Cypress

Quality Report

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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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated Cypress as requires improvement because:

- There was a lounge on the ground floor which could be used for women if required, but it was not designated solely for women, and there was not always a quiet room for patients to meet visitors. The building had few adaptations for patients with physical disabilities.
- Blood pressure monitoring equipment and scales had not been calibrated.
- 45% of staff were overdue for one to one supervision and 36% were overdue for annual appraisal. One appraisal was overdue by was more than three months.
- Staff did not have access to the electronic care notes system used by the local NHS provider. This led to duplication of records. There were ongoing discussions about providing the ward with access to the NHS provider's records for patients referred to the ward.
- Although there were a number of clear policies on the Mental Health Act on the organisation's website, all of these were overdue for review and none had been revised in the light of the new Mental Health Act Code of Practice, which came into force from 1 April 2015.

However:

- Staffing levels were good. Activities were rarely cancelled due to lack of staff and patients told us there were always enough staff. Staff offered patients one to one time twice a day and patients said staff were always available if they needed them. The manager had authority to increase staffing levels temporarily if needed, and could provide an individual with constant one to one time for up to 72 hours if required.
- There had not been any serious incidents reported on the ward in the last 12 months.
- Staff knew what incidents should be reported and understood safeguarding procedures. When incidents occurred, staff were debriefed. There was a portable alarm system and this was tested every day.
- Medicines, including controlled drugs, were stored securely and staff checked the temperature of the fridges that were used to keep medication.
- Care plans, which were referred to as work plans, were personalised, holistic and recovery focused. A physical health check form was completed when patients were admitted and patients could access specialist care when needed.
- Communication was good within the team and with other professionals. A detailed handover was conducted daily between the early and late shifts and there were brief handovers at the beginning and end of the day. There were regular multi-disciplinary team meetings and clinical reviews and staff attended handover meetings at the local acute ward.
- We observed friendly and informal interactions between staff and patients. The staff were respectful, positive and flexible. Patients were generally very positive about the ward.
- Patients were able to personalise their bedrooms, had keys to their rooms and access to the kitchen to make their own drinks and snacks. Patients told us that they liked the homely atmosphere.
- Patients were only moved if clinically appropriate. Discharge from the ward was carefully planned and beds could always be accessed on return from leave.
- There were a range of activities that staff facilitated during the week. Staff encouraged patients to see friends and family. Patients were encouraged to get used to doing things on their own as part of their recovery and in preparation for moving on.
- Most staff said they felt confident to raise concerns without fear of victimisation and spoke very positively about the team manager and clinical lead. Staff were motivated and enthusiastic and spoke favourably of working on the ward.

Summary of findings

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Requires improvement

Cypress

Services we looked at:

Acute wards for adults of working age and psychiatric intensive care

Summary of this inspection

Our inspection team

Team Leader: Julia Winstanley The team that inspected the service comprised two CQC inspectors, a Mental Health Act Reviewer and an Expert by Experience, who was someone who had experience of using mental health inpatient services.

A CQC National Professional Advisor provided telephone consultation to the team leader.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the registered manager
- spoke with 5 other staff members including nurses and support workers
- received feedback about the service from two consultant psychiatrists and a commissioner attended and observed a hand-over meeting and a daily planning meeting;
- collected feedback from comment cards
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management on the wards
- carried out a Mental Health Act monitoring visit and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Cypress

Cypress is an independent mental health hospital situated in a converted house in Paignton and provides "step-down" and short-term crisis admissions for up to 12 men and women over the age of 18 years. Step-down care is for people who are currently in acute hospital and who no longer need the support of an acute ward but still require hospital support and was usually for a maximum of 28 days. Crisis placements are for patients who need a short-term level of hospital support but do not need the facilities of an acute ward and was usually for a maximum of 14 days. Cypress is part of the acute care pathway for Torbay and south Devon and provides a service only for people who are normally resident in that area. It is run by The Community Care Trust (South West) Ltd which is a registered charity that provides a range of services for people with mental health problems in Torbay and South Devon.

Summary of this inspection

There were 11 patients on the ward at the start of the inspection, and a 12th patient was admitted while we were there.

Cypress is registered to carry out:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act There is a registered manager and accountable officer.

Cypress has been inspected three times since 2010 and the most recent inspection was in 2013. In November 2011, Cypress was non-complaint with management of medicines. In November 2012 it was found to be noncompliant with safety and suitability of the premises. However, there were no outstanding compliance actions at the time of this inspection.

What people who use the service say

Patients were generally very positive about the ward. They told us that the smaller, homely environment aided their recovery and was a more pleasant place to be than an acute ward. They told us they felt safe and that the facilities were kept clean and tidy. One patient told us that they liked it there because it did not feel like a hospital. Another patient said that staff offered lots of activities and helped them to keep busy. We heard that staff had meals with patients, chatted with them and did not spend "all their time in the office". Patients felt that staff understood their needs and they said they were involved in writing their own care plans. We received some very positive comments on feedback cards. One patient described the staff as "brilliant". Another said that the ward was wonderful and that he would not have survived without the staff.

However, one patient said that they sometimes got bored at weekends, as it was quieter and there was less to do. Another patient felt there should be better facilities for disabled patients and we were told that the choice of food for vegetarians could be improved.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were not able to easily observe all parts of the ward and mirrors were not used to improve observation of blind spots.
- There was a lounge on the ground floor which could be used for women if required but was not designated solely for women.
- Blood pressure monitoring equipment and scales had not been calibrated and there was no resuscitation equipment or defibrillator.
- Twenty six percent of staff had not completed first aid training.

However:

- Accommodation was arranged on single sex corridors. All patients had single bedrooms and used single-sex bathrooms on their corridors.
- The clinic room was clean and tidy. There was a locked fridge and temperatures where checked twice a day. Controlled drugs were kept securely.
- There was a portable alarm system and staff tested this on every shift. Staff told us that people responded quickly when they used their alarm.
- The manager had authority to increase staffing levels temporarily if needed, and could provide one to one staffing for a patient for up to 72 hours if required.
- Activities were rarely cancelled due to lack of staff.
- Risk assessments were present in all the care records that we looked at.
- Staff understood safeguarding procedures.
- There had not been any serious incidents on the ward in the 12 months before the inspection.
- Staff we spoke to knew what incidents should be reported and how to report them.
- Staff were debriefed after incidents.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- 10 staff (45%) had not received one to one supervision for more than eight weeks and eight staff (36%) were overdue for annual appraisal.

Summary of this inspection

- There were a number policies these were overdue for review and none had been revised in the light of the new Mental Health Act Code of Practice, which came into force from 1 April 2015.
- Rating scales were not routinely used.
- The ward did not have access to the electronic records used by the local NHS provider. There were ongoing discussions on providing the ward with read only or full access to the NHS provider's records for patients referred to the ward.

However:

- A physical health check form was completed for each patient when they were admitted. Patients were given guidance on smoking cessation, diet and exercise, weight and blood pressure.
- Care plans were individual, holistic and recovery focused.
- There was good access to specialist care when needed, including attendance at outpatient clinics and inpatient treatment for physical healthcare if indicated.
- A range of audits was undertaken. These included infection control, medication records and clinical documentation audits. These had action plans with dates for completion that were signed when completed.
- There were regular multi-disciplinary team meetings and clinical reviews.
- A detailed handover was conducted daily between the early and late shifts. There were also brief handovers at the beginning and end of the day.
- Staff demonstrated knowledge of the principles of the Mental Capacity Act and best interest decisions.

Are services caring?

Good

We rated caring as good because:

- We observed friendly and relaxed interactions between staff and patients. The staff were respectful, positive and flexible.
- Patients were generally very positive about the ward.
- A welcome pack was given to patients on admission.
- We saw evidence of patient involvement in care plans.
- An advocate visited regularly.
- Patients felt able to make requests about things they wanted to do and felt that staff responded positively to their ideas.
- Staff actively sought feedback and complaints.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- Beds could always be accessed on return from leave.
- Patients were only moved if clinically appropriate.
- Discharge from the ward was carefully planned.
- All but one patient spoke positively about the food. Patients had access to the kitchen and could make their own drinks and snacks.
- Patients were able to personalise their bedrooms. All rooms had lockable storage for medication and patients had keys to their rooms.
- There was a range of activities that staff facilitated during the week.
- Staff encouraged patients to see friends and family. Patients were encouraged to get used to doing things on their own as part of their recovery and in preparation for moving on.
- Staff accessed interpreting and translation services when necessary and patients could be referred to a multi-cultural counselling service.
- Food was cooked on the premises. Staff purchased food to meet specific dietary requirements when needed.

However:

- There was a lack of quiet space for patients to meet with visitors due to the size of the building.
- The front door had a raised step and doors and corridors were not wide enough for easy use of wheelchairs. There was no lift. The lack of disabled adaptations meant that patients with impaired mobility could not always be offered a bed as the facilities would not be suitable for them.
- Although there was a lounge which could be used for women if required, it was not designated solely for women.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew who the senior managers were.
- The ward manager attended governance meetings.
- Key performance indicators were in place and, with CQUIN (commissioning for quality and innovation) targets, were discussed at senior management meetings.
- There was a risk register that was specific to the ward and included strategic and operational risks, governance and management, and external and environmental risks.
- A staff satisfaction survey had taken place. An alarm system had been installed at the ward as a result of staff saying they did not always feel safe.
- Most staff said they felt confident to raise concerns without fear of victimisation.

Summary of this inspection

- Staff spoke very positively about the team manager and clinical lead.
- Most staff were motivated and enthusiastic and spoke very favourably of working on the ward.

However:

- There was no dedicated admin support on the ward.This meant that all staff, including the manager, spent time on tasks such as answering the phone instead of direct patient care.
- Staff told us that morale had varied with the new ways of working and that there was a much faster pace of work now with pressure to discharge patients.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

- A Mental Health Act (MHA) reviewer carried out a MHA monitoring visit during the inspection, which will be reported on separately.
- There were six patients detained under the MHA at the time of our inspection. All were detained under section 3. Section 3 of the MHA is for treatment of mental illness and can last for up to 6 months. The hospital did not accept admissions of patients under section 2 of the MHA, which is a section lasting for up to 28 days and is for assessment or assessment and treatment.
- Mental Health Act training was not mandatory. However, all staff received training in the Mental Health Act as part of their induction.
- Patients had their rights explained on admission and regularly throughout their admission.
- Detention paperwork was filled in correctly and it was up to date and stored appropriately. MHA documents were well organised.
- An independent mental health advocate visited the ward on a weekly basis.
- There were a number of clear policies on the MHA on the organisation's website. However, all of these were overdue for review and none had been revised in the light of the new Mental Health Act Code of Practice, which came into force from 1 April 2015.
- There was a sitting room, which could be used as women only lounge, but at times men used it. Men were using it when we inspected.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty seven percent of staff had been trained in understanding the Mental Capacity Act and 83% of staff had received training in the deprivation of liberty safeguards.
- Staff demonstrated knowledge of the principles of the Mental Capacity Act and best interest decisions.
- The organisation had an up-to-date policy on the Mental Capacity Act, to which staff could refer.
- Assessments under the Mental Capacity Act were undertaken appropriately. The majority of patients were judged to have capacity and assessments had been carried out when required to assess capacity to consent to medication and for consent to remain on the ward.
- There were no applications for deprivation of liberty safeguards for patients in the ward.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Requires improvement

Safe and clean environment

- The ward was in a large, detached house and therefore not purpose-built as a hospital. This meant that it was a homely environment but created some challenges observing all parts of the ward. Staff had to walk around the building to observe all parts. The lounge and dining room were open plan and there was a hatch in the wall between the dining room and the kitchen. The women's bedrooms were along two corridors, one of which could not be observed easily. The upstairs areas, where the men's bedrooms and bathrooms were located, were least able to be observed. None of the bedroom doors had glass observation panels and there were no mirrors to improve observation of blind spots. The staff explained that this was because they wanted to maintain a relatively homely and domestic environment. In mitigation, the patient's risks were lower than on an acute ward as the clear purpose of the ward was as a step-down from acute wards and crisis admissions that did not require acute hospital care. Staff were easily accessible, night-time observations were carried out by entering the patient's room and this was explained to patients before admission.
- Two members of the organisation's staff undertook an annual ligature point audit using the Manchester ligature points audit tool. A ligature point is a place to which someone intent on self-harm might tie something to strangle themself. Ligature points had been identified and there was an action plan to reduce these. Work had been done to reduce the number of potential ligature points, for example, replacing light fittings and boxing in exposed pipework. The remaining potential ligature points were being mitigated by the staff's management of the ward. The team described their approach to the management of risk of suicide. This included risk assessment prior to admission and not admitting anyone deemed to be high risk, ongoing monitoring of risk through therapeutic engagement and multidisciplinary review, supportive observations every 15 minutes, or one-to-one observations for up to 72 hours. Patients who required longer than 72 hours of one-toone support were transferred to an acute ward. Ligature cutters were accessible to staff.
- The ward had four bedrooms for women and eight for men. These were on separate floors, and men could access the male corridor without having to go through the female corridor. Bedrooms were not en suite but all had their own wash hand basin. There were three bathrooms on the men's corridor and two bathrooms on the ground floor for women to use. All patients had their own bedrooms and used single-sex bathrooms on their corridors.
- There was a lounge on the ground floor which could be used for women if required but was not designated solely for women. The Mental Health Act Code of Practice states that women-only day room should be provided. On the day of our visit there were men sitting in this lounge at times. The absence of a dedicated women-only lounge had been identified in the re-audit on eliminating same-sex accommodation in April 2015, and there was evidence that this was kept under regular review and was subject to patient feedback. There was a

service-wide policy regarding same-sex accommodation. This was informed by the south Devon and Torbay clinical commissioning group's operating principle on eliminating same sex accommodation. This stated that patients must be informed of the ward's accommodation arrangements including a description of any separate single sex areas. If the prospective patient had concerns but still wished to use the service, the person could outline how they wished to have their concerns monitored and supported during placement.

- The clinic room was clean and tidy. There was a locked fridge and the temperature was checked twice a day. Controlled drugs were kept securely. The consultant and pharmacist signed medication charts and photocopies of prescriptions were kept. There was no examination couch but there was blood pressure monitoring equipment and scales, however, these had not been calibrated. There was first aid equipment but no resuscitation equipment or defibrillator. Staff would call 999 in an emergency.
- There was no seclusion room or de-escalation room. Staff told us that neither seclusion nor restraint were used on the ward, and that if anyone required this type of intervention they would be transferred to an acute ward.
- The ward was clean and well maintained internally. It was in reasonably good decorative order except for some areas of peeling paint on stair rails and in bathrooms. The quality of furnishings was good and the rooms were all light, airy and comfortable.
- A provider-wide infection control policy included hand washing. There was an infection prevention and control lead for the provider and a nominated lead for the ward whose role was to monitor and review practice. Infection control was included in induction training for all new staff. Liquid soap was available and hand-washing signs were displayed. There were signs above the hand washbasins in the kitchen, bathrooms and toilets reminding people to wash their hands. Infection control audits were carried out.
- There was a cleaning schedule and staff signed the schedule when tasks were completed. The bathrooms, toilets and the kitchen were cleaned each day.
- Environmental risk assessments were undertaken and had action plans for each risk. However, it had been identified that pillows need replacing but there was no timescale for this.
- There was a portable alarm system and staff tested this on every shift. Staff told us that other staff responded quickly when they used their alarm. There was also an intercom/tannoy system in the rooms.

Safe staffing

- The ward had 22 substantive staff.
- Between 1 November 2014 and 31 October 2015 the vacancy rate was 4% and sickness was at 2%.
- Staff worked a three-shift system, 7.30am to 3.00pm, 2pm to 9.30pm and 9pm to 7.45am.
- Staffing on the shifts comprised during the weekday of two qualified and two unqualified staff and at weekends of one qualified and two unqualified staff. At night staffing levels were one qualified and one unqualified staff. An on-call rota operated 24 hours a day at weekends and from 5pm until 9am at weekdays. This meant that planned staffing levels during the day met or exceeded the Royal College of Nursing's 2009 reported average on mental health wards.
- The service had recently recruited a full-time occupational therapist also worked Monday to Friday 9am to 5pm.
- The manager or deputy manager also worked in the service during office hours.
- We looked at a sample of rotas that covered the two months preceding the inspection visit. These showed that the vast majority of shifts were staffed as planned.
- Agency staff were sometimes used and were supplied through one regular agency. One member of agency staff had worked on the ward for many years. The manager told us that she was usually able to book staff that had worked at the ward previously which ensured agency staff were familiar with the ward.
- The manager had authority to increase staffing levels temporarily if needed, and could provide one to one staffing for up to 72 hours if required.
- All the patients we spoke to except one thought there were plenty of staff, and said that activities were rarely cancelled due to lack of staff.
- Junior doctors employed by the local NHS trust provided medical cover from Haytor ward at Torbay hospital. Haytor ward is an acute mental health inpatient ward run by local NHS trust. The junior doctors did not visit, but staff took patients to Haytor ward. Emergency physical healthcare was accessed via A&E

and by calling 999. A consultant psychiatrist from the NHS trust's crisis team attended the ward for two days per week and fulfilled the role of responsible clinician for all detained patients.

- Mandatory training was a mixture of face-to-face and electronic learning. The ward's 22 staff had a total completion rate of 87% up to and including November 2015. Mandatory training included fire safety, breakaway techniques, Mental Capacity Act and deprivation of liberty safeguards, and safeguarding children and adults. Most training was above 80% completion with the exception of first aid (74%) breakaway (69%) and information governance (69%). We saw updated records that showed completion rates for these courses had improved to 91% for breakaway and 83% for information governance. The next available first aid course was the following month and the manager had planned for staff to attend.

Assessing and managing risk to patients and staff

- We carried out a general check of four patient records, and a specific Mental Health Act monitoring check on a further three patient records.
- There was a clear referral and admission policy. It stated that crisis referrals and hospital step-down placements would require the referring team to provide a risk assessment that had been updated in the previous 24 hours and, where possible, the previous seven days progress notes. The policy stated that after admission, a crisis and a referral and admission checklist should be completed although the policy did not stipulate a target time for this to be completed by. Staff received a risk assessment from the referring ward or crisis team before admission. There were regular updates of risk assessments through therapeutic engagement and multi-disciplinary reviews. Risk assessments were present in all the care records we looked at. We looked at the care record of a patient who was admitted during the inspection. We examined these the day after admission and found limited information documented by staff but the file contained copies of computerised case records from the acute ward which they had been transferred from. Admission paperwork was in the process of being completed and daily running records were sufficiently detailed to ensure staff were up to date on any changes.
- The risk assessment prior to admission would generally be done on "care notes" which was the electronic recording system used by the local NHS trust. Staff at Cypress could not access the NHS trust's electronic patient records but would arrange for the patient records to be faxed or emailed and then printed out the information for their paper files. The ward had its own risk assessment tool, and the risks were RAG (red, amber, green) rated for severity. There were plans for the ward to have access to care notes which would mean that recording of information was not duplicated and make it easier to share information about risk effectively.
- We did not observe any blanket restrictions.
- There was an open door policy. Informal patients could leave at will. They were asked to let staff know when they expected to return.
- A clear observation policy described general, intermittent and one-to-one patient observations. However, the version on the organisation's website was due for review in December 2014 but had not been updated. This meant that the policy did not take account of the most recent Mental Health Act Code of Practice. The ward had a clear up to date search policy which set out the circumstances when a search of personal belongings might be made, and addressed issues of consent, patients' rights, and the need for staff to have good reason to believe a search to be necessary.
- Staff did not use restraint but were trained in breakaway and de-escalation. Rapid tranquilisation and seclusion were not used.
- Staff were able to demonstrate that they knew the safeguarding procedures. There were two different numbers to contact, one for Torbay and one for Teignbridge depending on where the patient lived. We observed a hand-over meeting where a safeguarding issue was discussed appropriately.
- There was a clear and comprehensive medicines management policy and a service level agreement with the local NHS trust's pharmacist department. A pharmacist from the local NHS trust visited the ward on a weekly basis and was available to talk to patients about their medication if requested. Staff could contact the pharmacist by phone each weekday for consultation and advice if needed. A number of patients managed their own medication prior to discharge and had small, lockable medicine cupboards in rooms to enable this. Medication reconciliation was carried out by nurses and checked weekly by the pharmacist.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- There was a policy for children visiting the ward. The policy was informed by safeguarding principles with the well-being of the child at the centre of the guidance. The manager told us they would encourage patients to see children away from the ward if appropriate but when necessary they could use the back annex for children's visits. This had a separate entrance and a lounge, kitchen and bathroom.

Track record on safety

- There had not been any serious incidents reported on the ward in the 12 months before the inspection.

Reporting incidents and learning from when things go wrong

- There was a policy for incident reporting and a separate policy for investigating serious incidents. The team recorded incidents on the provider's incident reporting form which was shared with the service manager and governance lead. The provider submitted their monthly incident audit reports for May 2015 to October 2015. The highest number of incidents occurred in May (55) and the lowest in September (19). Incidents that were reported included self-harm, medication concordance, medication errors, staffing issues and threatening behaviour.
- Staff we spoke to knew what things should be reported and how to report them.
- A monthly audit of incidents was presented to the governance committee to review trends and identify learning. The ward manager attended these meetings, which were intended to look for themes and identify action plans which were then discussed in monthly team meetings. For example, a plan to reduce medication incidents had been agreed, which included the local NHS trust's pharmacist monitoring incidents in order to provide additional support and training for the staff team.
- The governance meeting minutes showed that a decision had been made to ensure staff names were entered on incident reports for medication errors so that themes could be investigated. Copies of incident forms were filed in patient's notes where relevant. However, it was not always clear if the incident led to a review of the risk assessment or care plan.
- Staff were debriefed after incidents and the manager of the ward kept a record of the date that individual staff had received debrief.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- All patients were transferred from either the acute ward or the crisis team, who had already carried out an assessment. The ward had an admission checklist.
- Three out of four case notes showed that a detailed physical health check had taken place on admission. A physical health check form was completed when patients were admitted. This was thorough and included height, weight and pulse, current medications, smoking and alcohol, sexual health, and gender specific checks. A healthy lifestyle leaflet was included in the welcome pack. This included information about smoking cessation, alcohol, physical activity, health eating, weight management and mental wellbeing. The leaflet also gave details of local resources to support healthy lifestyles.
- Care plans were referred to as work plans and were individual, holistic and recovery focused. Progress notes, care plans and risk assessments were printed out and sent to the ward for patients who had been transferred from the local acute ward.
- Case records were kept in paper files which were kept securely but were readily accessible to staff. Files were well organised. On transfer from another ward, the receiving nurse completed a comprehensive admission checklist. The ward did not have an electronic record system and did not have any current access to the electronic records used by the local provider. There were ongoing discussions on providing the ward with access to the NHS provider's records for patients referred to the ward.

Best practice in treatment and care

- There were no nurse prescribers on the ward. Consultant psychiatrists and junior doctors who were employed by the local NHS trust prescribed medication.

National Institute for Health and Care Excellence (NICE) guideline updates were e-mailed to staff and discussed at clinical governance meetings but were not routinely discussed by the team.

- There were no specific psychological therapies offered on the ward. Psychological therapies could be accessed through the care co-ordinator. One patient told us that staff had talked to him about cognitive behaviour therapy. Ward staff could refer to voluntary sector organisations for counselling. Staff understood the importance of patients receiving NICE recommended care. An example of this was given by a nurse, who told us that she had assisted a patient in looking up information about treatment for bi-polar that was recommended by NICE.
- The junior doctors from the NHS trust's Haytor ward at Torbay hospital carried out physical health checks and ongoing monitoring. There was evidence that there was good access to specialist care when needed, including attendance at outpatient clinics and inpatient treatment for physical healthcare if indicated.
- Staff did not routinely use rating scales to monitor patients' progress. The manager told us that staff assessed symptom severity as part of their regular interaction with patients. The provider had an action plan to introduce a recognised and validated assessment and outcome tool to measure recovery outcomes, for example recovery star. However, this was still to be evaluated after being trialled at pilot sites. We did not see recovery star or WRAP (wellness recovery action plans) in care records, although staff did say they sometimes used them.
- A range of audits was undertaken. These included medication records, physical health monitoring and clinical documentation audits. These had action plans with dates for completion and were signed when completed. However, we did not see audits that demonstrated best practice in care and treatment.

Skilled staff to deliver care

- The staff on the ward were mainly nurses and support. The service had identified a gap in occupational therapy provision and had recently appointed a fulltime occupational therapist to address this. Doctors, psychologists and social workers were not employed by the ward but could be accessed via the local NHS trust. A pharmacist from the local trust visited the ward weekly.
- There was a provider wide induction policy and procedure and a structured induction programme. An experienced team colleague mentored new employees. An induction checklist was completed within the first two weeks of employment. Registered nurses completed a preceptorship package within 6 months of the date of employment. New employees were supernumerary for their first two weeks to enable them to experience a range of shifts and duties under the supervision of a qualified and experienced staff member.
- The provider wide supervision policy stated that individual supervision should take place every six to eight weeks. This was combined clinical and managerial supervision. All staff were receiving supervision, but 10 staff had not received one to one supervision for more than eight weeks. An external facilitator provided additional group supervision to the team on a monthly basis. Team meetings took place monthly and staff support meetings six weekly. Staff could contribute agenda items and these were prioritised to be discussed first. We saw that recent meetings had included discussion about medicine reconciliation, physical health observations and discharge checklists. Feedback from clinical governance meetings was discussed at this meeting.
- Staff received annual appraisals although eight staff (36%) were overdue for annual appraisal. The longest was overdue by more than three months. The manager was aware that these needed to be done. The clinical governance group were looking at ways to make the appraisal process more meaningful for staff.
- Training was available through a range of sources. South Devon Healthcare and The local NHS trust provided safeguarding training and courses in drugs and alcohol. Staff could attend the Devon Recovery Learning Community, although this was primarily for serviceusers and carers, and training included wellness recovery action planning (WRAP), self-management of self-harm and self-management of anxiety. Professional development training could also be accessed via Plymouth University.

Multi-disciplinary and inter-agency team work

- There were regular multidisciplinary team meetings and clinical reviews. Staff attended handover meetings at the local acute ward weekly, to discuss patients that might be ready for step-down care. There was a regular

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Requires improvement

joint clinical governance meeting with the local NHS trust . A recent joint clinical governance meeting had included discussion about difficulties the ward was experiencing in accessing junior doctors for physical healthcare, and agreed a process for delayed discharges. The NHS trust's crisis team consultant psychiatrist visited twice a week and acted as the responsible clinician for detained patients. A responsible clinician is someone who has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act.

- A detailed handover was conducted daily between the early and late shifts. There were also brief handovers at the beginning and end of the day. We observed a handover meeting. This was thorough and effective. Information being shared demonstrated that staff had good knowledge of the patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Mental Health Act training was not mandatory. All staff received training in the Mental Health Act as part of their induction.
- There were six patients detained under the Mental Health Act (MHA) at the time of our inspection. All were detained under section 3 of the MHA. Section 3 of the MHA is for treatment of mental illness and can last for up to six months. The hospital did not accept admissions of patients under section 2 of the MHA, which is a section lasting for up to 28 days and is for assessment or assessment and treatment.
- Consent to treatment forms were kept with medication charts, and were also in the patient's MHA file.
- Patients had their rights explained on admission and repeated at regular intervals during admission.
- The Mental Health Act administrator from the local NHS provider provided MHA administration and advice. Detention paperwork was filled in correctly, up to date and stored appropriately.
- Mental Health Act records were included in clinical audit.
- Rethink provided independent mental health advocacy (IMHA) services. There were notices and cards giving information about the service on the ward. The IMHA visited the ward on a weekly basis.
- There were a number of clear policies on the MHA on the organisation's website. However all of these were overdue for review and none had been revised in the light of the new Code of Practice.
- There was a sitting room which could be used as a women only lounge, but this room was also used by men at times. Men were sitting in this room when we inspected.
- The provider was the detaining authority and had its own MHA managers to undertake managers' hearings and other responsibilities as outlined in the Code of Practice. MHA administration was provided by the local NHS mental health trust although there was not a service level agreement in place for this.

Good practice in applying the Mental Capacity Act

- Eighty seven per cent of staff had been trained in the Mental Capacity Act (MCA) and 83% of staff had received training in the Deprivations of Liberty Safeguards.
- Staff were able to demonstrate knowledge of the principles of the MCA and best interest decisions.
- The organisation had an up-to-date policy on the Mental Capacity Act, which staff could refer to.
- Assessments under the Mental Capacity Act were undertaken appropriately. The majority of patients were judged to have capacity and assessments had been carried out when required to assess capacity to consent to medication and for consent to remain in the ward. We observed a discussion in the handover meeting regarding concerns about a patient's capacity to make some decisions, and the team decided to do a capacity assessment. We saw capacity assessments in two sets of case notes.
- There were no applications for Deprivation of Liberty Safeguards for patients on the ward.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- We observed friendly and relaxed interactions between staff and patients. We saw staff treat people with dignity

and respect. We observed a breakfast meeting with patients and staff and saw that staff were positive and flexible in their approach and everyone was given the opportunity to speak.

- Patients were generally very positive about the ward. They told us that the smaller, homely nature of the ward aided their recovery and was a more pleasant place to be than an acute ward. They told us they felt safe, and that the facilities were kept clean and tidy. They had keys to their bedrooms. One patient told us that they liked it there because it did not feel like a hospital. Another patient said that staff offered activities and helped them to keep busy. A patient told us that they felt the staff knew them well, and understood their needs. We heard that staff had meals with patients, chatted with patients and did not spend "all their time in the office". We received very positive comments on feedback cards. One person described the staff as "brilliant". Another person said that the ward was wonderful and that he would not have survived without the staff.

The involvement of people in the care that they receive

- There was an admission checklist that staff completed and kept on patient's records. A welcome pack was given to patients on admission. One patient was admitted on the first day of our inspection visit. The following day they told us that he had been shown around the building when he arrived and made to feel welcome. It was their first admission to the ward and they said staff had been very helpful and kind.
- Patients were offered one to one time twice a day and staff used these sessions to talk to patients about their goals and aspirations. This was organised at the breakfast meeting, which all patients were encouraged to attend. Staff told us that they wrote care plans with the individual patients and one staff member gave an example of amending a care plan that a patient had been unhappy about. We saw evidence of patient involvement in care plans. A patient told us that staff were available if needed and that "my individual needs are taken care of".
- Devon advocacy consortium provided independent advocacy under the Care Act, general and health complaints advocacy, IMHA (independent mental health advocacy) and IMCA (independent mental capacity advocacy). Information on advocacy was displayed on notice boards, along with information on PALS (patients' advice and liaison service). A patient told us that the advocate visited regularly.
- One patient was being visited by a friend while we were there. There were restricted visiting times, but we saw that staff were flexible about this. Staff told us that they encouraged patients to meet with friends and family outside of the ward as part of preparation for discharge.
- We observed a morning coffee meeting. These meetings took place every weekday and all patients were encouraged to attend. The meeting was used as an opportunity for patients to feedback any concerns or complaints and to plan for the day, including planning one to one time. There was an open and friendly atmosphere. While a nurse led the meeting, everyone was given an opportunity to speak. The staff were respectful, positive and flexible throughout. Patients were told who their allocated staff member was that day and offered one to one support at a time that suited them. The nurse let residents know which activities were being held and asked if there were other things residents wanted to do that day. Patients suggestions were acknowledged. Staff also actively sought feedback/complaints.
- A patient satisfaction survey questionnaire had been distributed to everyone who left the ward from April 2014 to March 2015. The questions were placed into six sections to cover the experience that patients had within the service and to help identify where the ward was working well and which areas need improvement. Friends and family satisfaction surveys (FFSS) were also undertaken. An FFSS undertaken in August 2015 showed that 92% of respondents were satisfied with the service their family member or friend received.
- A person who had previously been a patient at the ward worked as a volunteer there and offered peer support. Patients felt able to make requests about things they wanted to do and felt that staff responded positively to their ideas. For example, they had recently been bowling after a patient suggested it.
- We did not see any examples of advance decisions in care records. An advance decision is a statement of instructions about what medical and healthcare treatment you want to refuse in the future, in case you

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Requires improvement

lose the capacity to make these decisions. Staff were not able to give us examples of having supported patients to do this. The manager told us this was not something that they did routinely.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- Bed occupancy between May and October 2015 was 70%. The purpose of the ward had been changed since this time and the ward had moved away from providing long-term placements to providing step-down care and crisis admissions. This had resulted in faster turnover of patients with admissions rising from approximately 20 per year to 100. The manager told us they decided two admissions per day was the maximum that could safely be managed. At the start of the inspection all but one bed was occupied, the remaining bed was filled during the inspection.
- The ward was part of the acute care pathway for Torbay and south Devon and provided a service only for people who were normally resident in that area. People from the catchment area who had been placed in acute hospitals outside of the catchment would be considered for placement so that they could return to their local area.
- Staff attended handover meetings at the local acute ward each week, to discuss patients that might be ready for step-down care.
- Beds could always be accessed on return from leave. The service provided graduated return to the community and was not an acute admission.
- Patients were only moved if clinically appropriate. For example, the ward could provide one to one care for a maximum of 72 hours but if this was needed for longer, patients would be transferred to the acute ward. Patients who become too unwell to be managed at the ward were transferred back to the acute ward. There was good communication between the ward, the local acute unit and the crisis team to ensure this was facilitated.
- Discharge from the ward was carefully planned and was the focus of care planning. The staff worked in a recovery focussed way to increase independence of patients and supported patients to maintain and develop skills for successful discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a homely feel and was in a converted detached house. There was a very spacious combined dining room and living room with a television and pool table. There was a separate lounge, which could be used as a women-only lounge, but was not solely dedicated to use by women. There was a clinic room. Staff had a small office at the front of the house with an adjoining room with two sofas, and patients had open access to this space unless it was being used for private time with individuals or confidential conversations. The door was left open to encourage patients to seek support from staff.
- Patients maintained links with their community mental health team during admission.
- There was a lack of quiet space for patients to meet with visitors due to the size of the building. Staff encouraged patients to meet people in the community and would try to facilitate space if it was more appropriate to meet at the ward. However, a patient was visited while we were inspecting and they had to use the waiting area by the front door. This had a sofa and was comfortable but it was the main entrance to the ward and not an appropriate place to have private conversations.
- There was a pay phone available and patients could use the portable phone and take it to a private space.
- There was a garden with an area for smoking. All patients could access this area.
- All but one patient spoke positively about the food. The menu was organised on a 4-week rotation. Patients could bring in their own food if they wanted. Different dietary needs were catered for and the support workers cooked food on the premises, with patients helping with cooking and clearing up. Patients had access to the kitchen and could make their own drinks and snacks. The occupational therapist undertook assessments of patient's kitchen skills to assist in working towards independence.

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Requires improvement

- Patients were able to personalise their bedrooms. All rooms had lockable storage for medicines and patients had keys to their rooms. Bedrooms were light and airy and all had double beds.
- Staff facilitated a range of activities during the week, for example, trips to the cinema, a gym group, a swimming group, a walking group and a coffee group. There were links to Daybreak, which provided art therapy and crafts and a men's network in the community. There were games on the ward and a pool table in the shared living room. We were told that weekends were quieter and more informal and staff encouraged patients to see friends and family. Although there were groups and staff supported patients individually, patients were encouraged to get used to doing things on their own as part of their recovery and in preparation for moving on.

Meeting the needs of all people who use the service

- There was a sloped access with a handrail at the back of the house. Some parking was available in front of the house and cars could pull up to the front door or the sloped entrance, although there was no identified disabled parking space and disabled access was very limited. The front door had a raised step and doors and corridors were not wide enough for easy use of wheelchairs. There was no lift. The lack of disabled access into and around the building meant that patients with impaired mobility could not always be offered a bed as the facilities would not be suitable. This issue had been raised on a comment card that we collected as part of the inspection. One patient said they had tripped on the step at the entrance. We saw that trip hazards had been identified on their health and safety risk assessment with a plan to put "white nosing" on all potential trip hazards.
- Interpreting and translation services were available through The local NHS trust. Staff gave us examples of having accessed information in different languages and of accessing interpreters.
- We did not see information on mental health problems and treatments on display, but staff told us that they helped patients access this information from websites, such as MIND. We saw information about PALS (patient advice and liaison service) and advocacy information was displayed on a noticeboard. Staff referred patients to Ubuntu counselling service, a multi-cultural counselling service based in Exeter. There was a range of leaflets in the dining room about local services.
- Food was cooked on the premises. The manager told us that they purchased food to meet specific dietary requirements when needed. This had included buying halal food for a service user. Patients could store buy and store their own food in the kitchen. One patient told us they thought the menu for vegetarians could be improved.
- Patients were able to access spiritual support in the community.

Listening to and learning from concerns and complaints

- The service had not received any formal complaints in the past 12 months. There was a complaints handling procedure. This contained a flow chart showing the steps staff should follow when processing a complaint.
- Patients told us they knew how to complain and would feel able to do so if they needed to. We saw that staff asked patients about complaints at the daily coffee meeting and patients told us that they always had the opportunity to raise concerns at that meeting. There was information about how to make a complaint in the welcome pack and there was a box for patients to put anonymous complaints in. Staff managed complaints proactively so that they did not escalate to formal complaints.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- The organisations visions and values were not displayed. The providers statement of purpose said they provided services which promoted emotional wellbeing and social inclusion to adults and strived to ensure that these were consistent in the standard of delivery, based upon a shared understanding of human need and were recovery supportive. Staff were able to explain these principles in their own words when telling us about how they worked and demonstrated them through the care they provided.
- Staff knew who the senior managers were within the organisation.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Good governance

- Eighty seven percent of staff had completed mandatory training up to and including November 2015. There were plans in place to raise completion levels where training was below 80% for individual courses.
- Staff received supervision and support in a number of ways, for example, an external facilitator provided group supervision to the team on a monthly basis. Team meetings took place monthly and staff support meetings six weekly. However, 45% of staff had not received one to one supervision for more than eight weeks and eight staff (36%) were overdue for annual appraisal.
- Rotas showed that the vast majority of shifts were staffed as planned.
- Staff spent a lot of time with patients. The manager told us that they tried to keep paperwork to a minimum so that staff could spend as much time as possible engaging with patients.
- A range of clinical audits were undertaken, including folder administration, medication, discharge processes and Mental Health Act administration. An audit report was produced which highlighted good practice and "shortfalls". However, although areas of practice requiring improvement were identified, there was not a clear action plan.
- Staff knew what incidents should be reported and how to report them. The ward manager attended governance meetings which looked for themes and identified action plans to prevent incidents reoccurring and these were discussed in monthly team meetings. We saw that changes had been made as a result of learning from incidents.
- Staff showed a good awareness of Mental Capacity Act, and Mental Health Act procedures were followed. Staff could demonstrate their understanding of safeguarding procedures and knew how to make a safeguarding referral.
- The provider clinical governance committee reviewed incidents, events and near misses to ensure lessons were learnt and was responsible for improving service delivery. A joint clinical governance group from the provider and The local NHS trust monitored governance issues, joint working protocols and improvements to build on good practice.
- The provider had a range of commissioning for quality and innovation (CQUIN) targets, and although none of these were specific to the ward, they were all relevant. These included introducing the recovery star outcome measure and health promotion for service-users. CQUIN targets were reviewed monthly to ensure compliance. Key performance indicators were in place and the ward manager attended quarterly contract monitoring meetings and progress was reviewed at senior management meetings.
- There was no dedicated admin support on the ward. This meant that all staff, including the manager, had to do their own administration. We noticed that the phone rang very frequently and responding to this meant that a staff member was prevented from carrying out other tasks.
- A risk register was being kept specifically for the ward and included strategic and operational risks, governance and management, and external and environmental risks. Plans were in place to address and monitor risks.
- Staff were open and honest, and understood their obligations under the duty of candour.

Leadership, morale and staff engagement

- The provider submitted their staff satisfaction survey report for November 2014. This was the first time that staff had been surveyed. Action had been taken as a result of the survey, for example an alarm system had been installed due to staff saying they did not always feel safe on the ward.
- The total vacancy rate between 1 November 2014 and 31 October 2015 was 4% and sickness was 2.4%. The total vacancy rate for that period was 4%.
- There were no cases of bullying or harassment made known to us.
- Staff were aware of the whistleblowing policy and felt confident whistleblowing if this became necessary.
- Staff generally felt their manager was supportive and were confident to raise concerns without fear of victimisation.
- Staff told us that morale had varied with the new ways of working and that there was a much faster pace of work now with pressure to discharge patients. The manager acknowledged that the changed way of working had been difficult for some staff. However, most staff were motivated and enthusiastic and spoke very favourably of working on the ward, although one member of staff reported feeling unsafe at times due to the new client group.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- The clinical lead described the team as happy and supportive. Staff spoke very positively about the team manager and clinical lead.

Commitment to quality improvement and innovation

- The ward had not participated in national quality improvement programmes and was not involved in research or innovation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all policies are updated in line with the Mental Health Act Code of Practice.
- The provider must ensure that a female-only lounge is provided at all times.

Action the provider SHOULD take to improve

- The provider should ensure they continue to reduce ligature points and review lines of site so that blind spots can be reduced.
- The provider should ensure that blood pressure monitoring equipment and scales are checked and calibrated and that resuscitation equipment is available.
- The provider should ensure staff receive regular supervision and appraisal, as per their policy.
- The provider should ensure the environment meets disability discrimination legislation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect A women-only day space was being used by men when we inspected. This space was not always available for the exclusive use of women, as is required by the Mental Health Act Code of Practice (paragraphs 8.25-6). This was a breach of regulation 10(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance Policies had not been updated in relation to the Mental Health Act Code of Practice, which came into force in April 2015. The CQC allowed providers a “bedding in” period to update policies, which should have been completed by 1 October 2015. This was a breach of regulation 17(2)(d)