Requires improvement

Devon Partnership NHS Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWV55	Torbay Hospital	Beech Unit	TQ2 7AA
RWV98	Franklyn Hospital	Belvedere ward	EX2 9HS
RWV12	North Devon District Hospital	Meadow View	EX31 4JB
RWV98	Franklyn Hospital	Rougemont ward	EX2 9HS

This report describes our judgement of the quality of care provided within this core service by Devon Partnership NHS Trust. 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 Devon Partnership NHS Trust and these are brought together to inform our overall judgement of Devon Partnership NHS Trust.

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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act / 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 wards for older people with mental health problems as requires improvement because:

- Ligatures cutters were not accessible on all wards.
- Wards were not fully complying with same sex accommodation guidance to ensure that there was gender separation and privacy.
- The extra care area was used for seclusion and segregation on Rougemont and Belvedere wards. This did not fully comply with seclusion and segregation Mental Health Act (MHA) code of practice.
- Extra care facilities at Franklyn hospital were not included in the designated areas for seclusion, identified in the seclusion and segregation policy.
- Seclusion facilities were not safely accessible for Beech ward patients.
- Medical equipment was not always regularly checked in accordance with trust policy and guidelines.
- There were times when patient's personal information displayed on white boards was not fully protected.
- Treatment escalation plans (TEPs) were not fully completed.
- Leave authorisation forms for detained patients did not always clearly define the conditions of leave and did not contain specific leave risk assessments.
- At least two staff on each ward did not demonstrate a clear understanding of the Mental Capacity Act (MCA), although additional training for staff was in place at the time of our visit.
- Independent mental health advocates (IMHA) arrangements were not in place for some patients and independent mental capacity advocate (IMCA) arrangements were not always clear.
- There were pressures on beds caused by high demand and delayed discharges. The pressure on beds meant that beds were not always available for patients on return from leave.

However:

- All the wards were clean and bright and well maintained with pleasant courtyards and gardens, with most wards providing dedicated areas to support treatment, care and activity.
- There was a dementia friendly environment including sensory garden and portable sensory equipment in use on Belvedere ward.
- The trust had highlighted staffing as a risk in older people's services and were actively monitoring staffing and recruiting new staff. Wards were mainly staffed as per the agreed establishment and the number of estimated nurses matched the actual numbers that were working.
- The trust had highlighted delayed discharges as a risk and was actively monitoring. There was a discharge coordinator and a part time social worker on the ward with the most delays in discharge.
- The trust used NHS professionals as temporary staffing whenever possible as they were familiar with the wards and included in staff training.
- Risk assessments, physical and mental health monitoring and investigations followed a clear system and were up to date. Assessment of needs and planning of care was comprehensive.
- All the staff we spoke with were caring and committed.
- Patients and carers told us that staff were respectful, responsive and kind.
- There was participation in ward community meetings and patients were able to get involved in decisions about their service and give feedback.
- There was a commitment to improving the quality of food and staff worked with the catering teams and dieticians to ensure this.
- Staff were regularly appraised and supervised and were up to date with mandatory training.
- The senior management team were visible and approachable and staff were familiar with the trust's visions and values.
- There was evidence of good practice for example, the older person's team had been shortlisted for a nursing times award for their successful falls reduction programme.

Summary of findings

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

Are services safe?

Requires improvement

We rated "safe" as **requires improvement** because:

- Ligature cutters were not easily accessible on all wards. On Belvedere ward ligature cutters were not immediately accessible and a number of items had to be removed from the emergency 'grab bag' before cutters could be located.
- Beech ward did not have female only day space available at all times and there was not always gender separation in sleeping areas on some wards. However, bedrooms had en suite bathroom facilities and alternatives were discussed with patients when they could not access the female only day space.
- Monitoring and checks of equipment were not always systematic and maintenance checks had not always been completed in a timely way.
- There was a lack of medical equipment such as air mattresses and a lack of storage space so that beds were stored in corridors or multipurpose rooms.
- The extra care area at Franklyn house used for seclusion and segregation did not meet the MHA code of practice guidelines and was not listed in the trust policy as one of the identified sites for seclusion and segregation.
- There was one example of a segregation record that was not in line with the MHA code of practice guidelines or the trust policy on seclusion and segregation which requires staff to keep detailed and contemporaneous clinical records.
- When Beech ward patients needed to use the seclusion and segregation facilities they could not access the shared seclusion facilities on the adult acute ward in a safe way.
- Staffing vacancy rates were high particularly on Belvedere and Meadow view where there was a high use of bank and agency staff.
- There had been nine changes in locum consultant cover on Meadow view over the last two years and gaps in psychology support across the service.
- Rapid tranquilisation was not always written up according to individual clinical need.

However;

- Wards were clean and bright and well maintained with pleasant courtyards and gardens. Patient led assessments of the care environment (PLACE) scores for cleanliness were high across all older people's wards.

Summary of findings

- There was a dementia friendly environment including sensory garden and portable sensory equipment in use on Belvedere ward and PLACE scores were high for facilities.
- There were some good practices to mitigate ligature risk across the service, including ligature free en suite shower facilities and modified bins with no liners.
- Staff carried out regular audits such as ligature audits, infection control and hand washing.
- Wards were mainly staffed as per the agreed establishment and the number of estimated nurses matched the actual numbers that were working.
- Staff regularly updated risk assessments of individual patients.
- Staff were up to date with their mandatory training.

Are services effective?

Requires improvement

We rated "effective" as **requires improvement** because:

- Treatment Escalation Plans (TEPS) for patients on Belvedere ward were not individual and were written in a blanket way. This did not clearly set out how the decision-making process regarding the person's capacity was made.
- The wards did not always have the appropriate skill mix as they were still recruiting to some posts such as nursing and psychology. The locum consultants on Meadow view changed frequently. Recruitment for a permanent consultant was in progress at the time of our inspection.
- Leave authorisation forms did not always clearly define the conditions of leave and did not contain specific leave risk assessments.
- Patients who were mentally frail were not routinely offered services from an independent mental health advocate (IMHA) on Belvedere ward and staff on Meadow view wards were not always clear as to how and when to arrange independent mental capacity advocate (IMCA) support.
- Staff did not always demonstrate a clear understanding of the Mental Capacity Act.

However;

- Assessments were comprehensive and physical health monitoring was embedded across the older peoples inpatient services.
- All records showed evidence of multi-disciplinary review. Patients were actively involved in meetings such as 'planning your recovery' meetings on Beech ward.
- Detention paperwork was up to date and stored securely. However, this was only available electronically.

Summary of findings

- There were arrangements in place to monitor adherence to the Mental Capacity Act.
- Deprivation of Liberty Safeguards applications were made when required. However, applications were not being processed in a timely manner by the supervisory body.

Are services caring?

Good

We rated "caring" as **good** because:

- We observed that staff were caring towards patients and treated patients in a respectful way. Patients and carers told us staff were very caring, compassionate and supportive.
- During the short observational framework for inspection (SOFI) observation the majority of staff showed genuine warmth toward patients and they displayed respectful attitudes. We saw one staff member speak to a patient in a sharp way. The ward manager dealt with this immediately.
- Each of the wards were calm even though they were busy and full. We saw staff stop, speak to, and answer people in a calm way at a pace that suited the individual.
- We saw that staff were discreet and respectful with personal care needs and could explain clearly how to care for people with dignity.
- There was some patient and carer involvement and participation in care planning and risk assessments which was evidenced in care plans.
- We observed patients participating in the ward community meetings. They got involved in decisions about the service and gave feedback. For example, on Beech ward and Rougemont patients asked for more nutritious snacks.

However;

- There was limited recording of patients' views in their own words, particularly on Belvedere ward.
- Staff were not always familiar with the support that could be available to carers.
- Some carers were not aware of the support available to them and one carer told us that they would like to see their relative and be involved, but could not afford to as they lived too far away.

Are services responsive to people's needs?

Good

We rated "responsive" as **good** because:

Summary of findings

- There was a commitment to ensuring patients had nutritious food and access to hot drinks and snacks and there was access to hot drinks and snacks at all times.
- Ward staff and the dietician ensured that there were additional nutritious choices and snacks to meet individual dietary needs and requirements of religious and ethnic groups. Ward and catering staff met regularly to improve the quality and standard of the food.
- Most wards had the full range of rooms and equipment to support treatment and care. For example, each ward had well designed courtyards providing open access to outside space.
- There were high PLACE scores for facilities where Franklyn hospital had the highest rating in older people's services with a rating of 98% for facilities.
- There was a discharge coordinator and a part time social worker to support discharges from Belvedere ward which had the highest number of delayed discharges.
- There was a range of useful information displayed in recovery areas and notices boards.
- Compliments, such as thank you cards were displayed and there were 21 compliments recorded between January and June, with 11 of these from Beech ward.

However;

- Bed occupancy was high across all wards and as a result beds were not always available when needed for patients living in the 'catchment area.' On each ward there were patients who were out of the catchment area.
- Bed pressures had resulted in patients transfers between wards during an admission episode and we found one example where there was no access to a bed on return from leave due to the high demand on inpatient beds.
- At times patients could not be discharged because of non-clinical issues. Delayed discharges was identified as one of the top five risks for older people's in-patient services and discharge was often delayed because of a shortage of suitable placements and meeting the requirements of the local authority funding panels.
- Two carers we spoke to did not know how the complaints process worked and had not contacted the ward when they had concerns.

Are services well-led?

Good

We rated "well-led" as **good** because:

Summary of findings

- Staff were aware of the trust's vision and aims and each ward had recently displayed the refreshed trust vision and values 'daisy' poster. There was a commitment to the trust's vision to provide care, treatment and support which was 'good enough for my family.'
- There had been recent senior management staff changes and staff reported that the new senior management team were approachable and friendly.
- There had been regular and recent visits to the all the older people wards by the executive team and staff were positive about this.
- Incidents were reported with examples of sharing and learning through root cause analysis. For example, action by the Rougemont ward team to reduce falls had been successfully rolled out to all older peoples in patient services resulting in embedded falls prevention.
- Belvedere ward had been shortlisted for a nursing times award for their falls prevention work.
- There were some good ward designs, such as the 'dementia friendly' environment on Belvedere ward, where staff had been proactive in applying for additional funding to improve the quality of the environment for patients.

However:

- Ward staff reported variable access to senior management with unfilled vacancies in senior management on Beech ward at the Torbay hospital site.
- There were some key risks that were identified on the trust's risk register that were affecting staff morale, such as, work related stress exacerbated by staffing vacancies and bed pressures.
- The pressure on beds meant that managers accepted admissions that did not meet the referral criteria in the operational policies.

Summary of findings

Information about the service

The older people's inpatient service had four older people's wards across Devon. The service had been reconfigured in 2011 to provide assessment and treatment for older people with severe mental health needs, such as depression, anxiety and psychosis. One ward was based at Franklyn hospital in Exeter, one at Torbay hospital in Torquay and one at North Devon district hospital in Barnstaple. In addition there was a county wide unit for the assessment and care of people with complex care and dementia based in Exeter.

Belvedere ward was a 16 bedded complex care and dementia mixed sex ward for older people. It was based at Franklyn Hospital in Exeter and shared the building and some facilities with Rougemont ward, such as the activities room and the family room.

Rougemont ward was a 16 bedded ward for older people with functional mental health problems such as depression, anxiety and psychosis.

Meadow view was a 13 bedded unit for older people with functional mental health problems and was based at North Devon District Hospital on the same site as two adult mental health wards, Ocean view and Moorland view.

Beech ward was a 14 bedded unit for older people with functional mental health problems and was based at Torbay Hospital on the psychiatric services site with Haytor ward.

Each ward had undergone extensive refurbishment in 2011 and had purpose built courtyard areas and attractive gardens. Further improvements were initiated by staff on Belvedere who had been successful in obtaining finance from Kings Fund Healing Environments in 2011 to create a dementia friendly environment on the ward. In 2014 the ward obtained Prime Ministers Dementia Challenge Funding for a sensory garden on the dementia unit**.** The ward had been imaginatively decorated with furnishings and fixtures designed to provide a therapeutic environment, such as a snug which was decorated and furnished like a small cottage living room and several lounges and seating areas, including a female lounge which had access to its own courtyard garden.

During the year, the trust extended their older peoples ward's admission criteria to include adults who were aged 50 and over who needed specialist expertise from older people services.

Beech ward had been inspected in February 2014 as part of an inspection of mental health inpatient services at Torbay Hospital. Compliance actions were not directly associated with the older people's inpatient service, although the use and suitability of the seclusion room, which was a shared facility with the working age adult inpatient service, was included in the regulatory action.

Our inspection team

The comprehensive inspection was led by:

Chair: Caroline Donovan, chief executive, North Staffordshire Combined Healthcare NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Team Leader: Michelle McLeavy, inspection manager, Care Quality Commission

The team who inspected Devon Partnership NHS Trust wards for older people with mental health problems included one CQC inspector, a Mental Health Act reviewer, three nurses, a pharmacist, and one expert by experience (people with experience of using services).

Summary of findings

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, asked a range of other organisations for information and sought feedback from patients at local groups e.g. Be Involved Devon and local Healthwatch and circulated comment cards around the trust for people to comment on the services they had received.

During the inspection visit, the inspection team:

- Visited all four of the wards at the three hospital sites and revisited two wards on a second day as part of a separate Mental Health Act (MHA) monitoring visit.
- Looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 14 patients who were using the service.
- Spoke to eight relatives or carers of patients on the phone or in person.
- Observed care on each ward.
- Observed care using the short observational framework for inspection (SOFI) tool on the dementia unit.
- Observed a community meeting on Beech ward and Meadow view.
- Spoke with the managers for each of the wards.
- Spoke with 30 other staff members; including doctors, nurses, dietician, catering manager, pharmacists and occupational therapists.
- Observed one handover meeting and two multi-disciplinary meetings.
- Looked at 35 care records including risk assessments and care plans of patients using the service.
- Carried out a check of the medication management on each of the wards including a review of 29 prescription records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Carried out Mental Health Act (MHA) monitoring visits on Belvedere and Beech wards.

What people who use the provider's services say

During our visit we spoke with a total of 14 patients and eight relatives on the phone or in person. We also observed two community meetings on Meadow view and Beech ward.

Patients and relatives or carers spoke positively about the staff and felt supported by the multi-disciplinary teams on each ward. Patients who were able to speak with us told us that staff were friendly, efficient, polite and attentive. Relatives described staff as caring and six out of the eight felt involved in the care of their relative.

However, some carers described difficulties with transport and the travelling distance to older people's wards, particularly when patients were staying at Belvedere which was the only ward in the county for people with dementia. Two carers commented that they could not visit their relatives as often as they wanted to or be as involved in their relatives care as they wanted to be because of the distance and the cost of travel.

Summary of findings

There were 21 compliments recorded as being received for older peoples' inpatient services in relation to patient care between January and June 2015. The most were received for Beech ward where they had received eleven compliments.

There were systems in place to encourage patients and their relatives to comment on the ward experience.

Information on how to contact the ward manager to comment on any aspect of the service was clearly displayed on Beech ward. Rougemont ward displayed detailed feedback of comments from patients and relatives post discharge.

Good practice

Staff had been successful in obtaining Kings Fund healing environments funding in 2011 to create a dementia friendly environment at Belvedere and the Prime Ministers' dementia fund in 2014 for a sensory garden on the dementia unit**.**

There was a trust wide initiative to remove plastic bags, in conjunction with the infection control team and a regular 'plastic bag sweep' took place each day.

The interactive white board on Beech ward supported patient care with a traffic light rating touch screen for each patient to enable staff to provide more responsive and effective care. This was an easy to read board with checks, such as physical observations reminders. When not in use the screen timed out so that information was not visible. This was the only interactive white board in mental health hospitals in the country and would link directly to the care records system that the trust was implementing during August.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that secluded or segregated patients are monitored in line with the trust seclusion policy and MHA Code of practice guidelines.
- The trust must ensure that all seclusion and segregation facilities meet the MHA code of practice guidelines and include Franklyn house within the seclusion and segregation policy as an area with a room for segregation and seclusion.
- The trust must ensure that ligature cutters and emergency equipment are always accessible.
- The trust must ensure that monitoring and checks of medical equipment follow a systematic plan.
- The trust must ensure that alarm and nurse call systems are regularly checked to ensure they are charged and fit for purpose.
- The trust must ensure all Treatment Escalation Plans (TEPs) are completed in full.

Action the provider SHOULD take to improve

- The trust should ensure they are meeting same sex accommodation guidelines at all times.
- The trust should ensure maintenance arrangements with South Devon Healthcare are reviewed to ensure that prompt safety checks are undertaken.
- The trust should ensure that information on white boards in ward offices are not visible to patients or ward visitors.
- The trust should ensure rapid tranquilisation is written up according to clinical need and kept under regular review.
- The trust should ensure carers are aware of available carers support.
- The trust should ensure IMCA arrangements are robust and accessible.
- The trust should review inpatient services for older people and community services to ensure that people under 65 who need older people's community services can have the same access as people over 65.
- The trust should gather and monitor evidence about the impact of bed management practices and consider leave arrangements and access for visiting carers and relatives.

Devon Partnership NHS Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Beech unit	Torbay hospital
Belvedere ward	Franklyn hospital
Meadow view	North Devon district hospital
Rougemont ward	Franklyn hospital

Mental Health Act responsibilities

- We carried out Mental Health Act (MHA) monitoring visits on Belvedere and Beech wards which will be reported separately.
- Mental Health Act training and the MHA code of practice was not part of the mandatory training programme for trust staff. Ward doctors had received some additional training on the new code of practice, but most nursing staff told us that they had not received this. The ward manager for Rougemont contacted the Mental Health Act office and a date was set for additional training on the revised code of practice for Belvedere and Rougemont staff.
- Administrative support and legal advice on implementation of the MHA was accessible and sailable. Staff on each ward described receiving good support from the mental health act offices to support them in their adherence to the MHA and MHA Code of practice.
- We reviewed ten capacity assessments and consent to treatment records on Belvedere and Beech wards. Records had been fully completed and updated regularly for all detained patients on Belvedere and Beech wards. These records were in line with MHA code of practice guidelines.
- We observed a ward round meeting on Rougemont ward for a detained patient and a 'planning my

recovery' meeting on Beech ward. Staff were knowledgeable and clear in ensuring that patients' rights were clearly explained and patients were given sufficient time to express their views.

- On Belvedere and Beech ward a report by an approved mental health professional (AMHP) had been completed on RiO for records we reviewed. All ten admission documents we reviewed were available and in order.
- Records confirmed that patients were presented with their rights verbally on both wards. However, on Belvedere ward we could not find any evidence recorded on RiO in four out of five detained patients' records that their rights under section 132 of the Mental Health Act had been presented in writing on admission and re-presented in line with MHA code of practice guidance. Staff told us that this information could be provided easily but on Belvedere ward where most of the detained patients were mentally frail. We did not see any evidence that information was available or had been presented to patients in a more accessible format. Hospital managers have a statutory duty to ensure that rights under section 132 are presented both orally and in writing.
- Detention patient work was up to date and stored securely on electronic records on both wards. However, leave authorisation forms did not always clearly define the parameters and conditions of leave and we could not find any record of specific leave risk assessments. This did not comply with MHA code of practice guidelines on the recording of leave.
- There were regular audits to ensure that the MHA was being applied correctly. There was evidence of learning from these audits such as the revised seclusion and segregation policy which included recommendations from MHA internal audits.
- There was access to an independent mental health advocacy service (IMHA) on most wards. On Beech ward and Meadow view, the managers explained that visits took place as needed and information was displayed. Patients on Rougemont received a weekly visit from an IMHA service but the manager explained that this did not routinely take place on Belvedere. IMHA information was only available in the shared area outside the wards to Rougemont and Belvedere so was not easily accessible to patients on Belvedere as the route to the shared area was locked.
- Five staff we spoke with were not clear how to access and support engagement with the IMHA service, particularly for patients on Belvedere ward and Meadow view. This was supported by our review of records which found no evidence that patients had been informed of their right to have support from the IMHA service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were trained and were up to date with e-learning on the Mental Capacity Act with completion rates of 100% across all four wards. Staff also received additional face to face training on the Mental Capacity Act and the five statutory principles. During our inspection we saw that additional training was taking place for staff on Belvedere and Rougemont wards. There was also a policy on the MCA including deprivation of liberty safeguards (DoLS) which staff were aware of and could refer to. Despite this, understanding of the principles of the MCA and consent was variable across all the wards. Four staff we spoke to showed a clear understanding of the MCA 2005, in particular the five statutory principles, but others were less clear and there were two staff on each ward who could not demonstrate a basic understanding of the MCA.
- We reviewed 23 treatment escalation plans (TEPs) on Belvedere and Beech wards and found that there were gaps in recording, particularly in relation to consent and capacity. Only six TEPs were completed in full. Plans were not always individual and had not clearly set out decision-making process regarding the patient's capacity. Most forms did not include whether an advance decision was completed. There was also insufficient evidence on the forms to indicate that patients, carers and family members were fully consulted.
- There were no regular visits from independent mental capacity advocacy (IMCA) services and staff and patients needed to request this through the IMHA services. Two staff we spoke with on each ward were not aware of the arrangements to contact the IMCA services.

- However, staff knew where to get advice regarding the MCA and DoLS within the trust and all reported good relationships with the Mental Health Act offices that monitored adherence to the MCA and provided support and advice for staff.
- DoLS applications were made when required. There were 16 DoLS applications made in the six months between November 2014 and May 2015. These were highest on Belvedere ward with 13 applications and the remaining three were applications from Rougemont ward.
- However, DoLS applications were not being processed in a timely manner by the supervisory body. We were told that patients were usually discharged before the assessment was made. We saw a copy of a letter from the local authority stating that there was a huge backlog and that they would be unable to involve a DoLS assessor for a considerable period of time.

Requires improvement

Are services safe?

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

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Safe and clean environment

- All ward areas were clean, had good furnishings and were well-maintained. There were weekly cleaning audits and daily checks across all older peoples inpatient wards. This was supported by high PLACE (patient led assessments of the care environment) scores for cleanliness where all older people's wards achieved a score of over 99% for the period between January to June 2014, published in August 2015.
- Staff adhered to infection control principles, including hand washing. We saw staff use hand gel regularly. There were regular infection control audits and hand washing audits and ward staff knew who their infection control leads were.
- Ward layouts allowed staff to observe most parts of the wards. However, there were some blind spots and areas that could not be observed from the main lounge areas. All wards used individual risk assessments and observation levels to mitigate this. Belvedere ward had mitigated this further by the use of mirrors in corridors which increased the visual observation of the ward areas.
- We saw that ligature risks were reduced through individual risk assessments and observations. There were ligature free ensuite shower facilities and modified bins with no liners. There were some potential ligature points, such as doors and door handles and the high / low beds, which staff were aware of and were managed through observations and risk assessments. On Belvedere ward there were alarm sensory mats in use that were a ligature risk due to the length of the cord and position of the plug. This had been identified as a ligature risk by the ward and we saw that this was mitigated by individual observation. Staff were awaiting an outcome of this identified ligature risk at the time of our inspection.
- Since the lowering of the age of admission, Meadow view had identified that potential risk from the case mix of patients had increased and this was one of the top five risks on the older people's trust risk register.
- Each bedroom had en suite toilet and shower facilities. There were two assisted bathrooms on each ward that were used interchangeably so they could be designated to males or females. Female patients on Beech , Belvedere and Meadow view wards were located in rooms next to and opposite male bedrooms. The wards were full and some patients were in rooms next to patients of the opposite sex. However, each of these rooms had en suite facilities. One patient on Belvedere ward told us that male patients had wandered in to her room. The risk of this had been mitigated by the patient locking their room at night.
- On Beech ward many of the day facilities had a dual function due to the limited space. For example, the female only lounge was used for regular meetings and a 'plan my recovery' meeting was taking place during one of the days we visited. However, staff had mitigated this risk by consulting with patients, considering the individual needs of patients and using the spaces available to meet individual needs.
- The clinic rooms on each ward were clean and kept locked and secure. There was no examination table on Meadow view, but we were told that patients could be examined in their bedrooms, if needed.
- There was well stocked emergency and resuscitation equipment on each ward and equipment checks were systematic on Beech and Rougemont. However, we found that monitoring of medical and emergency equipment was variable on Meadow view and Belvedere. For example, there were gaps in regular recording checks on Belvedere ward.
- On Belvedere ward the emergency 'grab bag' was large and heavy for staff to lift and move quickly if needed. Ligature cutters were not immediately accessible and a number of items had to be removed from the bag before cutters could be located.
- Beech ward fridge temperatures for the storing of patient food had been noted as higher than safe limits.

Requires improvement

Are services safe?

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

This had been reported by the ward staff but had not been actioned by maintenance services. We were told that maintenance was managed by South Devon Healthcare trust and that the issue had been escalated.

- Environmental risk assessments were undertaken regularly across all wards. Most equipment was well maintained, clean stickers were visible and in date. However, portable appliance tests (PAT) were out of date on some equipment on Beech ward. PAT testing was also managed by the maintenance services of the same provider, this was raised with the staff and we were advised that this had been escalated with South Devon Healthcare trust.
- On Belvedere a lack of ward equipment had been reported on the trust risk register as a high risk. The ward had three pressure area mattresses which were all in use and any other mattresses required were rented. The ward also rented all their high/low beds, so there were delays in accessing equipment at times. There was also a lack of storage space for ward equipment on some wards. Beds and frames were stored in a corridor outside Beech ward.
- On Meadow view, some ward equipment was insufficient. For example, blood pressure monitoring cuffs were not available in a smaller size to fit some of the patients.
- Each ward had an emergency call system and had separate management arrangements for alarms and nurse call systems. On Meadow view staff carried personal alarms**,** on Beech ward there were alarms in bathrooms and bedrooms but staff did not have personal alarms. On Belvedere ward nurses had personal alarms but reported problems with charging the equipment. During our visit there were not sufficient charged alarms for staff to use.
- Each of the wards had used a seclusion room on one occasion in the six months leading up to May 2015. At Franklyn House between Belvedere ward and Rougemont ward the seclusion room was referred to as the 'extra care area' and staff did not identify this room as a seclusion facility. However, records showed it was used for seclusion and segregation. There was also a seclusion and segregation area referred to by staff as an 'extra care area' facility for Meadow view, which was linked to the section 136 suite on the inpatient psychiatric unit.
- On Beech ward the seclusion facilities had been relocated close to the acute ward where seclusion was used more frequently. This had so far not been used by Beech ward patients. There were concerns identified by staff about the suitability and location of the seclusion facility because access to the new facility was through a corridor where overflow equipment was stored. The route to the seclusion area had to be accessed through this corridor to the stairs or lift.
- Each of the facilities used for seclusion and segregation had clear observation, two-way communication and toilet facilities. The walls were bare and there were no clocks in the seclusion facilities at Torbay and Franklyn hospital. This had been identified as a requirement in the most recent trust seclusion policy dated July 2015.

Safe staffing

- Safe staffing levels were agreed in 2014 and were under regular review. The trust wide safe staffing group had continued to monitor and review staffing levels on older people's inpatient wards. For example, a recent decision had been made to improve the twilight skill mix on Rougemont ward to a qualified staff member. Twilight shifts had also been agreed for Belvedere. However, the ward manager and staff team were concerned that the agreed establishment was still not sufficient on Belvedere ward to meet patients' complex needs.
- During our visits to the wards we saw that the ward was staffed as per the agreed establishment and we cross checked this with the previous month. We saw that the wards were generally working to the agreed establishment and if the numbers were higher or lower then this had been risk assessed.
- We reviewed duty rosters on each ward and saw that there was appropriate use of bank and agency staff to cover staff sickness or vacancies and that shifts were covered when there were gaps. The wards were managing high use of agency staff at times and during April 2015 there were 90 shifts covered by bank or agency staff on Belvedere ward. Most of the temporary nursing staff used were familiar with older people's services, such as NHS professionals who received an induction and training with the trust. Staff expressed concern on Belvedere ward that there was sometimes high usage of temporary staff that were not familiar with the ward; however, we were unable to substantiate this during our visit.

Requires improvement

Are services safe?

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

- On Meadow view the ward was routinely working with three staff at night where the agreed safe staffing level was four staff at night. Staff were concerned that this could affect patient care. However, we did not find any evidence of this from discussions with patients and care plan reviews. There were also concerns raised on Beech ward, identified in the older peoples ward risk register, that staffing levels were not sufficient to support the new place of safety unit.
- The ward managers were usually able to adjust staffing levels for short term needs through the use of bank or agency, usually NHS professional's bank staff. For example, on Meadow view and Belvedere there were extra staff to cover an increase in observations levels and one to one support.
- There were pressures on staffing in this core service and recruitment to band 5 nursing posts, consultant vacancies and retirement and succession planning had been identified by the trust as some of the top risks in older people's service. Turnover was particularly high on Belvedere and Meadow view with the equivalent of five full time staff leaving on each ward in the last year. Until recently there was a lack of ward manager cover on Belvedere. The ward manager on Rougemont had recently started to cover both wards and this had been positively received by staff that we spoke with.
- On Meadow view there was a 22% vacancy rate and frequent changes in nursing staff due to recruitment and retention issues. There were also nine changes in locum consultant cover over the last two years.
- Staff sickness rates were above average at 5% overall with higher than average sickness on Beech and Belvedere and low sickness rates of 3% on Rougemont and 2% on Meadow view.
- There was a nurse present in communal areas of the ward at all times during our visits. Although on Belvedere ward there were times when staff were attending to other patients and staff told us that this sometimes led to delays with attending to patients promptly. For example, during our visit there were no staff present when one patient was crying out and couldn't access their call bell, although staff attended promptly when we alerted them.
- Staff reported there were usually enough staff so that patients could have regular 1:1 time with their named nurse and we saw that this was prioritised when we reviewed the care records.
- Staff reported that escorted patient leave or ward activities were rarely cancelled because there were too few staff. However, staff told us that accompanied patient leave for more than two or three hours could sometimes be reduced in order to limit the staff time away from the ward.
- There was adequate medical cover day and night where a doctor could attend the ward quickly in an emergency. However, the trust had highlighted issues on their older people's risk register in relation to timeliness of out of hour's attendance on Beech ward.
- Staff were up to date with their mandatory training and mandatory training rates were high across all older people's wards. The average mandatory training rate for staff was 81% for Beech ward, 96% for Belvedere, 93% for Meadow view and 94% for Rougemont.

Assessing and managing risk to patients and staff

- There was one episode of seclusion recorded on each ward in the six months up to May 2015. Since then there had been one episode of segregation on Meadow view and Belvedere.
- There were 51 episodes of restraint involving 24 patients in the past six months. We reviewed one care record where a recent restraint had taken place and saw that this was documented well and risk assessments were updated. The highest of these was on Rougemont ward with 18 episodes involving five patients and Belvedere ward with 15 restraints involving six patients. The lowest number was at Beech unit with 6 episodes of restraint on five patients.
- There were no episodes of prone restraints recorded and staff told us that prone restraint was not used.
- We reviewed 35 care records and saw that staff undertook a risk assessment of every patient on admission and updated this regularly. We observed a handover meeting and multi-disciplinary meetings where risk was discussed. All risk assessments were comprehensive, using recognised assessment tools, such as MUST assessments (malnutrition universal screening tools). There were management plans which were updated at regular intervals and more frequently if care changed and after any incident.
- Entrances and exits were kept locked. Informal patients could leave at will. We did not observe any delays in patients leaving the ward when they wanted to.

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- There were policies and procedures for use of observation and searching patients. Searching patients took place on an individual basis depending on risk.
- Staff were skilled in de-escalation. Restraint was only used after de-escalation had failed. Staff we spoke with described this well and we saw individual care notes that described de- escalation. However, some staff commented that they would like more specialist de-escalation techniques for working with older people who are elderly frail.
- We saw that the administration of rapid tranquillisation followed National Institute for Health and Care Excellence (NICE) guidance and trust policy. However, older people's prescription charts we reviewed on Belvedere, Meadow view and Rougemont had rapid tranquillisation prescribed. No doses had been administered on the forms we reviewed. This was not in accordance with the trust's policy and clinical protocol.
- We did not see any other blanket practices or restrictions.
- Staff on Meadow view, Belvedere and Rougemont wards were unclear as to whether the 'extra care areas' were seclusion and segregation facilities. The extra care area at Franklyn house was not one of the sites listed in the trust's latest policy of areas which could be used for segregation and seclusion. Also the layout of the room did not fit the MHA code of practice guidelines on the environment for a room used for periods of segregation. However, this area had been used for this purpose on at least two occasions since November 2014.
- The trust were in the process of improving seclusion and segregation processes and had undertaken recent internal audits which identified some problems with record keeping when patients were secluded or segregated. Changes were reflected in the revised seclusion policy but were not yet fully embedded. For example, there was one recent episode of segregation on Meadow view and Belvedere in the 'extra care areas' at North Devon psychiatric unit and Franklyn hospital. Records were kept but these were not in line with the MHA code of practice guidelines and the trust policy on seclusion and segregation to keep detailed and contemporaneous clinical records. The records we reviewed lacked detail of the patient's behaviour and we did not see evidence that an independent multi-disciplinary review had taken place.
- Staff were trained in safeguarding and staff we spoke with knew how to make a safeguarding alert and did this when appropriate. We saw that there were safeguarding flow charts and policies clearly displayed.
- There was good medicines management practice, including transport, storage, and dispensing and medicines reconciliation.
- Staff were aware of and addressing issues, such as falls or pressure ulcers. This practice was embedded and there were link nurses for areas such as tissue viability and falls and regular audits.
- There were safe procedures for children that visited the wards and staff we spoke with were aware of the policy. There were some designated areas in the older people's wards, for example, Franklyn hospital and Meadow view had space for children to visit, which provided a welcoming environment with a small selection of age appropriate toys and books.

Track record on safety

- There were three serious untoward incidents reported between January 2014 and February 2015. No incidents were recorded on either Rougemont or Meadow View. We reviewed two of the most recent incidents prior to 2014 on Rougemont and saw that detailed root cause analysis had taken place and learning had been disseminated to the ward team.

Reporting incidents and learning from when things go wrong

- Staff knew how to report and escalate appropriately and there was generally an open culture of reporting incidents. However, three staff from Belvedere and Meadow view wards did not feel that they always received enough feedback from investigation of incidents both internal and external to the service.
- There was evidence of change having been made as a result of feedback. For example, the older people's service had been proactive in improving safety following an increase in falls and had implemented a successful falls reduction programme across the older people's service.
- Most staff told us that they were debriefed and offered support after serious incidents had taken place on their

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shift. There was also opportunity to discuss incidents at the reflective practice meeting each fortnight and we reviewed records of regular staff team meetings that confirmed this.

Are services effective?

Requires improvement

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Assessment of needs and planning of care

- Thirty five care records across the four wards were reviewed during our inspection and we saw that these contained comprehensive and timely assessments, which were completed within 72 hours of admission. Care records were up to date, holistic and recovery-orientated with evidence of regular review. There were examples of care changes and updates. For example, when a physical need had changed, the care plan had been updated.
- All records across older people's services showed evidence of multi-disciplinary review. The recovery model was particularly good on Beech ward where there was evidence of active patient involvement in 'Planning your recovery' meetings.
- We saw that records were electronic and stored securely in lockable ward offices and readily available to the multi-disciplinary team.
- Patient information was recorded on white boards in ward offices which were visible from outside the office at times. We spoke with staff and they closed the side panels of the boards, which could be undertaken when not in use to protect patient information.

Best practice in treatment and care

- We looked at prescriptions charts and saw that prescribing practices appeared to be consistent with NICE guidance when prescribing medication. The in-patient pharmacy service reviewed prescribing and administration of medicines and the monitoring of medicine incidents and attended the wards each week.
- Physical health care monitoring was good and models of best practice in treatment and care were used. For example, the MEWS (modified early warning score) recommended by the NICE guidelines to ensure early recognition of acute illness and appropriate treatment was taking place.
- There was good access to physical healthcare; including access to specialists when needed. Speech and language therapists, physiotherapists and other allied health professionals supported the teams in providing effective physical health care monitoring. For example, a swallowing assessment was carried out on a patient by a speech and language therapist on Belvedere.
- There were link nurses identified on each ward for physical health areas, such as tissue viability, nutrition and diabetes. Each ward had links with medical staff at the acute hospitals. Specialist treatments were readily accessible, including input from hospice nurses. On Belvedere ward staff were supporting a patient with end of life care and had provided one to one support.
- Patient's nutrition and hydration needs were assessed on admission to identify patients who may be at risk of malnutrition and a care plan was developed when a need was identified. We saw that the older people's team accessed regular support and advice from the dieticians. Dieticians had provided input to care plans, for example, when caring for patients with diabetes.
- Staff participated actively in clinical audit, such as hand hygiene and physical care audits.

Skilled staff to deliver care

- There was a range of mental health disciplines and workers providing input to the wards, including nurses, doctors, occupational therapists, dieticians, physiotherapists and pharmacists. Vacancies were covered by NHS professionals and locum and agency staff, such as consultants on Meadow view and nursing staff on Meadow view and Belvedere.
- Meadow view and Rougemont had dedicated psychology time but there was limited access to psychologists due to vacant posts. This meant that individual psychology sessions were not readily available for all patients. There were also some gaps in other staff provision, for example the senior occupational therapist on Belvedere was covering the vacant post on Rougemont so there were times when patients could not receive occupational therapy support.
- Staff received appropriate induction and there was a preceptorship programme for newly registered nursing

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staff. Induction and training was in place for all staff, including NHS professionals and agency staff. Nursing assistants were supported to undertake the Care Certificate standards.

- Staff, including medical staff, were regularly appraised and supervised, although Belvedere was not up to date with its regular supervision and appraisal. However, since the ward manager on Rougemont had taken over the management of both wards 2015 appraisals had been planned and supervision meetings had taken place. Staff were positive about these line management changes and this had improved staff morale on Belvedere ward.
- There were regular team meetings and facilitated reflective practice meetings across the service and staff were up to date with their mandatory training.
- Staff told us that the trust supported additional training as part of their development and we saw that staff had undertaken additional clinical, management and therapeutic courses and most staff felt well trained to carry out their role. However, staff had not received all the appropriate training that could support them in working with older people. For example, Belvedere ward staff were supporting patients with challenging behaviour but had not received specialist training in understanding, preventing and managing aggression in older people. In addition, staff on Beech, Meadow view and Rougemont had not received recent training for working with patients with dementia and other age related conditions.
- On Meadow view and Beech ward in particular there were younger patients of working age. Since the admission age was reduced on older people's wards, staff had not received recent specialist training to support acutely ill people of working age.
- Ward managers were able to provide examples of addressing poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary meetings on each ward. We reviewed two meetings, one at Meadow view and one at Beech ward. The meetings were attended by members of the multi-disciplinary team, including doctors, nurses and occupational therapists
- We observed a ward handover between shifts and saw that there was clear and detailed communication. Multi-disciplinary staff confirmed that there were effective and regular handovers within the nursing team and the wider multi-disciplinary team.
- The crisis team were the gatekeepers for keeping people out of hospital and getting patients back home quickly. Staff reported that there were good working relationships with the local crisis team and they maintained regular contact as needed.
- All wards worked with the local authority teams to ensure effective and safe discharge planning. On Belvedere ward, which had the highest rate of delayed discharges, there was a discharge liaison worker who linked with the local authority and other agencies across the county. A part time social worker had recently been appointed to support timely discharges. However, planning and discharge meetings from social services staff or community mental health team staff were not regular. Staff told us this was particularly challenging when the patient did not live in the immediate locality as staff did not always have links with these local authorities.

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

- We carried out Mental Health Act (MHA) monitoring visits on Belvedere and Beech wards which will be reported separately.
- Mental Health Act training and the MHA code of practice was not part of the mandatory training programme for trust staff. Ward doctors had received some additional training on the new code of practice, but most nursing staff told us that they had not received this. The ward manager for Rougemont contacted the Mental Health Act office and a date was set for additional training on the revised code of practice for Belvedere and Rougemont staff.
- Administrative support and legal advice on implementation of the MHA was accessible and sailable. Staff on each ward described receiving good support from the mental health act offices to support them in their adherence to the MHA and MHA Code of practice.
- We reviewed ten capacity assessments and consent to treatment records on Belvedere and Beech wards.

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Records had been fully completed and updated regularly for all detained patients on Belvedere and Beech wards. These records were in line with MHA code of practice guidelines.

- We observed a ward round meeting on Rougemont ward for a detained patient and a 'planning my recovery' meeting on Beech ward. Staff were knowledgeable and clear in ensuring that patients' rights were clearly explained and patients were given sufficient time to express their views.
- On Belvedere and Beech ward a report by an approved mental health professional (AMHP) had been completed on RiO for records we reviewed. All ten admission documents we reviewed were available and in order.
- Records confirmed that patients were presented with their rights verbally on both wards. However, on Belvedere ward we could not find any evidence recorded on RiO in four out of five detained patients' records that their rights under section 132 of the Mental Health Act had been presented in writing on admission and re-presented in line with MHA code of practice guidance. Staff told us that this information could be provided easily but on Belvedere ward where most of the detained patients were mentally frail. We did not see any evidence that information was available or had been presented to patients in a more accessible format. Hospital managers have a statutory duty to ensure that rights under section 132 are presented both orally and in writing.
- Detention patient work was up to date and stored securely on electronic records on both wards. However, leave authorisation forms did not always clearly define the parameters and conditions of leave and we could not find any record of specific leave risk assessments. This did not comply with MHA code of practice guidelines on the recording of leave.
- There were regular audits to ensure that the MHA was being applied correctly. There was evidence of learning from these audits such as the revised seclusion and segregation policy which included recommendations from MHA internal audits.
- There was access to an independent mental health advocacy service (IMHA) on most wards. On Beech ward and Meadow view, the managers explained that visits took place as needed and information was displayed. Patients on Rougemont received a weekly visit from an IMHA service but the manager explained that this did not routinely take place on Belvedere. IMHA information was only available in the shared area outside the wards to Rougemont and Belvedere so was not easily accessible to patients on Belvedere as the route to the shared area was locked.
- Five staff we spoke with were not clear how to access and support engagement with the IMHA service, particularly for patients on Belvedere ward and Meadow view. This was supported by our review of records which found no evidence that patients had been informed of their right to have support from the IMHA service.

Good practice in applying the Mental Capacity Act

- Staff were trained and were up to date with e-learning on the Mental Capacity Act with completion rates of 100% across all four wards. Staff also received additional face to face training on the Mental Capacity Act and the five statutory principles. During our inspection we saw that additional training was taking place for staff on Belvedere and Rougemont wards. There was also a policy on the MCA including deprivation of liberty safeguards (DoLS) which staff were aware of and could refer to. Despite this, understanding of the principles of the MCA and consent was variable across all the wards. Four staff we spoke to showed a clear understanding of the MCA 2005, in particular the five statutory principles, but others were less clear and there were two staff on each ward who could not demonstrate a basic understanding of the MCA.
- We reviewed 23 treatment escalation plans (TEPs) on Belvedere and Beech wards and found that there were gaps in recording, particularly in relation to consent and capacity. Only six TEPs were completed in full. Plans were not always individual and had not clearly set out decision-making process regarding the patient's capacity. Most forms did not include whether an advance decision was completed. There was also insufficient evidence on the forms to indicate that patients, carers and family members were fully consulted.
- There were no regular visits from independent mental capacity advocacy (IMCA) services and staff and patients needed to request this through the IMHA services. Two staff we spoke with on each ward were not aware of the arrangements to contact the IMCA services.

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- However, staff knew where to get advice regarding the MCA and DoLS within the trust and all reported good relationships with the Mental Health Act offices that monitored adherence to the MCA and provided support and advice for staff.
- DoLS applications were made when required. There were 16 DOLS applications made in the six months between November 2014 and May 2015. These were highest on Belvedere ward with 13 applications and the remaining three were applications from Rougemont ward.
- However, DoLS applications were not being processed in a timely manner by the supervisory body. We were told that patients were usually discharged before the assessment was made. We saw a copy of a letter from the local authority stating that there was a huge backlog and that they would be unable to involve a DoLS assessor for a considerable period of time.

Good

Are services caring?

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Kindness, dignity, respect and support

- We spoke with 14 patients and observed care across all four wards. We undertook a short observational framework observation (SOFI) which was a tool used where people cannot communicate easily. We carried this out on Belvedere ward where patients could not communicate easily due to their mental frailty. We also observed community meetings on Beech ward and Meadow view and spoke to eight relatives or carers of patients both on the phone or in person. Patients and carers reported that staff treated them in a caring, compassionate and supportive way.
- During the SOFI observation we saw that some patients were occupied in activities and we noted reciprocal warmth between staff and patients. Staff in their interactions with people showed kindness and respect. However, one temporary staff member was observed talking to a patient sharply and in a manner that demonstrated little empathy. This was reported on the day of our visit and the manager took appropriate action.
- In general observations across all four wards we saw that staff were respectful and friendly and provided appropriate practical and emotional support. Staff were discreet and respectful in providing personal care. Despite wards being full and busy, the environments were calm and staff stopped to speak and answer people in a calm way that was individual and not rushed. Staff demonstrated understanding of individual needs of their patients and were able to explain how to care for people with dignity during personal care.
- This was supported by the most recent PLACE score for the trust overall which showed that the trust scored 92% for dignity privacy and respect. The average score for other similar services was 86%.
- Reports by patients of how staff treat them were mainly very positive and patients were enthusiastic about the staff that cared for them. Eight relatives described staff as caring and six of these told us they felt involved in the care.

The involvement of people in the care that they receive

- The admission process informed and oriented patients to the ward and the service and patients were always allocated a named nurse.
- There was some involvement and participation in care planning and risk assessments which was evidenced in care plans. However, it was not always clear from some records, particularly on Belvedere, how patients and carers had been involved in the process.
- There was little recording of patients' views in their own words, particularly on Belvedere ward. We also did not see evidence that patients were consistently offered paper copies of their care plans across all wards. Despite this, all patients we spoke with and all but one carer were satisfied with the level of involvement in their care plan.
- We observed participation in ward community meetings and patients were able to get involved in decisions about their service and gave feedback. For example, on Beech and Rougemont wards, patients had asked for more nutritious snacks to be available in the evening and this had been arranged.
- However, Belvedere had not held any recent community meetings due to the mental fragility of the patient group. An alternative forum had been considered that could allow patients with limited capacity to express their views but was not established. Staff reported that this had been delayed due to the recent ward management gaps and temporary staffing.
- We observed multi-disciplinary meetings on Meadow view and a 'planning my recovery' meeting on Beech ward where carers and relatives' views were included with consent from patients. Staff explained that feedback could also be given to families after the meeting. On Beech ward there were notices inviting patients and carers to talk to the ward manager. There was also a discharge liaison officer for Belvedere ward who linked with families in planning discharge.
- The trust had recently invited carers to take part in a carer's survey to find out if the trust were meeting their

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obligations towards carers as set out in the trust carer's charters. There was a carer's charter monitoring group led by Patient Advice and Liaison Service (PALS) to monitor the trust performance in supporting carers. However, this was not yet fully embedded across older peoples inpatient services and carers we spoke to were not aware of the survey or the jointly developed carer's charter by the Trust with carers in Devon. We also found that staff were not always familiar with the support that was available to carers.

- On Belvedere and Rougemont there was a carer's resource pack and information board with details of services such as PALS or advocacy. Franklyn hospital had tried different methods of support for carers. For example, in 2014 carers were offered a regular support group, but carers opted to have one to one contact or support. However, some carers were not aware of support for carers. One carer whose relative was on Belvedere was not aware of any support for carers because they had not been able to visit the ward. They told us that they would like to see their relative and be involved but could not afford to as they lived too far away; this was reported to the manager.

Are services responsive to people's needs?

Good

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Access and discharge

- Average bed occupancy over the last six months was high at 94% across all four wards. Each ward had bed occupancy of more than 85%. Beech ward had the highest occupancy at 97% and Meadow view the lowest at 88%.
- Due to high bed occupancy, beds were not always available when needed for patients living in the 'catchment area.' On each ward there were patients who were out of the catchment area.
- Patients were sometimes moved between wards during an admission episode when there was pressure on beds. For example, on Beech ward there was one patient who was moved from the acute ward for adults of working age and was below the age of the revised admission age criteria. On Meadow view a patient was recently admitted with dementia and remained on the ward until a bed was available on Belvedere. Staff told us that this took place with patient and family consultation and we saw that in these instances patients and family had been consulted.
- Staff reported that there was sometimes no access to a bed on return from leave due to the high demand on inpatient beds. We found evidence of this when we tracked one patient who went on leave from Beech ward. However in our review of records we could not find evidence that this was a common problem and could not ascertain how widespread this issue was.
- Staff told us that when people were moved or discharged, this took place in a planned way and at an appropriate time of day. This was confirmed during our visits to the wards when we saw discharges and transfers taking place at an appropriate time of day. There were no recent readmissions within 90 days across the four wards.
- There were plans in place to develop psychiatric intensive care unit (PICU) services and the trust did not currently have a PICU bed facility if a person required more intensive care.
- Older people's inpatient services admitted adults age 50 and over with a clinically appropriate need for this service. However, community older people's services only accepted patients of 65 years and over. Staff reported potential concerns for inpatients on the older people's ward aged between 50 and 65 who continued to need an older people's community service on discharge.
- Delayed discharges had been identified as one of the top five risks for older people's inpatient services and was monitored on the trust risk register. Each ward told us there were frequent delays in discharge planning due to shortage of placements and difficulties in completing necessary funding paperwork for local authority funding panels. For example, Meadow view reported a recent three week delay in discharge. Staff had been proactive in getting training to complete the funding applications to minimise the risk of this happening. In the six months between 1 November and 30 April there had been 24 delayed discharges from older people's inpatient facilities. The ward with the highest number of delayed discharges was Belvedere with 17 delayed discharges reported. The trust had a discharge coordinator for Belvedere ward and had recently recruited a part time social worker to support the discharge arrangements from the ward. This was not in place for the other older people's wards.
- The older people's wards liaised with community teams for adults and community teams for older people. All the wards reported that it was often difficult to get members of a community mental health team to liaise and engage with the discharge process. This was a particular problem if the patient was out of the immediate geographical area or with a team that the wards did not have established links with, such as community mental health teams for working age adults.

The facilities promote recovery, comfort, dignity and confidentiality

- Most wards had the full range of rooms and equipment to support treatment and care. For example, each ward had well designed courtyards providing open access to outside space. There were activity areas and some

Are services responsive to people's needs?

Good

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wards had separate male and female lounges, for example Rougemont and Meadow view. The facilities at Franklyn hospital also included Belvedere ward's sensory garden and a well-appointed activity and visitor's room shared between both wards. This was supported by high PLACE scores for facilities where Franklyn hospital had the highest rating in older people's services with a rating of 99% for facilities. All older peoples inpatient wards were above the England average of 92% for Mental Health and Learning Disability trusts.

- However, some areas that were designed for therapeutic activities were used for staff and clinical areas due to a pressure on space. For example, on Beech ward the activity room was used as the ward office and activity space was created in the dining room and the courtyard. There was no specific activity space. On Beech and Meadow view there was inadequate storage and we saw that beds and other equipment were stored in the corridor outside the ward on Beech and in the activity room on Meadow view so that it did not present as a hazard.
- Most wards had quiet areas and a room where patients could meet visitors, including children. However, the space was very limited on Beech ward with communal spaces being used as multi-purpose rooms such as dining room and activity room and there was no dedicated visiting room or a room for children to visit the ward.
- Patients could make telephone calls on all four wards in private through the use of ward cordless telephones and patients also had access to their mobile phones.
- The food was mainly of good quality. For example, on Belvedere and Rougemont, a locally sourced butcher was used for all their meats and there was a daily delivery of organic breads. This was supported by PLACE scores published in August 2014 for the period January to June 2014 where Franklyn Hospital rating was above the national average with a rating of 86%. However, comments from patients about food was mixed and two negative comments were received about the poor quality of food on Beech ward at Torbay hospital where PLACE scores of 79% were the lowest across the trust and significantly below average.
- The ward managers had worked to rectify this and provided additional snacks and food supplements to support the menu on Beech ward and all older people's wards. This was confirmed when we reviewed community notes and found examples of ward staff responding to patient comments about providing more food during the evening. Staff on each ward gave examples of listening to patients and obtaining additional ingredients such as to make sandwiches and snacks and provide alternative choices to the menu if required.
- Patients could make hot drinks and snacks throughout the day and evening on each ward. We saw that patients were accessing drinks on Meadow view and Rougemont. On Belvedere ward where 'natural waking' was in operation we saw that patients were supported to make drinks and snacks and we saw patients being made drinks and offered a selection of breakfast choices throughout the morning. On Beech ward access to drinks had been returned following patient request and completion of a risk assessment.
- Patients were able to personalise their bedrooms and we saw examples of this, such as pictures, photographs and takeaway menus in some rooms.
- There were lockers available for patient use in the ward area although patients did not have personal lockable space in their rooms. Each bedroom was lockable although patients did not have access to keys.
- There was access to activities including at weekends and we saw a range of activities during our inspection week. There were music, art and photography groups, with a purpose built shared activity room at Franklyn hospital. During our visit patients from both Rougemont and Belvedere wards were actively participating in a print class. We saw that each ward had planned activities, some were run by occupational therapy staff at Meadow view whilst others including Belvedere ward had activities coordinators.

Meeting the needs of all people who use the service

- The wards were purpose built in 2011 and there had been adjustments made for disabled access, such as walk in disability showers.
- There was limited information available in languages spoken by people who use the service other than

Are services responsive to people's needs?

Good

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

English which largely met with the make-up of the population. However, staff were clear that they could obtain information in a range of languages and arrange access to interpreters as needed.

- There was provision of information displayed such as local services and how to complain, with some examples of well laid out display areas of recovery information, such as on Beech ward. At Franklyn hospital there was a wide range of information for patients and carers in the shared entrance vestibule and family room. The trust had devised a useful information leaflet to improve information for patients who were admitted to wards that were not local to them.
- There was provision of accessible information on treatments, local services, patients' rights, and how to complain, although we did not see easy read leaflets. Staff told us that they accessed these as needed.
- Ward staff had ensured that there were additional choices to meet dietary requirements. The dietician was also involved in ensuring that patients with specific dietary needs were catered for and there were regular meetings with catering and ward staff.
- There was choice of food to meet dietary requirements of religious and ethnic groups, with dietary choices available to order, such as halal and kosher foods.
- There were regular visits from the pastoral team where patients could access spiritual support.There was access to multi faith rooms at each site.

Listening to and learning from concerns and complaints

- There were 11 complaints between April 2014 to March 2015. We saw that complaints were investigated and the outcome discussed with staff in minutes of staff meetings.
- A recent audit of complaints management had been completed. Staff we spoke with were aware of this and the complaints policy. There were patient advice and liaison (PALs) service leaflets and PALs information for staff, such as checklists for investigators.
- There were 21 compliments from patients or carers received between January and June 2015, with 11 of these received from Beech ward. We saw that compliments, such as thank you cards were displayed.
- Most patients we spoke with knew how to complain and expressed high levels of satisfaction. We saw that information was available in admission packs and information was displayed to encourage patients and carers to comment or complain. On Beech ward the manager had displayed information inviting patients and carers to contact her. However, two carers we spoke to were not aware of the complaints process and had not contacted the ward when they had concerns.

Are services well-led?

Good

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Vision and values

- Staff were aware of the trust's vision and aims and each ward had recently displayed the refreshed trust vision and values 'daisy' poster. On each ward we visited staff were familiar with the trust's vision to provide care, treatment and support which was 'good enough for my family.' There were staff team comments and ideas on how the organisation values reflect their own with post-it notes of staff comments on where they thought they were working well with the trust five quality priorities.
- Staff mainly knew who the most senior managers in the organisation were and reported that these managers had recently visited their wards. There had been recent senior management staff changes and staff reported that the new senior management team were approachable and friendly. Four staff spoke positively about the recent trust wide nursing conference which had given staff the opportunity to celebrate the nursing achievements at the trust.
- However, there were unfilled vacancies in senior management supporting Beech ward.

Good governance

- All the older people's ward managers were experienced staff who understood their service well. The dementia unit had recently improved their management arrangements with the experienced ward manager for Rougemont covering both wards on the Franklyn hospital site. All three functional wards had well established teams with a strong recovery focus.
- Staff were regularly appraised and supervised, although Belvedere was not up to date with its regular supervision and appraisal due to recent gaps in ward management. However, since the ward manager on Rougemont had taken over the management of both wards the appraisals had been planned and supervision had improved.
- Staff had received regular mandatory training, mainly through e-learning and some staff had received further development opportunities to support their practice. Training was monitored through appraisals and supervision. There was a system to remind staff to complete their mandatory training. However, most staff had not received recent specialist training to support acutely ill people of working age, neither had staff received recent training for working with patients with dementia.
- The majority of shifts were covered by staff at the right grades and the trust had built up a bank of qualified and experienced NHS Professional staff and agency staff who were included in the training. However, staffing was recognised in the top risks for the older peoples inpatient services and the vacancies on Meadow view and Belvedere were identified as a risk.
- We saw that staff could maximise their shift time on direct care activities as opposed to administration tasks and there were supernumerary posts to support this. These included the discharge coordinator on Belvedere ward and the occupational therapy and activity staff to support individualised activities across all wards. However, there were some gaps in psychology and occupational therapy across the service.
- Staff participated actively in clinical audit, such as hand hygiene and physical care audits. There were monthly reports on the 'orbit' performance management system with key performance indicators that were aligned to older people's services. This included information about sickness, training and supervision. We saw that this was readily accessible to the managers.
- We saw that incidents were reported and that staff learnt from incidents for example there was evidence of root cause analysis sharing on Rougemont. The ward managers held regular meetings with the multi-disciplinary team.
- All four wards were supported by dedicated administration staff. The ward managers on both wards felt they had sufficient authority to fulfil their roles. However, managers did not always feel they had the sufficient authority to refuse an admission; despite the patient not meeting the referral criteria as set out in

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their most recent ward operational policies. For example, patients with organic illnesses, such as dementia had continued to be admitted to the functional wards, when Belvedere ward was full.

- The ward managers on all wards told us that they would always escalate concerns and each manager had identified recent risks that were included on the trust wide risk register. Risks were regularly discussed at monthly, weekly and sometimes daily meetings.

Leadership, morale and staff engagement

- Staff were familiar with the new senior management team and reported that there had been regular and recent visits to all the older people wards by the executive team.
- The 2014 NHS staff survey results were worse than average overall and the trust were in the bottom 20% compared with similar organisations for engagement. Overall only 68% of all staff respondents said they felt satisfied with the quality of work and patient care they were able to deliver compared to the national average of 76%. We did not have staff survey information specifically for this core service.
- Job satisfaction and morale was recognised by the trust as a key priority to improve staff experience. The trust had carried out further surveys to test staff morale and engagement. These included the internal Friends and Family Tests between January and June 2015 which showed that most staff in older adult inpatient services would recommend the service to friends and family.
- The trust was aware that morale amongst the teams was mixed and had identified areas on the risk register that were affecting staff, such as staff vacancies and bed pressures. However, we found that morale was particularly good on Beech and Rougemont where there were cohesive multi-disciplinary teams and ward management. Staff also reported that morale had improved since the manager on Rougemont had started to manage both wards at Franklyn hospital.
- Staff told us that they would feel comfortable to raise concerns if they needed to and most staff expressed high levels of job satisfaction despite the pressures.
- Management and leadership training was available and staff expressed satisfaction about training opportunities.
- Staff knew how to use the whistle-blowing process and told us that they could be confident about raising concerns in the trust.
- Sickness and absence rates were variable across older people's services. Two wards had a higher than average sickness rate. Beech ward had 9% sickness in the last six months. Meadow view and Rougemont had low reported sickness from their permanent staff with 2% on Meadow view and 3% on Rougemont ward.
- Staff were offered the opportunity to give feedback on services and input into service development and the recent nursing conference was highlighted as a good opportunity to give feedback and celebrate successes.

Commitment to quality improvement and innovation

- There was use of improvement methodologies across the older peoples inpatient services. For example, falls reduction work had resulted in a significant improvement in the quality of care. Falls assessment and prevention was embedded in patient assessments and care planning and actions had resulted in a 35% reduction in falls since 2012. This had included Belvedere ward which had been shortlisted for a Nursing Times award for their work on falls prevention for patients with dementia.

- The environment on Belvedere ward had been designed to be specifically dementia friendly and included homely communal rooms and small seating areas around the ward for patients to sit and rest. There were clear signs in bold type face including patient bedrooms with pictures that were familiar to that patient. There was art work around the ward which was brightly lit or had different textures. However, the design of the unit had not fully taken account of observations and there were some blind spots which were mitigated by use of mirrors. The garden was a specially designed sensory garden, although patients needed to be accompanied to visit the garden due to the risk of falls. Staff had been proactive in applying for this additional funding to improve the quality of the environment for patients.

- Beech ward was piloting an interactive whiteboard with a RAG rated touch screen which could result in more responsive and effective care. This was an easy to read board with checks, such as physical observations and care plan meetings with a named nurse. This would be rolled out across the trust when they move to a new

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care records system in August which would link the care records with the interactive white board. We were told that the trust was the first mental health NHS trust in the United Kingdom to use an interactive white board.

- Patients on Beech ward had designed a system where they could easily see which staff were on duty each day. A photo board was changed each night with pictures of the staff that would be caring for people on each shift for the following day.

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 Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The seclusion facilities must be safe to use for their intended purpose and meet the MHA code of practice guidelines. Franklyn house must be included within the seclusion and segregation policy as an area with a room for segregation and seclusion. This was a breach of Regulation 12(2)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Accurate and contemporaneous seclusion and segregation records must always be kept in line with the trust seclusion policy and MHA Code of practice. This was a breach of Regulation 17(2)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust must ensure that monitoring and checks of medical equipment follow a systematic plan to ensure that all medical equipment is safe to use, in full working order and in date and accessible at all times. Ligature cutters and emergency equipment must always be accessible. Alarm and nurse call systems for ward staff must be in full working order.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 12(2)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The trust must ensure that all individual mental capacity assessments for patients with treatment escalation plans (TEPs) are completed in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11(1)