Outstanding ☆

Plymouth Community Healthcare CIC

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

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY
Tel: 08451 558085
Website: www.livewellsouthwest.co.uk

Date of inspection visit: 21 - 24 June 2016
Date of publication: 19/10/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-297635140	Glenbourne Unit	Bridford ward	PL6 5AF
1-297635140	Glenbourne Unit	Harford ward	PL6 5AF

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated acute wards for adults of working age as outstanding because:

- The Glenbourne Unit was well-led with a positive, supportive and motivated management team who ensured their passion for improving mental health services for patients was shared with the team members.
- Patient records were of very high quality. Care plans and risk assessments were up to date and thorough.
- The wards kept blanket restrictions to a minimum and ensured any blanket restrictions in place were justified by risk assessments.
- The 2015 mental health inpatient survey had rated nurses at the Glenbourne Unit highest in the country for treating patients with dignity and respect.
- All of the patients we spoke with were extremely positive and complimentary about the support they received from the ward staff.
- Patients were involved in their care and treatment plans, their opinions were respected and their views were recorded.
- The redesign and refurbishment of the unit was well thought through, prioritised improving patient care and the patient experience on the unit and had delivered a greatly improved ward environment.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff on both wards had fully assessed ligature points and environmental risks. They had carried out and recorded the actions required to reduce any risks. The unit had fully updated environmental risk assessments and safety procedures to cover the building work that was being carried out on site.
- All risk assessments we saw in patients' records were fully up to date.
- Staff received mandatory training.
- Staff on the wards kept blanket restrictions to a minimum and ensured any blanket restrictions in place were justified by risk assessments.
- Both wards provided single sex accommodation.
- A dedicated housekeeping team kept the wards clean and tidy.

However:

- Clinic room temperatures were not recorded.
- We found two errors in prescriptions charts on Bridford ward which had not been picked up by the unit's internal audits.

Are services effective?

Good

We rated effective as good because:

- The service maintained high quality care records.
- The electronic recording system was secure, clear, simple to use and all information needed to provide care was easily accessible.
- Staff received specialist training.
- Staff received regular supervision and had annual appraisals.
- The appointment of support time recovery workers and unit referral co-ordinators ensured that nursing staff could focus their time on direct nursing care.
- Handovers were effective and thorough.
- Staff demonstrated knowledge and understanding of the Mental Health Act and Mental Capacity Act both verbally and in records of care and treatment.

However:

- The service did not maintain records for completion of Mental Health Act and Mental Capacity Act training because it was not considered mandatory training by the provider.

Summary of findings

Are services caring?

Outstanding 

We rated caring as outstanding because:

- The 2015 mental health inpatient survey had rated nurses at the Glenbourne Unit highest in the country for treating patients with dignity and respect.
- All of the patients we spoke with were extremely positive and complimentary about the support they received from the ward staff.
- Staff interacted with patients positively and respectfully. They demonstrated that they knew the patients well in their interactions with patients and in their responses to them.
- Care plans documented detailed assessments of both the emotional and physical needs of patients and documented patients' wishes and feelings about their treatment.
- Patients were involved in their care and treatment plans, their opinions were respected and their views were recorded. The multidisciplinary team responded to patients' views and requests and amended treatment plans in response to patients' views where appropriate.
- Patients were actively involved in the refurbishment of the Glenbourne Unit.
- Patients and members of the Plymouth improvement and participation service were included in staff interview panels.
- The Glenbourne Unit had a monthly carers' group meeting. They also set up a working group for carers regarding the triangle of care – a working model of how to involve carers as an integral part of patients' care.

Are services responsive to people's needs?

Good 

We rated responsive as good because:

- The Glenbourne Unit had a range of rooms and facilities to aid patients' treatment and recovery. It also had a well-resourced occupational therapy department on site.
- The newly designed Harford ward was accessible for patients who required disabled access and all patients had single bedrooms.
- Patients' religious and cultural needs were respected.
- Patients had a range of meal options and were able to access drinks and snacks throughout the day.

However:

Summary of findings

- Bridford ward was not fully accessible for people requiring disabled access and had three dormitory rooms. The ward was due to move in two months' time to a redesigned and refurbished ward which was suitable for people who needed disabled access. The new ward would have single bedrooms.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The Glenbourne Unit was well run. The senior management team worked well together and prioritised patient care.
- Ward systems were effective in ensuring that staff received mandatory training, were appraised and supervised. The ward managers kept very good local staff records and ensured that organisational systems and processes were followed at ward level.
- The teams had key performance indicators and reviewed their progress using monthly scorecards.
- All staff we spoke with talked passionately and enthusiastically about the organisation, the management team at the Glenbourne Unit and the provider's senior management team.
- Staff at all levels felt supported and empowered. The management team was encouraged to be creative and innovative.
- The staff structure was innovative and aimed to ensure that staff could maximise time spent on direct care activities. The support time recovery worker role and unit referral co-ordinators freed up nurses to focus on delivering care and treatment. They also improved the patient experience and responsiveness of the service for patients and funders.

Summary of findings

Information about the service

The Glenbourne Unit was an acute inpatient mental health service for men and women located in Derriford, Plymouth. The service treated adults between the ages of 18 and 65 who had mental health problems such as severe depression, mania or psychosis.

The Glenbourne Unit had two wards:

- Harford ward which had 19 beds and treats male patients.
- Bridford ward which had 22 beds and treats female patients.

The unit also had central facilities for all patients such as an occupational therapy department, private interview rooms and a café area.

There was a health-based place of safety located at the Glenbourne Unit. This was inspected by a separate inspection team during our comprehensive inspection.

At the time of our inspection there was building work ongoing at the Glenbourne Unit. Harford ward had moved into a comprehensively refurbished ward in February 2016. An empty ward was being refurbished when we inspected the Glenbourne Unit. Bridford ward was due to move into the refurbished ward in August 2016. The gardens and outside spaces were being landscaped at the time of our inspection.

The Glenbourne Unit took referrals mostly from Plymouth but also treated some patients from the wider Devon and South West area.

The Glenbourne Unit has been registered with CQC since 30 September 2011. We have inspected the Glenbourne Unit twice before, on 29 August 2013 and on 27 November 2012. At both inspections all standards inspected were met.

Our inspection team

The inspection team was led by:

Chair: Andy Brogan, executive director of nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection manager: Nigel Timmins, Care Quality Commission

The team that inspected this core service comprised one inspection manager, an assistant inspector and two senior nurse specialist advisors.

Why we carried out this inspection

We inspected this core 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 these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of findings

- visited both wards at the Glenbourne Unit. We looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with seven patients who were using the service and collected feedback from seven patients using comment cards;
- spoke with the manager for each of the wards;
- spoke with the modern matron for the unit;
- spoke with 12 other staff members; including doctors, nurses, and occupational therapists;
- attended and observed two hand-over meetings;
- looked at nine treatment records of patients;
- looked at 22 medicines charts;
- carried out a specific check of the medication management on both wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

All of the patients we spoke with were extremely positive and complimentary about the support they received from the ward staff. One patient told us that their family had been very well supported by the ward staff.

Patients told us that the staff were responsive to their needs and wishes. Three of the comments received on comment cards stated the patients felt staff listened to them and responded to them. However, three comments received in comment cards were less positive. One stated that the patient had experienced delays in receiving alternative medication. Another stated that 80% of the staff were very good, 20% of the staff did very little. The third less positive comment stated that the nurses were sometimes slow in responding. However, on the same comment card the patient stated that the nurses listened to them and had looked after them well.

All of the patients we spoke with said they felt safe with the staff on the ward. Two of the seven patients we spoke with told us they felt unsafe with other patients.

During the inspection, we participated in an occupational therapy group, with the patients' permission. Two of the patients in the group talked to us about the activities and occupational therapy available at the Glenbourne Unit. The patients told us there was a good range of activities both on-site and in the community. The patients were very positive about both the occupational therapy staff and the ward staff.

Generally the patients we spoke with were positive about the medical treatment they received and thought their mental health had improved since being on the ward. One patient told us that they had arrived severely depressed and suicidal but after five weeks on the ward felt that life was worth living again. Another patient told us they had not agreed with their treatment at first but now felt that it had been the right decision for them.

Four out of the seven patients we spoke with said they had been involved in their care planning and had been given choices regarding their treatment. Three patients did not talk to us about their care planning.

Good practice

The unit used staff innovatively and had appointed unit referral co-ordinators and support time recovery workers. The unit referral co-ordinators managed the beds and co-ordinated admissions and discharges. Previously these tasks had been carried out by senior registered nurses. All nurses we spoke to told us that the unit referral co-ordinator had freed them to be able to spend more time on direct patient care. The ward managers and modern matron told us that the unit referral co-ordinators, who were not as senior as registered nurses, were able to do a better job of managing referrals and discharges because they were able to dedicate their time to the role. Nurses on shift had to juggle the tasks with many other competing demands on their time. The support time recovery workers worked Monday to Friday 9am to 5pm and their role was to facilitate patient activities and patient leave. The support time recovery workers were not part of the ward's nursing staff numbers. Patients and staff told us that activities and patient leave were rarely cancelled due to staff numbers because the support time recovery workers provided so much of the workforce that assisted patients to access the community and to take

Summary of findings

formal leave. For example, the support time recovery workers drove patients to their home polling stations so that they could vote in person in the European Union referendum.

Every nurse carried a small ligature cutter that was safe to carry with their personal alarm. The ward managers explained to us that these personal, folded ligature cutters had been introduced in response to an incident a few years earlier. The investigation report to the incident had identified there had been a delay in cutting a ligature from a patient's neck because a staff member had to run to the nurse's office to get the cutters. Afterwards all nursing staff were issued with the small ligature cutters to carry with their keys and personal alarm.

The Glenbourne Unit had a monthly carers' group meeting and a working group for carers regarding the triangle of care – a working model of how to involve carers as an integral part of patients' care.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all clinic room temperatures are regularly checked and recorded.
- The provider should ensure there are records of staff who have attended Mental Health Act and Mental Capacity Act training.
- The provider should identify which staff require essential MHA training and keep a record of their attendance.

Plymouth Community Healthcare CIC

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bridford ward	Glenbourne Unit
Harford ward	Glenbourne Unit

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.

The Glenbourne Unit had a Mental Health Act office based in the unit. All staff we spoke with told us the Mental Health Act administrative staff on site were supportive, knowledgeable and helpful.

Mental Health Act records were in very good order. Detention paperwork reviewed during the inspection was complete and accessible. Section 17 leave records were detailed, thorough and patients were given copies of their leave records. Treatment authorisation forms were up to date, correctly completed and copies were kept with the patients' medication charts. One patient had been prescribed antipsychotic medication in excess of the dose authorised on the patient's treatment authorisation forms. This was corrected as soon as we raised the issue to ward staff. The patient had not been given the antipsychotic medication.

All of the nine treatment records we reviewed contained evidence that both detained and informal patients had been informed of their rights. The patients we spoke with confirmed to us that they had been told of their rights on admission, and at other points during their treatment when their treatment had changed or if their detention status had altered. The detention status for a patient changes if they had been formally detained under the Mental Health Act on admission and then become an informal (voluntary) patient during their treatment; if a patient is admitted as an

informal patient and is detained during their treatment; or if the details of their detention change. For example when a patient's detention under the Mental Health Act is changed from section two to section three of the Mental Health Act.

Both wards had noticeboards containing details of the independent mental health advocacy service. Leaflets were available for patients informing them of how to contact the advocates who visited the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

All of the staff members we spoke with told us they had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We reviewed seven staff records, all of which contained confirmation that the staff members had attended Mental Capacity Act and DoLS training.

All members of the nursing staff we spoke with could tell us the principles which underpin the Mental Capacity Act. Every nurse could either give us examples of when they had used Mental Capacity Act best interests decision making themselves or of individual decisions that had been made on behalf of patients following the Mental Capacity Act guidance and Code of Practice.

One patient record we reviewed showed a very detailed record of best interests decision making. The multidisciplinary team had recorded why they believed the patient lacked capacity to make a specific decision. The doctor had recorded a detailed decision-specific assessment of the patient's capacity to make the decision. Family members had been consulted and an advocate had worked with the patient. The formal best interests multidisciplinary meetings were recorded clearly and in accordance with the Mental Capacity Act Code of Practice guidance.

There had been one DoLS application at the Glenbourne Unit in the twelve months prior to our inspection. This application was subsequently withdrawn when the patient's mental health deteriorated and the patient was formally detained under the Mental Health Act.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- The two wards were very different to each other because Harford ward had been recently re-modelled and refurbished whilst Bridford ward was a much older design. The layout of Harford ward had been re-designed to ensure there were clear lines of sight throughout the ward. Bridford had areas at the end of the bedroom corridors which were out of sight of the nurses' office. The risks of these areas were mitigated by mirrors positioned so that staff seated at observation points in the main lounge area could see to the ends of the corridors. A member of nursing staff was always positioned in the lounge area.
- There were very few ligature points in Harford ward. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The ward had been fitted with new anti-ligature fittings such as non-weight bearing curtain rails, bedroom furniture without doors or hinges and taps that were activated by pressing a button. All doors throughout the ward in patient areas had full hinge covers. The ligature points that did exist such as grab handles in the accessible patient bathroom or en suite bathroom doors were recorded on the ward's ligature risk assessment. Appropriate measures were recorded to mitigate the risk. The accessible patient bathroom was locked unless in use and patients were observed, discreetly, whilst they used this bathroom if they were at risk of harming themselves or of falling. Some of the en suite patient bathrooms did not have doors between the bathroom and the bedroom. These rooms were given to patients who had been assessed as at higher risk of harming themselves. The rooms with en suite bathroom doors were given to patients who had been assessed as being at low risk of harming themselves.
- Bridford ward had more ligature points than Harford ward. However, they had all been identified and recorded on the ward's ligature risk assessment. The ward ligature risk assessment had been updated at regular intervals in the twelve months prior to our inspection. The risks were mitigated by positioning staff at observation points throughout the ward and by ensuring that the patients who were at highest risk of harming themselves were in the rooms closest to the nurses' office with fewer ligature points. Also patients' observation levels were regularly monitored and directly linked to their assessed risk levels.
- Both Bridford and Harford wards were single sex wards. Harford ward was a male ward and Bridford ward was a female ward. Patients who used the occupational therapy department and the central café area of the Glenbourne Unit were able to mix with patients of the opposite sex. Patient access to these common areas of the unit was individually risk assessed. The occupational therapy department offered activities for both male and female patients. Patients were risk assessed prior to attending occupational therapy activities and some activities were offered for single sex groups only.
- Each ward had its own clinic room. The clinic rooms were clean and tidy. Both clinic rooms contained accessible resuscitation equipment and emergency drugs. The emergency drugs and equipment complied with national guidance and we saw records which indicated they were checked regularly by staff.
- All equipment in Harford ward was new and in very good condition. The equipment on Bridford ward was not all new but all of the equipment had stickers to indicate it had been safety checked.
- Neither ward had a seclusion room. There were quiet rooms that could be used as de-escalation rooms on each ward.
- Despite the physical differences between the ward environments, both wards were equally clean and tidy. The furnishings and decoration were newer on Harford ward and were in very good condition. Bridford ward had noticeably older furnishings. The ward was due to have completely new furniture and furnishings when it moved to its new ward environment in two months' time. Maintenance actions were still logged and carried out promptly on Bridford ward even though it was due to move to a new ward space. We saw that an issue with one patient toilet was fixed on the day it was reported during our inspection. Harford ward had experienced some maintenance issues after moving to the new ward. These issues had been logged and resolved quickly by the builders who were still on site.

Good

Are services safe?

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

- Both wards had dedicated hand wash basins. Also all staff and visitors to the Glenbourne Unit were asked to wash their hands at the hand wash basins in the main reception area before entering the rest of the building.
- The Glenbourne Unit had a dedicated housekeeping team. The housekeeping staff were on site every day, maintained a regular cleaning schedule and also responded promptly to requests for additional cleaning because of food or drink spills.
- The entire Glenbourne Unit had updated environmental risk assessments in place. There were also detailed risk assessments for the areas where building work was still being carried out such as the new Bridford ward area and the new patient garden areas. Additional safety procedures were in place to keep patients, staff and visitors safe during the building work. For example, most of the garden area was fenced off with temporary secure fencing whilst it was being landscaped.
- All staff carried personal alarms and there were nurse call alarms throughout the building.

Safe staffing

- Both wards operated three nursing shifts per day, 7am to 3pm, midday to 8pm and 7.30pm to 7.30am. Both wards had set safe minimum staffing levels and reported against these levels every day to the organisation's senior management team. The minimum staffing level for each ward was five members of staff (two registered and three non-registered nurses) on each day shift and four (one registered and three non-registered nurses) on the night shift. Additionally a unit co-ordinator worked overnight across the whole unit. The unit co-ordinator was a senior nurse.
- The ward managers were able to request additional staff when needed to ensure patients could access community leave and to ensure any increased patient observation levels could be maintained.
- The provider had its own bank of staff available to cover vacant shifts and staff sickness. Also, agency staff were used at the Glenbourne Unit when bank staff were not available to cover vacant shifts or staff sickness. The agency staff used, were, where possible, staff who had experience of working at the Glenbourne Unit. If a new agency staff member was employed they were asked to work as an additional staff member on a shift as an induction to the ward before working as part of the basic staffing numbers. If this was not possible the new agency staff member was asked to arrive early for their shift so they could have a full induction to the ward before starting their shift.
- The patients we spoke with told us they had regular time to speak with their named nurse. Also, we saw in the patient records we reviewed that nurses had recorded when they had one to one meetings with patients. Each patient's notes we reviewed had regular one to one meetings or discussions recorded.
- A doctor was on site at all times. The Glenbourne Unit had junior doctors on site out of hours. Also there was a rota for out of hours cover for consultant psychiatrists. The Glenbourne Unit was opposite a major general hospital with an accident and emergency department and an ambulance base. Therefore, in the event of a physical health emergency at any time of the day the nursing staff and junior doctor could call for urgent assistance or transfer a patient to the general hospital.
- Mandatory training rates were mostly very high. The average mandatory training rate for the Glenbourne Unit was 82%. Safeguarding children level one and three training rates were 100% and the adult safeguarding training rate was at 97%. The lowest recorded mandatory training rate was for basic life support training. The data provided to us from the provider prior to our inspection showed that only 54% of staff at the Glenbourne Unit had completed their basic life support training. The provider had experienced difficulties across the organisation in getting basic life support training. Each service had been asked to produce an action plan to ensure all staff were booked onto a basic life support training course. We saw the training plans for Bridford and Harford wards during our inspection and they showed that 75% of staff at the Glenbourne Unit had completed their basic life support training or the alternative advanced life support training. Every member of staff who was not up to date with this training, apart from staff members on maternity leave, was booked onto a course in the next two months. We saw confirmation of the staff training bookings.

Assessing and managing risk to patients and staff

- Seclusion was not used on either Bridford or Harford wards. However, there had been occasions when patients had been transferred to the place of safety at the Glenbourne Unit whilst waiting to be transferred to a

Good

Are services safe?

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

psychiatric intensive care unit or a secure service. The service could not provide figures on how many of these occasions the place of safety was used as a seclusion room. The place of safety was inspected by a separate inspection team.

- There were 79 incidents of the use of restraint at Bridford and Harford wards in the period from 1 August 2015 to 31 January 2016. Restraint had been used on 18 different patients. Prone restraint had been used 30 times, 24 of which had resulted in the use of rapid tranquilisation.
- We asked the nursing staff about their use of prone restraint. Every staff member told us it was only used to administer rapid tranquilisation and was used for the shortest possible time. We asked why prone restraint had been used on six occasions without rapid tranquilisation. We were told that the staff had thought they were going to have to use rapid tranquilisation but the patient had either calmed down or accepted oral medication when they realised that the staff were going to use an intramuscular injection (medicine delivered deep into the muscles to enable the medicine to be absorbed into the bloodstream quickly). We reviewed six restraint records from the three months prior to our inspection and saw that prone restraint was used for less than one minute on all occasions and only to deliver rapid tranquilisation. We saw a record of a restraint where the staff members involved were ready to give the patient rapid tranquilisation but the notes recorded that the patient became calmer and asked for oral medication instead.
- We reviewed nine care records. All nine records contained an up to date risk assessment. The risk assessment tool used on the organisation's electronic records system was very detailed and thorough. We saw that risk assessments were updated at each ward round and in response to incidents.
- There were very few blanket restrictions in place on Bridford and Harford wards. The entrance door to the Glenbourne Unit was locked and access was controlled by the reception staff. The reception staff had a list of patients who were able to leave the unit. We saw patients sign out of the unit. The doors to the wards were not locked. A member of staff was positioned at the ward doors at all times but did not prevent patients from leaving the ward if they were safe to do so. Most patients were able to access the common areas of the Glenbourne Unit including the café. Some patients could only access these areas escorted by a staff member. The toilets and bathrooms were not locked with the exception of the assisted bathroom because it contained ligature points which were managed by keeping the door locked. Patients could access their rooms at all times but some patients required a staff member to be with them. Patients were allowed to have their mobile phones and laptops on the wards as long as they complied with the unit's policy for safe usage.
- Nearly every staff member was up to date with their safeguarding training. All staff had completed safeguarding children level one and level three training but 10% of staff were not up to date with safeguarding children level two training. The compliance rate for adult safeguarding training was 97%. The staff members we spoke with knew and understood the safeguarding policy and could tell us the types of incidents that would be considered to be safeguarding issues.
- Medicines management was generally good. Either a pharmacist or a pharmacy technician visited each ward every day. Medicines were stored safely and regular audits of missed doses were carried out. The Bridford ward controlled drugs cabinet was not large enough so some excess stock for Bridford ward was stored in the Harford ward controlled drugs cabinet. This had led to some recording errors in the controlled drugs register. This issue was due to be improved once Bridford ward moved into its new ward and had a new clinic room and controlled drugs cabinet. Fridge temperatures were recorded daily and all temperatures recorded were within the safe range. However, the clinic room temperatures were not recorded. The clinic rooms felt cool but it was not possible to be sure the clinic rooms maintained temperatures within the required range. Patients' details were recorded on all of the 22 medicines charts we reviewed. All known allergies were recorded. We found two errors on the prescriptions charts, both for Bridford ward. One patient had a dose of lorazepam incorrectly prescribed (one gram instead of one milligram). The dose had not been given and this was recorded as an incident on the electronic incident recording system as soon as we notified the ward of the error. Also, one patient had been prescribed antipsychotic medication in excess of the dose authorised on the patient's treatment authorisation

Good

Are services safe?

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

forms. This was corrected as soon as we raised the issue to ward staff. The patient had not been given the antipsychotic medication. The unit's audit system had not picked up these prescription errors.
- The Glenbourne Unit had a visitors policy and had a designated visitors room for family visits that included children.

Track record on safety

- Two serious incidents were recorded at the Glenbourne Unit in the 12 months before our inspection. One incident had taken place on Harford ward before the ward had moved to its newly refurbished ward. We saw that the incident had been appropriately recorded and investigated. Lessons learnt from the investigation had been shared with all the staff and were recorded in handover meetings and team meetings. The second incident was still being fully investigated at the time of our inspection and a matron from another inpatient service had been appointed to write the investigation report. There had been an initial review of the circumstances to check for any immediate learning or changes required.

Reporting incidents and learning from when things go wrong

- All of the staff we spoke with understood the incident reporting policy and could tell us the process they used to record incidents. The new nursing assistants we spoke with told us that they would report any issues to the nurse in charge.
- We saw in minutes of team meetings and in handover meeting minutes that learning from incidents in other parts of the organisation was shared and discussed. Also, national safety alerts were highlighted and discussed. All staff signed records to confirm they had read the national safety alerts.
- Every nurse carried a small ligature cutter that was safe to carry with their personal alarm. The ward managers explained to us that these personal, folded ligature cutters had been introduced in response to an incident a few years earlier. The investigation report to the incident had identified there had been a delay in cutting a ligature from a patient's neck because a staff member had to run to the nurse's office to get the cutters. Afterwards all nursing staff were issued with the small ligature cutters to carry with their keys and personal alarm.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We reviewed nine care records. The quality of the care records was very high. On Bridford ward all care records were up to date and personalised. Care plans included the full range of patients' problems and needs and were focused on recovery. On Harford ward one care record, out of the five we saw, did not include a record of the patients' views about their treatment. Also one of the five records had not been fully updated following an incident. The records showed that patients were routinely given a copy of their care plan. Only one patient had not been given a copy but it was recorded in the care record notes that this was due to the patient's current mental state and the decision would be reviewed in a week's time.
- Every care record we saw showed that the patient had received a physical examination and there was ongoing monitoring of physical health problems. For example, we reviewed the records for a patient who had type two diabetes and had nerve damage in one leg. The records showed that the patient had received specialist treatment for the nerve damage and had seen a dietitian regularly to help them understand and manage their diabetes better.
- The electronic recording system was secure, clear, simple to use and all information needed to provide care was easily accessible. There was a disciplined approach to storing information on the electronic system. All staff followed the same approach so all information could be found easily and quickly.

Best practice in treatment and care

- The unit offered a range of psychological therapies, particularly cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT) and specialist eating disorders therapy.
- We spoke with two psychologists who praised the recent increase in psychology input to the wards. They were also positive about the additional training that ward staff had received in treating people with eating disorders. They stated there had been a reduction in specialist eating disorder service referrals as a result of the ward staff feeling more confident in treating people with eating disorders. The psychologists also provided a monthly eating disorders supervision group for staff which allowed the staff time and space to reflect on how they had worked with patients with eating disorders and share good practice.
- Both wards had rooms to carry out physical health assessments of patients. These rooms contained an examination couch and equipment to monitor the physical health of patients such as blood pressure monitors and scales. Patients were able to access specialist physical healthcare services such as speech and language therapy, tissue viability nurses, dietitians and specialist diabetes services.
- The health of the nation outcome scales were used to record and measure patient outcomes. The occupational therapy department used the model of human occupation assessment model.
- The Glenbourne Unit used the recovery star approach to assess and measure the needs of patients and to assist patients in planning their own recovery journey.

Skilled staff to deliver care

- Psychologists and occupational therapists worked as an integral part of the staffing of the Glenbourne Unit. The occupational therapy team included two psychotherapists and three technical instructors as well as five registered occupational therapists. Social workers and pharmacists provided regular input to the Glenbourne Unit teams.
- The unit used staff innovatively and had appointed unit referral co-ordinators and support time recovery workers. The unit referral co-ordinators managed the beds and co-ordinated admissions and discharges. Previously these tasks had been carried out by senior registered nurses. All nurses we spoke to told us that the unit referral had freed them to be able to spend more time on direct patient care. The ward managers and modern matron told us that the unit referral co-ordinators, who were not as senior as registered nurses, were able to do a better job of managing referrals and discharges because they were able to dedicate their time to the role. Nurses on shift had to juggle the tasks with many other competing demands on their time. The support time recovery workers worked Monday to Friday 9am to 5pm and their role was to facilitate patient activities and patient leave. The support time recovery workers were not part of the ward's nursing staff numbers. Patients and staff told us that activities and

Are services effective?

Good

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

patient leave were rarely cancelled due to staff numbers because the support time recovery workers provided so much of the workforce that assisted patients to access the community and to take formal leave.

- Staff told us that the provider prioritised providing training to staff. Staff members told us that they were supported and encouraged to attend specialist training. We saw training records which confirmed that nurses had received CBT and DBT training. There were two mental health nurses who were trained as tissue viability nurses. Nurses received specialist training in working with people with eating disorders and in working with people with a learning disability. One of the ward managers had completed her nurse prescriber training. In the occupational therapy team 90% of the staff were trained in solution focused therapy and 50% were trained in compassion based therapy.
- All managers had leadership training and completed a leadership module at Plymouth University.
- We reviewed seven staff files. Records were up to date. Line management meetings and personal development needs were recorded in all of the seven files.
- All staff had received an appraisal in the last 12 months.
- All staff had attended the organisation's induction and had also received a local induction to the Glenbourne Unit.
- We saw in the staff files that poor performance was addressed promptly and that the ward managers followed the organisation's capability and performance management policies. We also saw that the ward managers followed the organisation's sickness and attendance policies. Managers and supervisors recorded discussions with staff regarding their attendance and referred staff to occupational health services or other specialist support services if needed.

Multi-disciplinary and inter-agency team work

- Multidisciplinary meetings took place every day. These included doctors, nurses, assistant practitioners, social workers, psychologists, occupational therapists and pharmacists.
- We observed two handover meetings, one on each ward, both of which were very effective. The handover meetings included a thorough handover of patients' needs and risks. Staff demonstrated they had a good working knowledge of each of their patients. The nurse leading the handover gave full information on patients who were newly admitted including their care plans and risks. The receiving nurse recorded the handover. Communication alerts were discussed.
- Care co-ordinators and community mental health team members were routinely invited to care programme approach meetings.
- The ward staff felt they had very good relationships with the community mental health teams and the eating disorder service.

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

- Mental Health Act records were in very good order. Detention paperwork reviewed during the inspection was complete and accessible. Section 17 leave records were detailed, thorough and patients were given copies of their leave records. Treatment authorisation forms were up to date, correctly completed and copies were kept with the patients' medication charts. One patient had been prescribed antipsychotic medication in excess of the dose authorised on the patient's treatment authorisation forms. The patient had not been given the antipsychotic medication. The error was corrected as soon as we raised the issue to ward staff.
- All of the nine treatment records we reviewed contained evidence that both detained and informal patients had been informed of their rights. The patients we spoke with confirmed to us that they had been told of their rights on admission, and at other points during their treatment when their treatment had changed or if their detention status had altered. The detention status for a patient changes if they had been formally detained under the Mental Health Act on admission and then become an informal (voluntary) patient during their treatment; if a patient is admitted as an informal patient and is detained during their treatment; or if the details of their detention change. For example, when a patient's detention under the Mental Health Act is changed from section two to section three of the Act.
- Both wards had noticeboards containing details of the independent mental health advocacy service. Leaflets were available for patients informing them of how to contact the advocates who visited the ward.
- Training in the Mental Health Act was not considered to be mandatory training and the service could not provide us with figures for how many of their staff had completed Mental Health Act training. However, every

Are services effective?

Good

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

staff member we spoke with told us they had received training. There was a certificate of completion of Mental Health Act training in each of the seven staff files we reviewed.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act was not considered to be mandatory training and the service could not provide us with figures for how many of their staff had completed Mental Capacity Act training. All of the staff members we spoke with told us they had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We reviewed seven staff records, all of which contained confirmation that the staff members had attended Mental Capacity Act and DoLS training.
- All members of the nursing staff we spoke with could tell us the principles which underpin the Mental Capacity Act. Every nurse could either give us examples of when they had used Mental Capacity Act best interests decision making themselves or of individual decisions that had been made on behalf of patients following the Mental Capacity Act guidance and Code of Practice.
- One patient record we reviewed showed a very detailed record of best interests decision making. The multidisciplinary team had recorded why they believed the patient lacked capacity to make a specific decision. The doctor had recorded a detailed decision-specific assessment of the patient's capacity to make the decision. Family members had been consulted and an advocate had worked with the patient. The formal best interests multidisciplinary meetings were recorded clearly and in accordance with the Mental Capacity Act Code of Practice guidance.
- There had been one DoLS application at the Glenbourne Unit in the 12 months prior to our inspection. This application was subsequently withdrawn when the patient's mental health deteriorated and the patient was formally detained under the Mental Health Act.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed discreet and respectful staff interactions with patients. Staff respected the privacy and dignity of patients and responded to both their physical and emotional needs. For example, a new patient had been admitted to Bridford ward who did not have any toiletries with her. The patient was distressed because she wanted to take a shower. A nurse quickly reassured her that the ward had basic toiletry packs for patients who needed them and the patient could take a shower and clean her teeth. The nurse gently, verbally persuaded the patient to go to her room and then took a toiletry pack to the patient. The patient returned to the patient lounge a little while later looking visibly calmer after having had a shower. We also saw two interactions between staff and patients involving a patient who had become loud and verbally aggressive. Staff calmed the upset patient whilst being firm that they needed to stop shouting. The patient agreed to go to the quiet room and staff went with them but no physical restraint was used, only verbal de-escalation. Other staff members spoke with all the other patients on the ward at the time to check they were all right and to support them if they were upset by the shouting.
- All of the patients we spoke with were extremely positive and complimentary about the support they received from the ward staff. Patients described staff as "guardian angels", "five star" and "wonderful". One patient told us that the staff had helped them to want to live again.
- In the staff handovers we observed staff demonstrated a thorough knowledge of patients' needs.
- Care plans documented detailed assessments of both the emotional and physical needs of patients and documented patients' wishes and feelings about their treatment.
- The 2015 mental health inpatient survey had rated nurses at the Glenbourne Unit highest in the country for treating patients with dignity and respect.

The involvement of people in the care that they receive

- All patients received a welcome pack to the ward which gave them basic information about the ward. They were also given a tour of the ward.
- Patients were routinely invited to attend their weekly review with their doctor and other members of the multidisciplinary team. The patients' views and input to the meeting were recorded in the meeting notes. The notes indicated that the multidisciplinary team listened to patients' views and responded to them. Patients were encouraged to ask for support from an advocate or from a friend or family member if they wished to do so.
- Patients were routinely given copies of their care plans. Patients' views were respectfully recorded in the care plans. Where patients did not agree with their treatment plans, this was recorded sensitively but clearly. The clinical teams had made amendments to treatment plans in response to patients' requests. For example, one patient had asked for their antipsychotic medication to be reduced. The patient's records showed that the multidisciplinary team had discussed the request and the doctor had talked to the patient. It was agreed that the medication would be reduced, but at a more gradual rate than the patient had originally requested. The patient consented to the amended treatment plan.
- Patients and members of the Plymouth improvement and participation service had been very involved in the refurbishment of the Glenbourne Unit. Patient groups had been part of the team that planned the changes from the start of the project. In addition, on one day the staff had asked suppliers to set up displays of fabrics, flooring materials and sample furniture ranges for the patients to view. Patients gave their comments and views on the choices available and were fully involved in the decisions that were made about the appearance of the new wards.
- Patients took part in patient satisfaction surveys during their stay at the Glenbourne Unit.
- Patients and members of the Plymouth improvement and participation service were included in staff interview panels.
- The Glenbourne Unit had a monthly carers' group meeting. They also set up a working group for carers regarding the triangle of care – a working model of how to involve carers as an integral part of patients' care.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Bridford ward had an average bed occupancy rate of 85% which indicates that patients in the Plymouth area could access beds when they needed to do so and patients were only placed out of area in exceptional circumstances. Harford ward had an average bed occupancy rate of 97% which indicates that there were potential occasions when male patients in the Plymouth area would not be able to access a bed on Harford ward and may have to be admitted to a service much further from their home.
- Bridford ward had 22 beds and five of them were available for patients outside of the local area because there was insufficient need within the Plymouth area for 22 female acute mental health beds. After the refurbishment, the new Bridford ward was due to reduce to 19 beds.
- Harford ward had 19 beds following its refurbishment. It had previously had 22 beds. The reduction in beds had impacted on the service's ability to respond to demand for male acute mental health beds. On the day of our inspection the ward was full and one patient was due to return from leave. Fortunately one patient was discharged that day so that there was a bed available for the patient returning from leave.
- The wards worked hard to stay in touch with patients who had been admitted to wards out of area and tried to return them to the Glenbourne Unit. Eight patients in the previous 12 months had been referred to out of area acute admission services. However, 21 patients had been referred out of area to psychiatric intensive care units. The organisation did not provide any psychiatric intensive care units and there was no psychiatric intensive care unit in Devon.
- Bridford ward had 14 delayed discharges in the six months prior to our inspection. Harford ward had eight delayed discharges in the six months prior to our inspection. Most of the delays were caused by delays in putting together support packages for patients who needed additional support from external providers to return home or to move to more suitable accommodation. There were no delayed discharges waiting for occupational therapy assessments because all assessments were carried out by the Glenbourne Unit occupational therapy department.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had clinic rooms, quiet rooms, lounges and interview rooms. Harford ward had a wider range of rooms available for staff to meet privately with patients because these had been specified as required in the refurbishment process.
- The Glenbourne Unit had a dedicated occupational therapy department which had a range of craft rooms, an art therapy room, a therapy kitchen and a recreational activity room used for groups and activities such as yoga, music therapy, table tennis and relaxation groups. The occupational therapy department ran formal sessions six days per week. However, some of the activities provided, such as the onsite gym, were available for patients to access on a Sunday, subject to risk assessment and were supervised by nursing staff.
- Patients on both wards could use their mobile phones, subject to risk assessment, or could use the patient telephone. The patient telephones were sited in quiet alcoves off the main lounge area.
- During the building work most of the garden area had been fenced off for safety reasons. A small patio area with a smoking shelter was still available for patient use despite the building work. We saw that the gardens were being replanted and turfed whilst we were on site. Each ward was due to have its own outside space once the building work was completed.
- The patients on Harford ward all had single rooms. However on Bridford ward there were three four-bed dormitories. Each person had their own space and furniture. Curtains separated the bays. None of the patients we spoke with who had beds in the dormitories told us they were concerned about sleeping in dormitories. One patient told us they did not want the ward to move completely to single rooms. Once the ward moved into its new ward environment all patients would have single rooms.
- All of the patients who spoke to us about the food told us it was high quality. The Glenbourne Unit had a food hygiene rating of five, which is the highest rating.
- Patients had access to hot and cold drinks and snacks throughout the day and at night. Patients who were able to leave the wards could use the café which sold snacks, sandwiches, light meals and a range of hot and cold drinks.

Are services responsive to people's needs?

Good

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

- Patients were able to personalise their bedrooms and we saw art works on bedroom walls and photographs of patients' family members, friends and pets in their rooms.
- The rooms in Harford ward had lockable cupboards designed into the rooms. On Bridford ward each patient had a locker available to them on the ward.

Meeting the needs of all people who use the service

- Harford ward had been designed to be suitable for people who required disabled access. The ward was on a single level, all doorways were wide enough to take wheelchairs, one of the patient bedrooms had been designed to be more suitable for a patient with mobility issues and it had a purpose built accessible bathroom. Bridford ward was not as suitable for people who required disabled access. It had an accessible bathroom but doorways and corridors had not been designed for disabled access. The new ward that Bridford was due to move to was of the same specification as Harford ward.
- The occupational therapy department provided therapy for physical health care needs. The department had a stock of equipment such as mobility aids, adjustable beds, shower chairs and pressure relief cushions.
- The occupational therapy department held a daily planning meeting. They had a weekly timetable of planned activities but also provided one to one therapy on the wards for patients unable to visit the occupational therapy department. They liaised with the nursing teams daily and attended all multidisciplinary meetings in order to understand and respond to the needs of the patient group.
- Information leaflets were available on the wards regarding treatments, medications and patients' rights. The ward staff had access to an interpreting and translation service for patients who needed to use it.
- Posters on the wards informed patients how to complain or comment on the service.
- The wards had a mix of male and female staff members. Every ward ensured there was always a member of staff on shift who was the same sex as the patients. This enabled patients to have staff who were the same sex as themselves to assist them with personal care needs, if necessary. The majority of staff members on the female ward were female. Harford ward, the male ward, had close to 50% male staff.
- The occupational therapy department also had a mix of male and female staff. The occupational therapy team had seen increased numbers of male patients participate in occupational therapy activities since the wards had moved to single sex accommodation in the previous six months.
- Patients had a choice of cooked meals for lunch and evening meal. There was also a choice of breakfast options and snacks throughout the day. The patients who were receiving treatment for eating disorders had a managed eating plan. Various options of food were available to cater for religious, cultural or physical health dietary requirements.
- The Glenbourne Unit had a dedicated spiritual room. Patients could use the room throughout the day for prayers or quiet time. Faith leaders from different faiths also held services in the spiritual room. Patients were supported and encouraged to attend their regular religious services in the community.
- We inspected the Glenbourne Unit on the day of the European Union referendum. The unit had ensured there were sufficient staff during the day to enable patients to vote in person at their local polling station if they were well enough to do so. The unit had three cars in use all day to transport patients to their local areas to vote. We observed staff encouraging patients to participate in the referendum.

Listening to and learning from concerns and complaints

- Information for patients about how to complain or raise concerns was available throughout the Glenbourne Unit. In the notes of ward community meetings we saw that individual and group concerns were recorded and staff ensured they were answered at the following meeting. For examples, requests to change the food menu were responded to and patients were informed of changes to menus in response to their requests.
- Staff discussed outcomes of complaints investigations at team meetings and in supervision meetings. There were also formal written communications which detailed complaints information and learning that were produced centrally. The monthly carers group had been set up in response to complaints from carers.
- There were 17 formal complaints made to the Glenbourne Unit in the 12 months before our inspection, of which seven were upheld. No complaints were referred to the Ombudsman. We spoke with the

Are services responsive to people's needs?

Good

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

modern matron about the complaints and saw complaints responses. All complaints had been fully investigated and responded to. The numbers of complaints had reduced from the previous 12 month period. The modern matron believed this was due to a reduction in complaints from carers since they had introduced the triangle of care.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and values

- The provider's vision was to work together with others to help the local population to stay physically and mentally well, to get better when they were ill and to remain as independent as they can until the end of their lives. It had developed five aims to support its vision:

1. Based around local people and communities;
2. Providing seamless system leadership;
3. Experience exceeds expectation;
4. Sustainable, successful and admired;
5. A recognisable employee-led organisation.

- The staff in the Glenbourne Unit supported the organisation's vision and aims. They had developed local objectives that sat under each of the five aims. Staff spoke very positively about the responsiveness of the organisation to employee concerns and requests. Most staff members had previously worked for larger NHS organisations. They told us how pleased they were that the provider listened to staff ideas and could make changes and improvements relatively quickly.
- Every member of staff told us they knew who the chief executive was. He had visited the wards the week before our inspection because he was the on call senior manager and had responded to an issue out of hours. Staff members told us the chief executive visited the wards quite often. Many staff members said the chief executive visited the wards on Christmas Day and spoke with patients and staff. The modern matron was based at the Glenbourne Unit and was therefore well known to all staff and patients.

Good governance

- The Glenbourne Unit was well run. The senior management team worked well together and prioritised patient care. The ward managers, modern matron, head of occupational therapy and consultant psychiatrist met regularly and shared a passion for improving services for patients.
- Ward systems were effective in ensuring that staff received mandatory training, were appraised and supervised. The ward managers kept very good local staff records and ensured that organisational systems and processes were followed at ward level.
- The staff structure was innovative and aimed to ensure that staff could maximise shift-time on direct care activities. The support time recovery worker role and unit referral co-ordinators freed up nurses to focus on delivering care and treatment. They also improved the patient experience and responsiveness of the service for patients and funders.
- Staff participated in clinical audit. For example, the national audit of schizophrenia and the national audit of psychological therapies.
- The management team ensured that incidents were reported and learning was shared from incidents, complaints and patient feedback. Safeguarding, Mental Health Act and Mental Capacity Act procedures were followed.
- The teams had key performance indicators and reviewed their progress regularly. The ward managers met with the modern matron monthly to review all of their targets and key performance indicators.
- The ward managers told us they felt well supported by the modern matron and the organisation to do their jobs. They said they felt empowered to take decisions that were in the best interests of their service.

Leadership, morale and staff engagement

- All staff we spoke with talked passionately and enthusiastically about the organisation, the management team at the Glenbourne Unit and the provider's senior management team.
- Staff told us they felt well supported and they could raise concerns without fear of victimisation. Many staff members told us they felt they had opportunities to develop skills and to influence service improvement. They said the ward managers encouraged their ideas. Throughout the team, staff were encouraged to take on greater responsibilities and to participate in additional training and development opportunities. For example, all registered nurses were given a specific area of responsibility such as checking that incidents were reported promptly and that care plans were updated regularly.

Are services well-led?

Outstanding ☆

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

Commitment to quality improvement and innovation

- Bridford and Harford wards were accredited under the accreditation for inpatient mental health services (AIMS) scheme. Bridford ward was overdue for peer review because it had been postponed due to the building work.