Devon Partnership NHS Trust

Forensic inpatient or secure wards

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Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
Are services well-led?	**Outstanding** ☆

Summary of findings

Forensic inpatient or secure wards

Summary of this service

We carried out a focused inspection of forensic inpatient or secure wards run by Devon Partnership NHS Trust, specifically to follow up on issues of concern about patient safety. This was a focused inspection, so we did not rate the service during this inspection. The outstanding rating relates to the rating awarded at the previous inspection.

We visited Ashcombe ward and Holcombe ward. These are two of the medium secure wards at The Dewnans centre at Langdon Hospital in Dawlish.

During this responsive inspection we inspected some specific aspects of safe, caring and well led on Ashcombe and Holcombe secure wards.

The inspection of Ashcombe and Holcombe wards commenced on 18 August 2020 and was unannounced.

The inspection was prompted, in part, by notification of an incident following which a patient had died. This incident is subject to further investigation, separate to this inspection. As a result, we did not examine the circumstances of the incident as part of this inspection.

However, the information shared with CQC about the incident indicated potential concerns about the management of environmental and ligature risks. This inspection examined those risks.

At the time of our inspection, Ashcombe ward was used as an admission ward and changes had been made to the environment to create an isolation area. These changes were in line with the trust's infection and prevention strategy in response to the Covid 19 pandemic. The serious incident took place in an area of the ward that did not have good lines of sight due to the changes made to the ward environment to create the isolation area.

At the time of our inspection there were 15 patients on Holcombe ward and six on Ashcombe ward. Ashcombe ward was used as an admission ward.

We found that on Holcombe ward there were insufficient numbers of suitably qualified, skilled and experienced nursing staff on to meet the patients' care and treatment needs. There were high numbers of vacancies on both wards and a high turnover of staff on Holcombe ward.

Holcombe ward was short staffed and this affected the wellbeing of staff. We also found some gaps in staff rotas on Ashcombe ward prior to the inspection although the ward was generally staffed to a safe level. Some staff told us they were stressed, exhausted and burnt out following the demands of the Covid 19 pandemic and the low staffing levels on the wards. Some staff told us they felt the leadership team were not supportive or empowering and that managers could be more visible on the wards. Some staff raised concerns with us about the teams being divided.

Prior to the serious incident on Ashcombe ward, records of staff observations of patients contained gaps. This meant observations had either not taken place or they had not been recorded.

Prior to the serious incident on Ashcombe ward the trust had not ensured there were clear lines of sight to enable staff to have a good view of all ward areas. The change to the ward layout, due to Covid 19 arrangements, had meant that staff did not have clear lines of sight of the area where the specific incident occurred and this had not been recognised.

Some staff told us they were concerned about the areas on Ashcombe ward where patients had unrestricted access to items including sports equipment that could be used as weapons or for self-harm. The ward ligature risk assessment

Summary of findings

said that these areas were always supervised by staff when it was in use but staff told us this was not the case. We fed these concerns back to the trust at the time of our inspection. The trust informed us an inventory of items and equipment was to be developed and a review of the outside space and a security checklist was being developed and implemented.

The trust had not ensured learning from untoward incidents was fully, consistently or robustly shared and mitigated against across all relevant wards and services. Lessons from a serious incident that took place on Holcombe ward on 20 May 2020 had not be learnt and shared as the serious incident that took place on Ashcombe ward on 31 July was very similar.

However;

On Ashcombe ward, the majority of shifts were covered to safe staffing levels and where agency staff were used (due to vacancies) they were predominantly regular agency staff who knew the ward well. There was good multi-disciplinary team working and therapists were present on wards to complement the nursing staff. The trust had an active recruitment programme and a plan to address the shortage of staff.

At the time of the incident the trust had commenced a review of its observation and engagement policy. Following the serious incident on Ashcombe ward on 31 July 2020, the patient observation recording tool was reviewed and updated to ensure observation practice and recording was improved. The new process included a tick box form for staff to indicate an observation had taken place and a recording sheet that enabled staff to record the patient's mental state, behaviour and interaction with staff and patients. In addition, an observation competency framework had been introduced to ensure all staff thoroughly understood the reasons for diligent and effective observation practice.

The trust had responded to the serious incident on Ashcombe ward on 31 July 2020 and made changes to the ward environment. The trust was actively addressing lines of sight , for example, by moving lockers on the ward and preventing patient access to some areas including a telephone kiosk and library. The trust had provided additional training to upskill its staff and had immediately locked all similar windows across the site to mitigate the risk.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Staff developed holistic, comprehensive and recovery-oriented care plans and risk assessments informed by a comprehensive assessment.

Staff told us there was a good culture on the wards and that staff were encouraged people to speak up and to learn.

We conducted an unannounced focused inspection looking at specific areas of the following two key questions:

- Is it safe?
- Is it caring?
- Is it well led?

During this inspection, the inspection team:

- visited Ashcombe ward and Holcombe ward
- spoke with the clinical director, inpatient service manager and head of nursing and practice, governance lead and the managers of the wards
- held two focus groups for staff attended by 21 staff including registered nurses, nursing assistants, support workers, physical health practitioners, psychotherapists, psychologists, doctors, social workers
- spoke with three patients and four carers

Summary of findings

- received feedback from staff and carers via our website
- looked at five care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the wards.

Is the service safe?

This was a focussed inspection so we did not rate this key question during this inspection. We found that:

- A serious incident took place on Ashcombe ward prior to our inspection that highlighted poor lines of sight in some areas of the ward where patients had unrestricted access. The change to the ward layout, due to Covid 19 arrangements, had meant that staff did not have clear lines of sight of the area were the serious incident occurred and this had not been recognised.
- The ligature risk assessment process for Ashcombe ward had not comprehensively identified and mitigated ligature points on the ward prior to the serious incident. Following the serious incident, Ashcombe ward made improvements to the safety of the ward environment including.
- Some staff told us they were concerned about the areas on Ashcombe ward where patients had unrestricted access to items including sports equipment that could be used as weapons or for self-harm.
- Holcombe ward was short staffed. We also found some gaps in staff rotas on Ashcombe ward prior to the inspection although the ward was generally staffed to a safe level. Although the trust had an active recruitment programme and a plan to address the shortage of staff, there were insufficient numbers of suitably qualified, skilled and experienced staff to meet patients' care and treatment needs. Some shifts were not filled. There were vacancies on both wards and a high turnover of staff on Holcombe ward. Staff told us they felt stressed and fatigued by the short staffing. Some staff said the ward was unsafe as a result of short staffing.
- The trust's systems and processes for applying learning from untoward incidents was not robust. A serious incident that took place on Ashcombe ward on 31 July 2020 showed the trust had not learned from a similar incident on 20 May 2020 that took place on Holcombe ward. The process for learning from untoward incidents had not robustly included communicating and mitigating risks across all the trust's relevant wards and services.
- Prior to the serious incident on Ashcombe ward recordings of patient observations were incomplete, and managers did not know if the observations had taken place. Following the serious incident on Ashcombe ward on 31 July 2020, the patient observation recording tool was reviewed and updated to address this concern.

However;

- The trust had made improvements to the safety of the ward environment on Ashcombe ward. Following the serious incident on 31 July 2020 on Ashcombe ward, staff on both wards had made changes to the ward environments and to their systems for assessing and managing patient risk.
- Both wards were making improvements to the way they monitored patients' risks to themselves and others. Following the serious incident on Ashcombe ward, the wards improved the tool staff used to record patient observations. Both wards had taken steps to improve staff's competence in undertaking patient observations and to improve the overall quality of patient observations.

Summary of findings

- The trust was developing mandatory training so it could be delivered online. This was to enable staff to continue to access training while socially distancing during the Covid 19 pandemic. New training being provided included simulation training to help staff manage self-harm incidents and ligature training for all staff. Staff told us that as a result of the training they felt better supported and more confident. A practice education team was supporting newly qualified nurses on the wards.
- Staff completed risk assessments for all patients. Risk assessments were clear and comprehensive. Staff wrote about patients in a dignified and thoughtful manner. Care records were patient focused. Physical health care plans were good and detailed.
- There was evidence of learning from the serious incident on Ashcombe ward on 31 July 2020. A clinical advisory group met three times per week to monitor learning from serious incidents and disseminated learning to staff in a timely manner.

Is the service effective?

We did not have any concerns which related to this key question and did not inspect against it.

Is the service caring?

This was a focussed inspection so we did not rate this key question during this inspection. We found that:

- Staff treated patients with compassion, kindness, dignity, respect and support
- Carers described staff as polite, caring, respectful, kind and non-judgmental.
- Staff informed and involved families and carers appropriately.
- Carers said they knew how to complain or provide feedback to staff and were willing to do so if needed.

However;

- Carers told us they felt staff needed more support and that the wards needed more staff.

Is the service responsive?

We did not have any concerns which related to this key question and did not inspect against it.

Is the service well-led?

This was a focussed inspection so we did not rate this key question during this inspection. We found that:

- Holcombe ward was short staffed. There were also some gaps in staff rotas on Ashcombe ward prior to the inspection. The rotas we reviewed showed that there had been some shifts that were not filled on both ward This was affecting the wellbeing of staff. Staff told us they were exhausted and burnt out following the demands of the Covid 19 pandemic and the low staffing levels on the wards.
- Some staff were concerned about the divide between the staff teams that worked on the ward and those members of the multidisciplinary team that worked were based upstairs. They told us this was a design feature of the building but that it meant staff were not always as involved in patient care as they could be.

Summary of findings

- Some staff told us they felt that the leadership of the service needed to be more supportive and empowering and that managers could be more visible on the wards.

However;

- Managers told us the trust executive team were supportive and sensitive especially following the serious incident on Ashcombe ward.
- Staff told us they were encouraged to speak up and to learn.
- There was a well-being lead that staff could talk to on the wards.
- Managers met regularly to consider and plan for risks across the wards at Langdon hospital.

Detailed findings from this inspection

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Both wards completed security audits each day and a ligature risk assessment twice per day to enable staff to identify and mitigate environmental risks. There were security leads for the wards who were responsible for the completion of security audits.

There was a serious incident on Ashcombe ward on 31 July 2020 involving an open window that had been used as a ligature point in the garden of Ashcombe ward. Ashcombe and Holcombe Ward are two of four wards at Langdon Hospital with nearly identical physical layouts. The service has reviewed the risks across all of the wards and made safety improvements. Since the serious incident, windows across the four wards at the Dewnans centre had been locked, and staff we spoke with told us they thought the ward environment was now safe. The trust was reviewing the windows across the Dewnans centre to see if they needed to be replaced.

There were blind spots on Ashcombe ward that had been created by changes made to set up an isolation area. The development of an isolation area was part of the trust's infection and prevention strategy in response national guidance about to Covid 19 pandemic. Staff had not identified the blind spots created by these changes. There were plans to close the isolation unit that had created the blind spot. In addition the footfall of staff and patients on the ward was impacted reduced.

Sight lines onto the ward day area from the office were impeded by the lockers outside the office. Following our inspection, the trust advised that the lockers have now been removed from all four wards in the Dewnans centre at Langdon Hospital. The trust was actively addressing lines of sight on Ashcombe ward, for example, by moving lockers on the ward and preventing patient access to some areas including a telephone kiosk and library.

The wards had up to date ligature risk assessments and these showed planned works to reduce environmental risks. Some medium risk environmental risks were being mitigated by patient engagement, clinical risk assessment, staff awareness of ligature risks, staff presence and patient observations.

In addition, the ligature risk assessment process on Ashcombe ward had not comprehensively identified and mitigated ligature points on the ward prior to the serious incident. Following the serious incident, the wards were making improvements to the safety of the ward environment.

Some staff told us they were concerned about the areas on Ashcombe ward where patients had unrestricted access to items including sports equipment that could be used as weapons or for self-harm. We fed these concerns back to the trust at the time of our inspection. The ward ligature risk assessment stated that this area was always supervised by staff when it was in use but staff told us this was not the case.

Safe staffing

The trust recognised the need for more staff on the wards. The trust had been reviewing its staffing levels with its commissioners and NHS England and this had highlighted the need for a consistent and auditable tool in place to review shift plans.

There were 16 preceptee nurses due to start work on the wards in the autumn. Preceptee nurses are newly qualified nurses. The trust recognised it would take time to develop the experience of the new staff. Staff told us they were concerned about the lack of experience in the staff teams. For example, staff told us some staff teams did not consistently uphold boundaries with patients and that this made the ward less safe.

Detailed findings from this inspection

Ashcombe and Holcombe had different staffing requirements, with Ashcombe ward requiring more staff per shift. Ashcombe ward required seven staff on early shifts, seven on late shifts and six at night. Shifts on both wards were planned to include two nurses or a nurse and a Mental Health Practitioner or nurse associate plus support workers and unqualified staff.

The trust told us that ideal day shifts included two qualified nurses or a qualified nurse with a mental health practitioner or nurse associate. The rest of the numbers were then made up of support workers.

Nurses had protected time when they were not included in the numbers of staff required on the ward, to complete paperwork, competency assessments, supervisions and appraisals.

Langdon hospital had shortfall of four whole time equivalent substantive consultant psychiatrists. The trust was reviewing out of hours arrangements and recruitment to try to improve recruitment and retention of psychiatrists. The trust had a business plan and a number of business cases for secure services. These included workstreams that it expected would improve the provision of consultant psychiatrists and the care pathway for patients.

We looked at staffing numbers on each ward for the period 20 July 2020 to 21 August 2020. The data showed that there was an average deficit of 2.5 staff per shift on Ashcombe ward and 1.9 staff on Holcombe ward. No days on Ashcombe ward during the month were fully staffed. On Holcombe ward, the ward was fully staffed on six days during the month.

We looked at the average staffing fill rates for each ward from June to August 2020. Ashcombe ward had 102% in June, 87% in July and 90% in August. Holcombe ward had 86% in June, 81% in July and 71% in August. These rates showed significant short staffing in some months on both wards .

At the time of the serious incident on Ashcombe ward on 31 July 2020, the ward was fully-staffed and the trust did not consider staffing to be a factor in the serious incident.

We held focus groups with staff as part of the inspection and staff raised multiple concerns about staffing levels. Staff told us short staffing impacted on patient care and staff confidence and wellbeing.

Staff were frustrated that when the ward they worked on was fully staffed, they were often moved to another ward in response to risks or staffing shortages elsewhere in the Dewnans centre. The trust told us that although it recognised staff did not like having to move to other wards, it was the only way they could keep the wards safe.

Staff told us that shortages in staff impacted on the service they could provide to patients. Short staffing often resulted in patients' leave and activities not being facilitated and staff not being able to take breaks. Staff told us staffing levels were more challenging at night because senior staff were not around to help on the ward. Some staff told us the wards did not have enough control and restraint trained staff.

Staff told us about the impact staffing shortages were having on their wellbeing and morale. They said they were busy, short staffed and exhausted or burnt out. Because of staffing issues, some staff felt they could not perform well. Staff said their work had been particularly challenging because of additional demands caused by the Covid 19 pandemic. Some staff felt the ward was safe but others felt there were not be enough staff to run a safe service.

Staff told us that although managers could ask senior managers for agency staff, even if this was approved, the wards could not always get cover. Staff said ward managers often spent a great deal of time trying to source staff to cover gaps in the staffing rotas and this meant they were not always visible on the wards.

Staff from the multidisciplinary team also helped on the wards to increase numbers. For example, the sports team did additional sessions for patients on wards when numbers were low, but this meant cancelling planned activities for patients on other wards.

Recruitment

Detailed findings from this inspection

We looked at the nurse vacancies on both wards. Ashcombe ward had two band five nurse vacancies and one band six nurse vacancy making a total of 31% substantive qualified staff vacancies. Agency nurses were employed to make up the shortfall and this brought the total vacancy rate to 14%.

On Holcombe ward there were four band five nurse vacancies and 0.4 band six nurse vacancies making a total of 37% substantive vacancies. With agency employment they were left with vacancy level of 29%.

The trust predicted that due to the measures being taken to address the staff shortages, by 5 October 2020 it would have a nurse vacancy rate on Ashcombe ward of 23% and on Holcombe ward 20%. However, it expected that with agency nurses covering shifts, the vacancy rates would be 6% on Ashcombe ward and 12% on Holcombe Ward.

We looked at the vacancy rates for unqualified staff on both wards. Unqualified staff include support workers. Ashcombe ward had six unqualified staff vacancies and Holcombe Ward had five unqualified staff vacancies. This meant there was a 26.5% vacancy on Ashcombe ward and in 23% vacancy on Holcombe ward of unqualified staff.

The trust was recruiting unqualified staff and predicted improvements by 5 October 2020. The trust said it expected there would be unqualified staff vacancies of 10% on Ashcombe ward and 13% on Holcombe ward by 5 October 2020.

The current turnover rate for Ashcombe ward was 18 %. The current turnover rate for Holcombe Ward was 60%. The trust was making progress with recruitment. The trust told us that Langdon hospital had experienced staff losses recently due to retirements, staff leaving to work in the community forensic team and fatigue caused by the Covid 19 pandemic leading to staff being redeployed. The Dewnans centre had been the subject of a whole service safeguarding and several staff had left during that process. The whole service safeguarding ended in February 2020.

The trust also recognised it had a young and inexperienced staff group. In addition to ward-based staff, allied health professionals provided activities.

The trust employed agency staff on a long-term basis to enable them to become familiar with the wards. Agency staff completed the same training and induction as all other staff mandatory training.

Staff told us that because of the Covid 19 pandemic, training was being provided online, including conflict resolution and care recording. Some staff raised concerns about how well the training prepared staff for the environment and patients they would be working with. The trust advised us that key training such as proactive understanding of the management of aggression (PUMA) continued to be delivered in person with appropriate safety measures in place. Some staff said they thought there were inconsistencies in the standard of induction across the Langdon Hospital site. Staff told us the trust was planning on a trial of band four staff teaching new band three staff on the job while the band three remained supernumerary.

Following the serious incident on 31 July 2020, staff told us they recognised they needed more comprehensive training in managing ligature incidents. Ligature training had been developed and was being rolled out across the hospital site. This training included where ligature cutters were kept, how to use them and how to respond following a ligature incident. The new training also covered the key objectives from the trust policy. The training would be mandatory for all staff. Staff who had already completed the training told us that as a result of the training they felt supported and more confident.

The wards were also running simulation training for staff to help prepare them for incidents of self-harm. Multi disciplinary teams also held meeting specifically to look at risk including zoning meetings on week days and a weekly risk review.

Assessing and managing risk to patients and staff

Assessment of patient risk

Detailed findings from this inspection

We looked at five patient care records. Staff completed risk assessments for all patients. We found risk assessments were clear and comprehensive. Staff wrote about patients in a dignified and thoughtful manner. Care records were patient focused, and the patient voice was present. Physical health care plans were well detailed.

Staff assessed patients' risk to themselves and others. All the wards at Langdon hospital used the HCR20 which is a structured tool for assessing a patient's risk to others. However, the trust recognised following the incident on 31 July 2020, that it needed to improve the assessment of patients' risk of self-harm.

Management of patient risk

Staff completed observations of patients at levels determined by individual patients' assessed level of risk. Staff on both wards increased or decreased the frequency of patient observations flexibly in response to changes in a patient's risk.

In the records of staff observations there were gaps. This meant observations had not taken place or they had not been recorded. The observation recording tool did not have sufficient space for staff to record details about patients' presentation. This meant staff could not be assured that patients risks were being monitored safely.

Following the serious incident on Ashcombe ward on 31 July 2020, the patient observation recording tool was reviewed and updated to address this concern. The new process was a tick box form for staff to indicate an observation had taken place and a recording sheet that enabled staff to record the patient's mental state, behaviour and interaction with staff and patients.

The trust was trying to improve the quality of observations and encouraging staff to engage with patients rather than just observing them. The Trust was also reviewing the observation and engagement policy.

Staff said they had the opportunity to contribute to discussions about changes in patient observation levels and patient risks. Staff were encouraged to give their opinions.

The trust had developed a competency tool which was being rolled out. The target date for completion was the end of August 2020.

During our focus groups, staff raised concerns about patients having access to items on Ashcombe ward that could be used as weapons or for self-harm. This included sports equipment in areas where staff were not always present. We fed these concerns back to the trust at the time of our inspection. The ward ligature risk assessment stated that this area was always supervised by staff when it was in use, but staff told us this was not the case. We told the trust about these concerns and asked them to provide assurance about this area. The trust informed us an inventory of items and equipment was to be developed and a review of the outside space and a security checklist was being developed and implemented.

Safeguarding

Staff received training on how to recognise and report abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead. Managers told us staff were gaining confidence in reporting safeguarding concerns.

Track record on safety

A serious incident had taken place on 31 July 2020 involving a ligature point on Ashcombe ward.

Reporting incidents and learning from when things go wrong

Detailed findings from this inspection

Managers debriefed and supported staff and patients after any serious incident. The hospital used Trauma Risk Management methodology (known as TRiM) to support staff following incidents. TRiM is a structured peer risk assessment and ongoing support to staff who have experienced traumatic events. The hospital had 16 TRiM practitioners across the site. Following the serious incident on Ashcombe ward, staff were being offered TRiM. Staff spoke positively about this approach.

Changes had been made to the ward as a result of learning from the serious incident in July 2020. The ligature point involved in the incident was an open window and all similar windows on other wards at Dewnans centre had been locked. Patients did not have access to areas where they could not easily be seen on Ashcombe ward. In addition, ligature risk assessments on both wards had been updated.

Staff were keen to learn from the serious incident. Following the serious incident, staff told us they had become more aware of risk factors and potential triggers that may have been overlooked. All wards were asked to review risk to self of their patients.

The documentation used to record patient observations had been updated following the serious incident in July 2020. This was because the observation record for the patient involved in the incident had been incomplete on the day the incident took place. The trust had also implemented a new observation competency framework, and this was in the process of being completed by all staff at the Dewnans centre.

The trust had not learnt from a previous incident on Holcombe ward. In the serious incident on July 2020 the same kind of window was used as a ligature point. Learning from the previous incident on Holcombe ward had highlighted the need for windows to be kept shut but this learning was not applied to Ashcombe ward. The trust advised us that safety improvements had been made across all the four wards in the Dewnans centre.

In our focus groups, staff told us that since the serious incident, they were doing more intentional rounding and using higher levels of observations for patients if they were concerned about their risk. However, staff felt they could keep a closer watch on patients they thought might be at risk if there were more staff available to do this. Staff acknowledged a need to improve communication about patient risk between staff teams.

A clinical advisory group was meeting three times per week to monitor learning from serious incidents and disseminated learning to staff in a timely manner.

A trust wide learning from experience group was looking at key aspects of learning across all the trust's services.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness.

We spoke with two patients on Holcombe ward. They were positive about staff and described them as supportive and helpful. One patient said the hospital was the best hospital they had been in. Both patients told us they felt safe and that the ward was settled.

One patient said the ward being short staffed meant they could not always go out on escorted leave.

Staff enabled patients to have visits from families and carers.

Involvement in care

Involvement of families and carers

Detailed findings from this inspection

Staff informed and involved families and carers appropriately. Carers told us they felt involved in care and that they received regular updates from the wards about how their loved one was progressing. They liked the newsletter they received from the wards.

Carers said they had regular contact with their loved ones through visits and by telephone. Carers said they were involved in discharge planning. One carer told us they had been involved in patient reviews by teleconference.

Carers told us they were satisfied with patient care. Carers described staff as polite, caring and respectful, kind and non-judgmental. However, they felt staff needed more support and that there should be more staff. One carer felt patients could progress faster through the system to avoid patients becoming institutionalised. They said transitions between wards were not well handled although this was improving.

Carers said they knew how to complain or provide feedback to the staff and they were willing to do so if needed.

Is the service well-led?

Leadership

Staff said that across the Langdon site, there had been changes of managers and consultants and a high turnover of staff. There were new ward managers in post on both Ashcombe and Holcombe wards. The trust told us there had been four different ward managers in the past two years but that the management team was becoming stabilised.

The ward manager on Holcombe ward had been off sick for approximately four weeks prior to the inspection. The deputy ward manager was covering in the interim. The leadership team at Langdon Hospital were aware that the deputy ward manager needed more support in the role.

Staff described the substantive Holcombe ward manager, as highly experienced and approachable.

Staff were confident in the new substantive ward manager for Ashcombe ward who they said was experienced and approachable.

During our focus groups, staff said managers should more robustly manage the staff teams and be more supportive and empowering towards staff. Staff said ward managers were not always visible on the wards and managers spent a lot of their time trying to fill shifts with enough staff. They said they felt ward managers were not supported and empowered by senior leadership in the trust.

However, senior staff we spoke to during the inspection told us they felt the trust executive team were supportive and sensitive especially following the serious incident on Ashcombe ward.

Culture

Our discussions with staff demonstrated a caring, compassionate, supportive, hard-working and dedicated team. Staff wanted to deliver excellent care and keep patients safe. However, staff were exhausted and stressed by the challenges of the Covid 19 pandemic and short staffing. Some staff said they felt undervalued in their efforts. Some staff told us they thought some members of the staff teams were frightened and demoralised and often felt unsafe. The trust senior staff told us they recognised that staff were fatigued by the Covid 19 pandemic.

The trust recognised that due to the Covid 19 pandemic they had been unable to provide well being events for staff. There was a well-being lead that staff could talk to on the wards. A process was being devised to enable themes from these conversations to be reported to the trust so they could improve staff wellbeing.

Most staff said they knew the whistleblowing process and would be prepared to use it. They said the culture of the wards encouraged people to speak up and to learn. A small number of staff said they were reluctant to speak up about their concerns because of fears of repercussions due to past experiences.

Detailed findings from this inspection

Some staff spoke about a divide between staff teams based on the ward and those based in offices upstairs. The office-based staff were managed by different managers to ward-based staff.

Some staff said this divide reduced opportunities for communication between staff groups. They said staff not based on the ward were not always aware of or available to discuss incidents on the wards. Staff felt that if this divide could be overcome then staff could respond more immediately and effectively to patients needs and risks.

Staff said in the focus groups that although they reported their concerns about short staffing, they felt no one listened.

Governance

Staff had learned from the serious incident that had taken place on 31 July 2020 and they were making improvements to the service. The service was short staffed, and this was affecting the wellbeing of patients and staff. There were processes in place to ensure serious incidents were considered and that learning was being discussed, escalated and disseminated. However, the recent serious incident had illustrated that learning from untoward incidents was not robust.

Management of risk, issues and performance

The wards held 'zoning' meetings every day to manage risk across the forensic inpatient service. These meetings reviewed individual patients' risk levels over the previous 24 hours and anticipated the wards needs for the next 24 hours. All staff were invited to Zoning meetings. Staff who were not at the meeting received the information through handover meetings.

Ward managers attended directorate operational management meetings three times per week. The meetings covered staffing, restraint, training, incidents, violence and aggression. The minutes of these meetings showed managers were engaged in understanding the pressures across all the wards at Langdon. The minutes of the directorate operational management meetings were made available to senior managers including the ward consultant psychiatrists and manager on call.

Both wards had up to date risk registers to help them understand, rate and mitigate risks on the individual wards.

Information management

Managers advised us of concerns about the timeliness with which paper records were uploaded to electronic records. The trust was planning to introduce a new electronic care records system and managers hoped this would improve the issue.

Areas for improvement

Action the provider MUST take:

The trust must ensure there are sufficient numbers of suitably qualified, skilled experienced staff to meet the patients care and treatment needs.

Action the provider SHOULD take:

The trust should ensure learning from serious incidents and mitigating risks is shared across all the trust's relevant ward and services and that the learning is used to inform practice.

The trust should ensure that there is safe observation practice on all wards and that staff always account for items that pose a risk

Detailed findings from this inspection

The trust should ensure that themes from conversations with the well-being leads can be escalated so these can be used to inform methods to support staff

Our inspection team

Our inspection team comprised a head of hospital inspection, an inspection manager, two inspectors, an expert by experience and a specialist advisor who specialised in forensic inpatient care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing