly positive about staff and told us that they were compassionate and caring. Patients confirmed there was a recovery approach to care and support, which they found responsive to their needs and experienced at all stages of their hospital stay. This was supported by good occupational therapy services.

Patients said the accommodation was comfortable. The ward offered people privacy. All areas of the ward were clean.

Staff morale was generally positive and they worked together well in multi-disciplinary teams. There was an open culture and staff were confident in raising concerns. Governance arrangements were in place and monitored the performance of the services. The ward manager demonstrated a good knowledge and understanding about their service and wanted it to succeed.

There were a number of improvements needed in the services. Too many patients in crisis are being taken to police stations or to the local emergency department rather than to the trust's own 136 suites (which are the designated health-based places of safety). In the year ending November 2013 in South Devon 47 patients used the trust's own place of safety suite and 134 went to police custody.

For the past six months, 44% of adult patients from South and West Devon needing an acute admission have had to go to Exeter and a few to North Devon. This has meant they are a long way from relatives, carers and their community care professionals.

We were also concerned about the safety of patients who may need restraint or seclusion. In Torbay there is one seclusion room which is in a potentially unsuitable location on a suspended ward on a different floor to Haytor ward. We found that some recording of the use of seclusion is poor and this affects the effectiveness of monitoring of use across the trust. In addition 21% of staff on Haytor ward had not received up-to-date training to manage incidents where physical interventions might be required.

Acute admission wards

Patients and staff told us that engagement with patients does not occur as frequently as they would like. This was attributed to periods of high activity and being busy with office duties.

Engagement with staff was variable. Some staff on Haytor were negative about the trust's performance management. They said that the trust had its priorities wrong and focused too much on "targets rather than quality of care".

Are acute admission wards safe?

Safe Environment

We found that Haytor Ward was a secure environment and that safety was considered. The ward was operating a locked door policy which the manager told us was reviewed three times daily. The decision about whether to lock the ward was based on the needs of the patients. The ward had numerous potential ligature points. We saw that door handles and sinks were not anti-ligature. The clinical team leader told us that environmental risks were audited annually by the trust's risk department and that patients have individual risk plans if they are at risk of suicide.

There was separate sleeping accommodation for females and males. Most rooms were single apart from two rooms which were shared. There was a female only lounge which we observed was used by males and females. The staff told us that the facility could be provided to females only if this was requested.

The design and layout of the environment supported people who had disabilities. For example, there was access to a lift, level access to the garden, wide corridors and disabled bathroom facilities. The ward had areas where private meetings could be held and to provide space for visitors who have children.

Learning from incidents

Incidents are reported and there was evidence that some learning had taken place. For example we saw from meeting minutes that incidents and actions taken as a result of incidents had been discussed at local team meetings. We were also told that feedback was provided in supervision.

Some incident reports lacked detail. For example one stated that an individual had made threats to staff which resulted in safe holds being used to escort a person to the quiet room where it states they 'remained resistive and threatening'. This meant that it was not possible to see clearly what the rationale was for using a physical intervention or if verbal de-escalation attempts had been tailored to the specific needs of the individual.

Safe staffing levels

We were told that there is provision for six staff per shift but that only five were utilised. The clinical team leader and the area manager informed us that five staff was enough for the

ward. From what we saw patients often had to wait to speak to staff when they requested to do so. When communication was observed it was seen to be positive, kind, patient and caring. Patients told us that staff were kind and caring. However, they expressed concern at not always being able to speak to staff when they needed it. Staff acknowledged that they could not always speak with patients when they requested time.

We saw that the staff on the ward were attempting to implement 'protected time' where time is dedicated to engagement with patients. However, staff told us that this does not always occur as intended. Reasons given included other priorities occurring, managing risk and time spent in the office completing care records. We saw from team meeting minutes from 24 January 2014 that 'protected time' had been mentioned as an action that 'staff should utilise the protected time period to catch up with their allocated patients'. From observation and from what staff and patients told us this was not being successfully implemented. We were told that six staff was too many for the ward however it was evident that the current number of staff were not able to provide consistent and regular therapeutic engagement due to being busy. We observed that activity within the ward office was consistently high and staff spent frequent periods of time accessing the computer, liaising with doctors and discussing individual situations including the provision of leave for detained patients.

Staffing levels were sufficient to maintain safety as long as the ward was calm and stable. When incidents occurred safety was compromised. For example, when patients were restrained and secluded up to three members of staff had to leave the ward which left two nursing or support worker staff for the remaining patients.

The clinical team leader and Senior Nurse Manager told us that additional staff would be provided if a situation required it and that this is assessed on an ongoing basis.

Safeguarding was understood by staff on Haytor. Staff told us about different types of abuse and they knew the process for raising safeguarding alerts. We saw from records that staff had received safeguarding training. We saw that staff had referred concerns to the local authority safeguarding team following an incident on the ward. Staff told us that most referrals to the safeguarding team are not investigated further because the local authority safeguarding team do not consider the referral a safeguarding matter or they are satisfied with the actions taken by the staff.

Staff understanding of whistleblowing was variable. All staff were aware that it was about raising concerns however they did not all know to whom or in what circumstances they should be raised. Some staff told us that they had not looked at the trusts whistleblowing policy. There had not been any whistleblowing on Haytor ward.

Managing risk to the person

Patients had individual risk assessments in place but their comprehensiveness and implementation varied. For example most patients had a comprehensive risk history recorded however the risk management plans that we looked at were very basic, descriptive and not individualised or evidence based.

We found that observations were increased depending on the risk presented by patients. The reasons for increasing or decreasing the observation levels were often not clearly recorded. For one person their progress notes showed the observation levels were reduced while the person was still presenting the risks but no rationale was written as to why. This meant that it was not possible to know if this was the safe or correct decision for this person.

Risk management

There are performance targets that feed into a trust dashboard to inform the progress of services and identify where there may be issues that could impact on the safety of patients. While there was evidence that the management at Torbay hospital had knowledge of these dashboards the ward staff said that they did not find them very meaningful.

Medicines management

Patients reported that immediately on admission staff checked items brought in, including medicines which were then removed for safety. Reconciliation of patient medicines took place within the 72 hour target set by the trust.

There are detailed policies, procedures and clinical guidelines, which staff access through the trust's intranet. Staff said they check medicines before giving them to patients being discharged.

During ward rounds we observed staff actively monitoring the side effects of medicines with patients. Staff told us

they regularly given information about medication to ensure their practice was regularly updated. For example, the latest update about medicines to use in the event of a patient needing rapid tranquilisation were available to staff.

Governance groups and a link pharmacist ensure medicines are audited, prescribed and looked after safely.

Are acute admission wards effective? (for example, treatment is effective)

Use of clinical guidance and standards

For most patients we saw that their care and treatment reflected relevant research and guidance. We looked at nine patients notes and found that most contained a comprehensive physical, psychological and social assessment.

Physical health care was well documented and the ward used nationally recognised guidance, standards and assessment tools to monitor and assess physical health. This involved close working with the general hospital which was on the same site.

There was evidence of effective wellness and recovery work taking place. Patients were positive about the recovery focus.

Monitoring Quality of Care

We saw that Haytor Ward had achieved accreditation with the Royal College of Psychiatrists. In order to be accredited, services needed to provide a high standard of quality care, using national guidelines and standards. There were both local and Trust wide systems in place to monitor quality of care. Results of a wide range of data, such as staffing levels, audits of records, collected by the Trust database were collated for each team. The manager could access this information by looking at their `dashboard` to monitor team performance.

We were informed that care plans and progress notes were regularly audited.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

There was evidence of effective multi-disciplinary team (MDT) working on both wards. People who use the service had access to nursing and medical staff as well as psychologists, occupational therapists and art therapists.

We saw that care plans included advice and input from different professionals involved in people`s care. People who use the service and relatives told us that they worked with a number of professionals on the ward. Staff told us that patients consent and rights were respected and family were only involved if the patient wanted this to happen. The staff on Haytor told us that they provided support to relatives but they were clear that no personal or confidential information was shared about care and treatment unless this was agreed with the patient.

The clinical team leader told us that the ward had a good working relationship with Torbay General Hospital. We saw that there were written criteria for transferring people into acute medical services and this complied with recommended guidelines. Staff had a good understanding of this process. Care review meetings took place every week. These meetings included attendance by other health care providers, for example, the person`s community care co-ordinator. If they were unable to attend, the unit made sure that all involved people were kept up to date through telephone and e-mail.

Occupational Therapists worked as part of the team and we saw that they worked closely with patients in forming their wellness and recovery action plans. The patients we talked with spoke very positively about this.

The crisis team worked closely with Haytor Ward and attended meetings on the ward every morning to see who might be ready for discharge.

Are staff suitably qualified and competent

Staff received training and supervision. We saw staff files which contained up to date supervision records. The clinical team leaders and staff told us that supervision focused on performance management. Most staff were not receiving clinical supervision. Managers told us that staff could seek clinical supervision if they wanted it. Staff told us that they felt supported by the clinical team leaders. Staff told us that they were also able to access responsive supervision if they wanted it, for example, if they had a challenging shift and needed to reflect. Staff told us that clinical team leaders were approachable.

We saw electronic records that showed most staff were up to date with all core training, such as infection control, manual handling and safeguarding. Most staff were trained in the use of physical interventions. The manager told us

that all new staff have an induction programme. A new member of staff confirmed that they had commenced their induction. Staff told us that they were able to access additional training if they needed to.

Patients told us that staff were able to meet their care needs and that they had the skills and knowledge to support them. However, they consistently told us that staff were often busy in the office and not always able to provide them with the time they felt they needed. Staff also confirmed this. One person told us that "Some of them (staff) are very good". Relatives told us that they had confidence that the staff cared for people well.

Are acute admission wards caring?

Choice in decisions and participation in reviews

We observed that patients were involved in their care reviews. Some patients told us that they felt respected and involved in making decisions about their care. Whilst we saw some excellent examples of people being involved in decisions about their care and contributing to their care plan, we also found occasions where this was not the case and where staff found this hard to achieve. Two people we talked with told us that they had not seen or been involved with their care plan but that they had met with their named nurse. One person told us that they could not remember the name of their named nurse. We looked at the care plans of these people. The care plans did not reflect the opinions or wishes of the patients.

We saw that some care plans reflected the individual's patients' needs and choices as far as possible. However this was variable and some care plans were more descriptive and prescriptive as opposed to person centred.

Due to the health needs of the people who use the service, some elements of choice and care were therapeutically restricted. People told us that staff spent time explaining treatment options and why there may be restrictions. Carers told us that they were kept involved and informed. We observed that any restrictions were discussed in the nursing handover and MDT meeting. This meant that any restrictions were agreed by the MDT on an individual basis and reviewed regularly.

Effective communication with staff

Some patients told us that they felt informed about their treatment and communication with staff was clear.

However two patients who we talked with did not feel that this was always the case. There was a keyworker system which ensured that people had weekly one to one meetings with their keyworker, in addition to their planned care and treatment. However, two patients who use the service and two members of staff told us that this was sometimes difficult due to other demands on staff time. We saw meeting minutes dated January 2014 which showed that staff were trying to promote more consistency with individual meetings. In addition to this the use of 'protected time' was discussed however patients and staff told us that this was not always possible to implement due to other demands on staff time.

There were daily meetings held in the morning attended by patients. Patients discussed what activities they would like to do that day and where possible patient's choices were accommodated.

Carers told us that they felt supported by staff and were always able to speak to staff if they needed to. We saw that there was a wide range of information available to carers, including information about local support groups and resources about treatment.

Do people get the support they need

Out of the nine care records that we looked at we saw that most patient's needs were assessed and care was delivered in line with their care plans. However we saw from two care records that some care plans were not person centred or evidenced based. Records showed that risks to physical health were identified and well managed.

Staff and patients told us that care plans were reviewed with individuals. Three patients told us that this did occur. Two patients told us that this had not occurred. Staff told us that care plans were reviewed and updated as part of the weekly ward reviews. We saw from two care records that care plans had not been updated following changes in need or risk. We found that most care plans had been reviewed regularly however it was not always clear from records if this had involved patients.

People who use the service were offered a range of support and treatment options. Therapeutic options included group and individual therapy, art therapy and occupational activities. Staff told us that they also supported patient's recovery by supporting them to access leave into the community, for example, going to the shops or to a café.

Acute admission wards

Progress notes were mostly brief statements about a patient's day. They included statements about whether patients had 'eaten well' or been 'settled'. Except for the review notes which contained information on patient's mental state there were no daily assessments or monitoring of mental state or mental wellbeing. The staff told us that they did not prepare a report or notes before going into a care review. The clinical team leader told us that there was a plan to start doing this. We saw that this had been discussed in January at a team meeting and a form had been developed for staff to use.

Recovery services

Haytor ward used the recovery approach to work with patients. Patients were positive about this approach. We observed occupational therapists working with patients to progress their wellness and recovery action plans.

Privacy and Dignity

Patient's privacy and dignity was respected. The majority of patients and carers we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect. Patients told us that they felt most staff treated them with respect. We saw that all bedrooms had a privacy screens on the doors. We saw that staff always knocked before entering patient's rooms.

Staff told us that they took account of people`s cultural and religious needs. Patients told us that they felt these needs were respected by staff.

Restraint and seclusion

We found that restraint and seclusion was used on Haytor Ward. The clinical team leader told us that most staff were trained in the use of physical intervention. Trust training records showed us that 79% of staff on Haytor ward were trained in the use of physical intervention. This meant that 21% of staff were not up to date with restraint training which is below the trusts target. We were told there always sufficient staff working who had up to date training on physical interventions.

Trust data showed that there had been 14 reported incidents of restraint from April 2013 until November 2013. This data did not include incidents from December and January. We saw from incident reports that there had been four incidents in January 2014 and one incident in February 2014.

Care plans and risk management plans were not always clear about exactly when and how restraint and or seclusion should be used. For example they did not detail individually tailored approaches or interventions. So it was not clear what worked well or did not work well when attempting to de-escalate a situation.

The seclusion room was located on a suspended ward which was one level lower than Haytor. This meant that staff had to escort patients from Haytor using the lift and gain access to the ward. This was potentially not safe for patients or for staff.

The provision of interventions including restraint and seclusion needs to be reviewed to ensure they are being properly recorded to ensure their use is monitored across all parts of the trust.

Are acute admission wards responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

Too many patients in crisis are being taken to police stations or to the local emergency department rather than to the trust's own 136 suites (which are the designated health-based places of safety). In the year ending November 2013 in South Devon 47 patients used the trust's own place of safety suite and 134 went to police custody.

Haytor Ward is the only acute admissions in-patient ward for working age adults in Torbay and South West Devon. For the past six months 44% of adult patients from South and West Devon needing an acute admission have had to go to Exeter and a few to North Devon. This has meant they are a long way from relatives, carers and their community care professionals. At the time of our inspection the acute older adult ward in Torbay was occupied by 40% working age adults although many were over the age of 50 years. The need for significant numbers of working age adults to either go to other parts of Devon or to be treated on a ward for older adults has to be addressed.

Providers working together during periods of change

Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan.

Acute admission wards

There were regular care review meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning. The wards ensured that professionals who were unable to attend were kept informed through telephone and e-mail.

Learning from complaints

The service had a system in place to learn from any complaints made. Information about the complaints process was displayed.

People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. There was information about how to access advocacy displayed and we saw that staff proactively referred patients to advocacy services.

Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. Patients told us that staff were good at listening to and acting on their concerns "when they had the time" but told us "they were sometimes too busy" to hear them.

Carers raised concerns about the response time to complaints and about the PALS service which they felt was not always supportive or helpful. One carer said they have no faith in PALS. Another carer said "They (PALS) basically stopped me complaining".

Are acute admission wards well-led?

Governance Arrangements

The wards had governance meetings monthly. The minutes showed that issues were identified, discussed and an action plan agreed.

The clinical team leaders had access to the trust dashboard to enable them to monitor their quality and performance. We found that there were some local systems in place on the wards to check care and safety. For example, medication was checked weekly by a pharmacist.

The staff told us that there was a disconnect between the trust and Torbay. They told us that they felt the trust was focussing on performance and not enough on quality of care.

Engagement with patients

We found that the wards regularly talked to patients, carers and staff about their opinions of the service provided.

Service user surveys were sent out. We were told that information gathered would be used in developing the service.

There were daily meetings in the morning that patients attended. Managers told us that issues were fed back to the local governance meeting. We saw that action had been taken from some issues raised.

Information about individual experience of the service was gathered from patients at admission where appropriate, during admission and at the point of discharge.

Engagement with staff

Staff told us about the trusts events 'Listening in Action'. They told us that they felt this had not been a 'productive' exercise because the trust had not listened. Staff told us that while they felt supported by their line manager and Senior Nurse Manager they did not feel as if they were a part of the wider trust.

There was a monthly team meeting and staff told us that they felt able to approach the manager at any time.

The Senior Nurse Manager told us that de-brief sessions were provided following any incident on the ward.

Nursing staff told us that management roles had been developed to have more of a focus on performance and not so much on clinical nurse leadership. We were told there was a trust wide nurse forum held in Exeter. There have been several nursing professional meetings for nurses held in Torbay in the last two years. Supervision had a focus on performance management and not on clinical development.

Effective leadership

There was an open culture within the team. Staff told us that they felt supported by their clinical team leader and the wider multi-disciplinary team.

The clinical team leader on Haytor was knowledgeable about the ward and patients. He had an understanding of good practice for his area and had ideas on how to develop and improve the service.

Services for older people

Information about the service

The older adult mental health services provided by Devon Partnership Trust at Torbay Hospital consists Beech ward providing care and treatment for 14 older patients. The ward provides assessment and treatment for older people with mental health needs, such as depression, anxiety and psychosis.

Summary of findings

Beech ward provided a high standard of care to people using the service. It was a safe and secure place for patients to stay, where staff cared for them in the least restrictive way.

Patients told us that they felt safe and well cared for. However, two patients told us that there was not always a lot to do and they sometimes got bored.

Carers were full of praise about the service provided to their relatives. Where patients did not have mental capacity, appropriate steps were taken to promote their rights through best interest and involvement of carers. However, one capacity assessment we saw, which deemed the patient not to have capacity, was only partially completed. It was not evident from this assessment that the principles of the Mental Capacity Act had been followed.

Patients had thorough assessments, which considered appropriate risks and health issues related to the ageing process. Patients were involved in discussions about treatment options available and alternatives to inpatient care, such as adult social care providers in the community.

Management of risks and care planning was done on an individual basis. Good quality information was given to carer`s and individuals throughout their stay at the ward.

Collaborative working across all sectors and services was evident to ensure patients had the right support and experienced seamless care.

The manager on Beech was passionate and promoted best practice. Staff worked well together as a multi-disciplinary team. There was an open culture on the ward and staff were confident in raising concerns. Morale was positive on Beech Ward.

The governance of the hospital was monitored at both local and Trustwide levels by senior managers.

Services for older people

Are services for older people safe?

Safe Environment

Beech Ward was operating a locked door policy. We were given assurances that people who were informal could leave the ward when they requested. We saw that the design of the building was modern compared to Haytor and that anti-ligature handles and sinks were in place. The ward has an annual risk audit conducted.

The design and layout of the environment supported people who had disabilities. For example, there was level access to the garden, wide corridors and disabled bathroom facilities. The ward had areas where private meetings could be held and to provide space for visitors who have children.

Considerations were made to male and female areas. This meant that space was available to either males or females if they wished to spend time in single sex areas. All bedrooms were en-suite and provided private space to both males and females.

Learning from incidents

We saw from records that incidents were reported. Staff told us that learning did occur as a result of incidents and that incidents were discussed within team meetings. We saw from records that appropriate changes had been made to care records that reflected learning from incidents relating to individual patients.

Safe staffing levels

Staffing levels were sufficient to maintain safety. Beech Ward had fewer incidents than Haytor and seclusion was not used. The ward did use observation levels to manage different risks and this sometimes meant that they were not able to respond to incidents that occur on Haytor. On each occasion that we visited the ward we saw people just sitting in the lounge areas and did not observe any activities or sustained engagement with patients. When staff spoke with patients we saw that they were kind, patient and caring. One person told us that they are often "bored" and that "not enough goes on" on the ward.

Safeguarding

Safeguarding was understood by staff on Haytor. Staff told us about different types of abuse and they knew the process for raising safeguarding alerts. We saw from records that staff had received safeguarding training. We saw that the manager had completed a more advanced level of safeguarding training.

Whistleblowing

Staff understanding of whistleblowing was variable. All staff were aware that it was about raising concerns however they did not all know to whom or in what circumstances they should be raised. Some staff told us that they had not looked at the trust's whistleblowing policy. There had not been any whistleblowing on Beech Ward.

Managing risk to the person

There was evidence of effective care planning and risk assessments that had been regularly reviewed and updated. Risks to patients had been assessed and management plans had been put into place to reduce and where possible prevent identified risks.

Risk management

There was evidence of effective risk management on Beech Ward. The clinical team leader was knowledgeable about potential and actual risks. Falls risk management was in place and there had been no falls on the ward.

Medicines management

Patients reported that staff checked items brought in on admission, including medicines which were then removed for safety.

Patients told us that they have confidence that they have their medicines as prescribed. Medicines are recorded, stored, administered, reviewed and disposed of safely. There are detailed policies, procedures and clinical guidelines, which staff access through the trust's intranet.

During ward rounds we observed staff actively monitoring the side effects of medicines with patients.

Staff told us information about medicines and current practice is regularly updated. Governance groups and a link pharmacist ensure medicines are audited, prescribed and looked after safely.

Services for older people

Are services for older people effective? (for example, treatment is effective)

Use of clinical guidance and standards

We looked at patients notes and found that most contained a comprehensive physical, psychological and social assessment.

Physical health care was well documented and the ward used nationally recognised guidance, standards and assessment tools to monitor and assess physical health. This involved close working with the general hospital which was on the same site.

There was evidence of good practice with falls prevention which followed nationally recognised standards.

Monitoring Quality of Care

We saw that Beech ward had achieved accreditation with the Royal College of Psychiatrists. In order to be accredited, services needed to provide a high standard of quality care, using national guidelines and standards. There were both local and trust wide systems in place to monitor quality of care. Results of a wide range of data, such as staffing levels, records audits, collected by the Trust database were collated for each team. The manager could access this information by looking at their `dashboard` to monitor team performance.

We were informed that care plans and progress notes were regularly audited. However, these audits consisted of a check of whether all elements had been commenced or completed. The audits did not have a focus on the quality of care plan or progress note contents.

Collaborative multi-disciplinary and multi-agency working for planning and access to health services

There was evidence of effective multi-disciplinary team (MDT) working on both wards. People who use the service had access to nursing and medical staff as well as psychologists and some therapy input. We saw that care plans included advice and input from different professionals involved in people`s care. People who use the service and relatives told us that they worked with a number of professionals on the ward. Staff told us that patients consent and rights were respected and family were only involved if they wanted them involved.

The clinical team leader told us that the ward had a good working relationship with Torbay General Hospital. We saw that there were written criteria for transferring people into acute medical services and this complied with recommended guidelines. Staff had a good understanding of this process. Care review meetings took place every week. These meetings included attendance by other health care providers, for example, the person`s community care co-ordinator. If they were unable to attend, the unit made sure that all involved people were kept up to date through telephone and e-mail.

Are staff suitably qualified and competent

Staff received training and supervision. We saw staff files which contained up to date supervision records. The clinical team leaders and staff told us that supervision focused on performance management. Most staff were not receiving clinical supervision. The clinical team leaders told us that staff could seek clinical supervision if they wanted it. Staff told us that they felt supported by the clinical team leaders. Staff told us that they were also able to access responsive supervision if they wanted it, for example, if they had a challenging shift and needed to reflect. Staff told us that clinical team leaders were approachable.

We saw electronic records that showed most staff were up to date with all core training, such as infection control, manual handling and safeguarding. Most staff were trained in the use of physical intervention. The manager told us that all new staff have an induction programme.

Patients told us that staff were able to meet their care needs and that they had the skills and knowledge to support them. However, they consistently told us that staff were often busy in the office and not always able to provide them with the time they felt they needed. Staff also confirmed this.

Are services for older people caring?

Choice in decisions and participation in reviews

On Beech ward we saw assessments around a person`s capacity to make decisions. The capacity assessment indicated the reasons why the person did not have capacity however it was not clear how the person had been given every opportunity to understand or weigh up the decision being made. These sections of the assessment were blank. This meant that it was not possible to tell if the principles of the Mental Capacity Act 2005 had been adhered to.

Services for older people

We saw that care plans reflected the individuals person`s needs and choices as far as possible. Due to the health needs of the people who use the service, some elements of choice and care were therapeutically restricted. People told us that staff spent time explaining treatment options and why there may be restrictions. Carers told us that they were kept involved and informed. We observed that any restrictions were discussed in the nursing handover and MDT meeting. This meant that any restrictions were agreed by the MDT on an individual basis and reviewed regularly.

Effective communication with staff

Patients told us that they felt informed about their treatment and communication with staff was clear. Progress notes and review meeting documentation indicated that there was effective communication with staff. For example we saw that people had been asked about their views and opinions and that this had been incorporated into their care plans.

Do people get the support they need

We observed that the staff on Beech were kind and compassionate when they engaged with patients. Patients were positive about staff.

There was a disparity of resources between Haytor and Beech Ward. Beech had access to one occupational therapist and did not have access to all of the facilities and activities on Haytor such as the gym.

The clinical team leader told us that there were activities available for people if they wanted to access them. There was no information about which of the patients had actually accessed these activities.

One patient was receiving ECT treatment. This had been care planned. We saw that the multi-disciplinary team, relatives and the person had been involved in the process.

Progress notes were mostly brief statements about a patient's day. They included statements about whether patients had 'eaten well' or been 'settled'. Except for the review notes which contained information on patient's mental state there were no daily assessments or monitoring of mental state or mental wellbeing.

Recovery services

Beech Ward used the recovery approach to work with patients. Staff worked with patients collaboratively, providing care and treatment in the least restrictive way.

Privacy and Dignity

The majority of patients and carers we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect. We saw that all bedrooms had a privacy screens on the doors. We saw that staff always knocked before entering patient's rooms.

Restraint and seclusion

The clinical team leader told us that restraint and seclusion were not used on Beech Ward. She told us that the staff use de-escalation techniques if patients become agitated or unsettled. However, staff on Beech were expected to respond to incidents on Haytor which could require staff to use restraint.

The trust's training records showed that 77% of staff on Beech were trained in the use of physical intervention. This meant that 23% of staff on Beech were not up to date with training in the use of physical intervention which is below the trusts target.

Are services for older people responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

Older people's Community Mental Health Teams (CMHT) staff, carers and people who use the service raised concern that they were not able to access timely admission or support for people. CMHT staff told us that it is difficult to access a bed for older adults. They told us that older adults were often admitted to beds in Exeter or out of area. They told us that this was a concern to the person being admitted and to the relatives who often have difficulty with traveling. At the time of the inspection 40% of the beds on Beech Ward were occupied by working age adults although we were told that many are over the age of 50 and the service meets their needs.

Providers working together during periods of change

Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan.

Services for older people

There were regular care review meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning. The wards ensured that professionals who were unable to attend were kept informed through telephone and e-mail.

Learning from complaints

The service had a system in place to learn from any complaints made. Information about the complaints process was displayed.

People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. There was information about how to access advocacy displayed and we saw that staff proactively referred patients to advocacy services.

Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. Patients told us that staff were good at listening to and acting on their concerns "when they had the time" but told us "they were sometimes too busy" to hear them.

Carers raised concerns about the response time to complaints and about the PALS service which they felt was not always supportive or helpful.

Are services for older people well-led?

Governance Arrangements

The wards had governance meetings monthly. Minutes from meetings showed that issues were identified, discussed and an action plan agreed.

The clinical team leaders had access to the trust dashboard to enable them to monitor their quality and performance. We found that there were some local systems in place on the wards to check care and safety. For example, medication was checked weekly by a pharmacist.

Engagement with patients

We found that the wards regularly talked to patients, carers and staff about their opinions of the service provided.

Service user surveys were sent out. We were told that information gathered would be used in developing the service.

There were daily meetings in the morning that patients attended. Managers told us that issues were fed back to the local governance meeting. We saw that action had been taken from some issues raised.

Information about individual experience of the service was gathered from patients at admission where appropriate, during admission and at the point of discharge. On Beech there was a 70% response rate to discharge questionnaires.

Engagement with staff

There was a monthly team meeting and staff told us that they felt able to approach the manager at any time.

The ward team had participated in Listening in Action and staff said this was a positive experience.

Effective leadership

There was an open culture within the team. Staff told us that they felt supported by their clinical team leader and the wider multi-disciplinary team.

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The area manager told us that they felt senior managers in the Trust listened to concerns that they raised and acted on them.

The clinical team leader Beech Ward was knowledgeable about the ward and patients and was passionate and motivated. She had an understanding of good practice for her area.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Many adults of working age who need acute inpatient care are being admitted to services long distances from their homes. People are being taken to police custody rather than the preferred hospital based place of safety. Not everyone has a care plan that reflects their individual needs and is given a copy of this document. This was a breach of Regulation 9(b)(1)(i)(ii), 9(2)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Many adults of working age who need acute inpatient care are being admitted to services long distances from their homes. People are being taken to police custody rather than the preferred hospital based place of safety.

This section is primarily information for the provider

Compliance actions

Not everyone has a care plan that reflects their individual needs and is given a copy of this document.

This was a breach of Regulation 9(b)(1)(i)(ii), 9(2)

Regulated activity	Regulation
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 planning and delivery of care does not meet the service users individual needs or ensure their welfare and safety as follows: Many adults of working age who need acute inpatient care are being admitted to services long distances from their homes. People are being taken to police custody rather than the preferred hospital based place of safety. Not everyone has a care plan that reflects their individual needs and is given a copy of this document. This was a breach of Regulation 9(b)(1)(i)(ii), 9(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of such physical intervention being excessive as follows: The use of seclusion and restraint is not being correctly recorded so its use can be effectively monitored. A seclusion room in Torbay is potentially in an unsafe location.

This section is primarily information for the provider

Compliance actions

There are not enough staff who have completed or refreshed their training on restraint in line with the trust's training target on the acute admission ward.

This was a breach of Regulation 11(2)(b)

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of such physical intervention being excessive as follows: The use of seclusion and restraint is not being correctly recorded so its use can be effectively monitored. A seclusion room in Torbay is potentially in an unsafe location. There are not enough staff who have completed or refreshed their training on restraint in line with the trust's training target on the acute admission ward. This was a breach of Regulation 11(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding service users from abuse** **How the regulation was not being met:** Seclusion is being used without suitable arrangements in place to protect service users against the risk of such physical intervention being excessive as follows: The use of seclusion and restraint is not being correctly recorded so its use can be effectively monitored. A seclusion room in Torbay is potentially in an unsafe location.

This section is primarily information for the provider

Compliance actions

There are not enough staff who have completed or refreshed their training on restraint in line with the trust's training target on the acute admission ward.

This was a breach of Regulation 11(2)(b)