

Devon Partnership NHS Trust

Forensic inpatient/secure wards

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)
RWV73	Langdon Hospital	Medium secure service at the Dewnans Centre: Ashcombe Ward; Holcombe ward; Coften ward; Warren ward; Low secure service at: Connelly house; Owen house; Chichester house; Avon house	EX7 0NR

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.

Summary of findings

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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Outstanding 

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

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Summary of findings

Overall summary

We rated Devon Partnership NHS Trust forensic inpatient/secure wards as **good** because:

- Care and treatment was delivered in a person-centred, kind, respectful and considerate way.
- Patients and their carers told us that staff treated them with kindness, dignity and respect.
- Patients and their carers were involved as partners in care planning.
- Patients and families told us they were satisfied with the care provided.
- All but two of the 29 patients we asked, said they felt safe on the wards.
- Care Programme Approach and patient clinical ward reviews were routinely carried out in a timely manner.
- Patients had suitable care plans and risk assessments, which were regularly updated and reviewed.
- There was a strong culture of staff managing complex patient behaviours effectively, using restraint and medication only when needed.
- Staff had a good understanding of the Mental Health Act. They had access to support when they needed it and the legal paperwork was completed correctly, recorded effectively and stored appropriately.
- The electronic records systems were effective in supporting staff to deliver care.
- The onsite pharmacy team were accessible to ward staff and provided both monitoring and support with medication management.
- The ward environments promoted dignity and well-being for patients and there was good access to outdoor space.
- Patients had routine and regular contact with a range of onsite and local community health professionals to promote their physical health and well-being.
- Different professions worked effectively together to assess the needs of patients and to support the admission and discharge process.
- There was an active occupational therapy and sports activity team that developed individual plans and therapeutic activities with patients.

- Staff showed a clear understanding of the Mental Capacity Act, including Deprivation of Liberty Safeguards (DoLS) even though they had no reason to use DoLS.
- Staff told us they felt valued and supported by the trust and felt confident they could report their concerns without fear of reprisal.
- There was suitable training available for staff to enable them to keep up to date with their clinical skills and to develop them further. Clinical staff had access to leadership training and there were opportunities for career development.
- There were robust systems to record incidents of harm or risk of harm and learning from incidents was routinely shared among staff.
- Morale among the staff we spoke to was good; they enjoyed their jobs and were clear about their roles and responsibilities.
- Local leaders were visible and available to support staff.
- Robust governance was in place, including audits of service quality and clinical practice.
- Senior managers had good oversight of the service and change was being managed effectively.

However, we also found that:

- Some patients could not access psychological therapies in a timely manner but the hospital had acknowledged this and had recently recruited more psychologists to fill vacant posts.
- Patients in seclusion had access to toilet and washing facilities but these were located outside of the room, requiring staff to facilitate access. Patients in seclusion at the Dewnans centre had to share the facilities with patients in long-term segregation. The seclusion room at Avon house had no intercom, no air conditioning and there was limited natural light from a small window.

Summary of findings

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

Are services safe?

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

- All except two patients we spoke to, said that they felt safe on the wards.
- Staff knew how to protect patients from harm.
- Ward areas were clean, clutter free and well maintained.
- The hospital was trying to recruit new staff to fill vacancies.
- Staffing numbers were in line with the trust's policy and contained a mix of staff from different professions.
- Clinical team managers were able to request additional staff when needed.
- Staff carried out risk assessments and managed risks to keep patients and staff safe.
- Staff were confident they could report errors, near misses and incidents because there was an open culture where managers listened to them and did not blame them.
- Mandatory training for staff was routinely undertaken and managers monitored training records to ensure compliance.
- Staff had a good understanding of the process for safeguarding patients from abuse.
- Safety audits of the ward areas and patient records were regularly undertaken.
- There were systems in place so that lessons could be learned when things had gone wrong. The learning was shared among the wards in order to inform staff and enhance patient care.

Good



Are services effective?

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

- There was good practice in assessing, supporting and monitoring patients' nutritional needs.
- In line with the Mental Health Act Code of Practice (2015) and the National Institute for Health and Care Excellence (NICE) guidelines, patients received thorough physical health checks and medical attention to promote their well-being.
- Patients had access to community health services when they needed them.
- Care Programme Approach (CPA) reviews were routinely held to monitor patients' progress.
- Occupational therapy, physiotherapy, social work, medical and nursing staff worked well together to plan and deliver multidisciplinary patient care.

Good



Summary of findings

- Staff had good opportunities for learning and development and showed a good understanding of the Mental Health Act and the Mental Capacity Act.
- Staff were supported to deliver effective care and treatment to patients because good systems and processes were in place.
- Staff and patients knew how to access an Independent Mental Health Advocate (IMHA).

However, we also found that:

- The electronic records system held the most up to date section 17 leave plan but staff also wrote patient leave status on a white board in the office. Staff said it was quicker to read the white board but we found that this was not always updated effectively, which almost led to a patient being given the wrong leave.
- There was limited access to psychological therapies on some wards but the service had recently recruited more psychologists to improve patient access.
- We could not find evidence that patients were offered a copy of their Section 17 leave authorisation form. (Section 17 of the Mental Health Act covers arrangements for patients detained for treatment taking leave from the hospital.)
- Section 17 leave was authorised by the responsible clinician using the electronic database. There was a potential risk that other staff could amend the records.

Are services caring?

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

- Patients told us that staff were kind and provided them with good care.
- Most patients told us that staff were willing to talk to them and support them when they needed it.
- Patients told us that staff showed them respect.
- We observed kind, considerate and positive interactions between staff and patients and saw they were treated with kindness, dignity and respect.
- We observed warm interactions between staff and patients and saw that staff delivered care with compassion.
- Staff took time to interact with patients and to engage them in activities.
- We saw some very person-centred care, which was working well for patients with highly complex needs and behaviours.
- Patients received a timely and compassionate response to their needs and requests.

Good



Summary of findings

- Patients knew that they had a care plan and had been involved in developing it.
- Most patients could make telephone calls in private if they wanted to.
- Patients and carers were routinely involved in developing the service.
- Staff demonstrated that they had a good understanding of their individual patients and their specific needs.

Are services responsive to people's needs?

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

- All wards had excellent access to occupational therapy, sports activity and equipment.
- Patients could engage in meaningful activity and gain work experience. Educational certificates such as NVQs were available for patients to access.
- Staff also arranged fun activities and these included BBQs, crab-catching competitions, movie nights and music.
- At the Dewnans centre, the wrist fob system enabled patients to have a wide range of access around the unit based upon their assessed level of risk. They could manage their own access within the unit without requiring escorting by staff.
- Warren ward displayed a number of collaborative pieces of artwork, one of which was a collective mural depicting the different interests of the patients and staff. This was a striking piece and patients were particularly proud of their involvement.
- The outside spaces were well maintained and there were many examples of patients involved in horticulture.
- Patients gave examples of their cultural needs being met such as access to culturally appropriate food and visits to local faith buildings or visits from faith leaders. The Chaplains were key in facilitating this contact.
- Patients using the service told us that they felt listened to and were confident that if they had a complaint it would be acted upon.
- Patients were assessed and treated in a timely manner and were effectively supported to move on from the service when it was appropriate for them to do so.
- There were notices informing patients how to complain and how to access an advocate.
- The purpose-built facilities at the Dewnans centre were well appointed and appropriate for the service that was being delivered.

Outstanding



Summary of findings

- Specialist assessments such as speech and language therapy were arranged when needed.
- There were innovative approaches to providing integrated person centred pathways of care that included patients in their local community.
- The service collected patient feedback and made changes to reflect this.

However, we also found that:

- In the low secure service, only Chichester house was accessible to patients with restricted mobility. Owen house, Avon house and Connelly house were old and built over two floors, which made it difficult for anyone with restricted mobility to access them. The stairs were steep and there were limited bathroom facilities at Owen house.

Are services well-led?

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

- Staff told us that they were clear about their role in delivering the strategy of the service.
- Managers were visible on the wards and demonstrated the skill, knowledge and experience to lead their service effectively.
- Managers said they had both the support and autonomy to do their jobs effectively and were confident they could raise issues of concern with senior colleagues.
- Poor performance was managed effectively, with support from the human resources department if needed.
- Staff said they felt confident to raise concerns to senior colleagues or to use the whistleblowing procedure and felt their concerns would be taken seriously.
- Well-developed audits were in place to monitor service quality.

Good



Summary of findings

Information about the service

Langdon Hospital is an NHS forensic hospital based in Dawlish, Devon. The hospital site occupies 111 acres of rural land with sea views over the south Devon coast. The hospital is owned and managed by Devon Partnership NHS Trust. Langdon hospital provides forensic / secure inpatient services to men detained under the Mental Health Act (MHA).

The Dewnans centre has 60 inpatient beds on four medium secure wards: Ashcombe; Holcombe; Warren and Cofton. The Dewnans centre supports men on treatment pathways from admission through to long-term and step-down care as their health and wellbeing improves. Ashcombe is an admissions assessment ward and Holcombe is a ward for patients with complex mental health needs, which might include Personality Disorder. Warren and Cofton provide on-going care and treatment for patients who are still deemed to require medium secure care. Patients can move on to low secure services from all wards within the medium secure care unit.

Langdon hospital provides low secure services at Connelly house, an open six-bed rehabilitation ward; Avon house, a 14-bed low secure ward; Chichester house,

a 15-bed low secure ward for men with stable but enduring mental health conditions; and Owen house, a 16-bed open ward for men with complex mental health needs.

Most patients at Langdon hospital are from Devon, Plymouth and Cornwall but the hospital does provide care and treatment to patients from other counties. The service was treating five patients from other areas when we carried out the inspection. The hospital accepts admissions from high secure services, other secure units, adult mental health services, prison and the courts.

Langdon hospital was last inspected in February 2014. At that time, it did not meet regulations on safeguarding people who use services from abuse, assessing and monitoring the quality of service provision, and meeting the nutritional needs of patients. CQC inspectors carried out an unannounced inspection in March 2015 to see if the hospital had made improvements to meeting patients' nutritional needs and found that they had. In November 2014, CQC visited Ashcombe ward, Holcombe ward and Owen house to monitor how the Mental Health Act was being applied. CQC issued provider action statements to the hospital, which explained what issues they needed to address in order for them to comply with the Mental Health Act 1983 Code of Practice 2015.

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 that inspected Devon Partnership NHS Trust forensic inpatient / secure wards included two CQC inspectors, a Mental Health Act reviewer, two consultant forensic psychiatrists, five nurses, a manager, a pharmacist, and two experts by experience (people with experience of using services).

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

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 with comment cards that we placed around the hospital site.

During the inspection visit, the inspection team:

- Visited all eight of the wards at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 29 patients who were using the service and collected feedback from 13 patients using comment cards.
- Spoke with four carers or relatives of patients using the service.
- Spoke with six managers or acting managers of the wards.
- Spoke with 72 other members of staff including administrators, housekeepers, doctors, nurses, occupational therapists, sports and leisure activity coordinators, students and social workers.
- Interviewed the clinical director and three other senior managers with responsibility for the service.
- Attended and observed nine hand-over meetings, care programme reviews and multi-disciplinary meetings.
- Attended and observed a community meeting, a Recovery Star meeting, a Health and Well being meeting and a Quality Improvement meeting.
- Looked at 74 care and treatment records of patients.
- Carried out a specific check of the medication management on all eight wards and looked at 64 patient medication charts.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients told us that they were satisfied with the care and treatment they received from the service.
- Patients told us that staff treated them with kindness, dignity and respect.
- Most patients told us they received their allocated one-to-one time with their named nurse and most reported that their leave or activities were almost never cancelled due to short staffing.
- Patients said they enjoyed the variety of activities available to them and almost all patients said they participated in their activities.
- All patients said they had been involved in developing their care plans and almost all knew they had a copy of their care plan.
- Patients said they could see their friends and family and that staff routinely facilitated visits. However, some patients and families said that the rooms used for visits were not always available for them to use and that visitors did not have easy access to use the toilets.
- Patients and relatives knew how to make a complaint about the service and were confident they would be taken seriously if they made a complaint. However, one family member said it had taken more than six months to receive a reply to their complaint.
- We received 13 comment cards from the comment boxes we placed at the service. Eleven of the comments were positive, typically giving positive feedback about the care received. Two were negative, one of which related to a building not being suitable for the care provided there.

Summary of findings

Good practice

- Devon Partnership NHS Trust's forensic/secure inpatient wards provided a wealth of diverse patient activity opportunities. These ranged from relaxation and pat dog therapy to motor-cycle maintenance, crab-catching competitions, mountain biking, cricket and surfing.
- Patients at the Dewnans centre had access to an education and information technology room where "animation" classes had been run. Patients had been involved in producing a "Feedback Monkeys" film that had been displayed in the reception area to encourage patients and families to give feedback about the service. Patients had also been involved in producing a marketing video for volunteering campaigns.
- Strong links with the local community had been developed, which meant that patients could take part in a range of voluntary opportunities. These opportunities included working in a church-run café, working in a charity shop or on a local farm. Patients with more restricted leave opportunities could also develop work skills by undertaking placements in the hospital café or car-vaiting project.
- The service employed sports and leisure activity co-ordinators, who specialised in supporting patients to access sporting activities. Patients could use the gym, play basketball, play tennis, go swimming (in the nearby pool or in the sea), play cricket, and go cycling or mountain biking. This meant that patients could incorporate a healthy lifestyle and a wide range of fun activities.
- Chaplains were employed at the service and they supported patients to meet both their traditional spiritual needs and their therapeutic social needs. Consequently, the chaplains were able to escort patients on Section 17 leave so they could visit the shops or participate in voluntary work as well as meet their spiritual needs in places of worship. The chaplains were a well-established part of the multidisciplinary team and the level of their support was positively acknowledged by both staff and patients.
- The service had an embedded culture of patients being allowed to demonstrate positive risk taking. Examples of positive risk taking included self-medication programmes and access to exhilarating sporting activities.
- Senior managers gave examples of refusing to appoint to vacant posts if candidates failed to demonstrate the values and attitudes they felt were important for the service. Managers wanted to be sure that new staff could promote a compassionate culture in the service. One senior manager was due to retire but because the service had been unable to appoint to the post, they chose to continue working and lead the service until a suitable replacement could be found.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that there is a clear and effective policy in place for use of the patient wrist-tag tracking system.
- The trust should ensure that the extra care area and seclusion rooms at the Dewnans centre and the Seclusion room at Avon house comply with the recommendations set down in the Code of Practice 2015.
- The trust should ensure that all staff follow trust guidelines and make accurate checks before allowing patients to take their Section 17 leave.
- The trust should ensure that staff complete detained patients' Section 17 leave authorisation forms in line with the Mental Health Act Code of Practice and offer copies to patients.
- The trust should ensure that all confidential patient information is stored effectively and securely.

Devon Partnership NHS Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Name of CQC registered location

The Dewnans centre medium secure wards:

Ashcombe ward

Holcombe ward

Cofton ward

Warren ward

Langdon Hospital

Low secure wards:

Avon house

Chichester house

Owen house

Connelly house

Langdon Hospital

Mental Health Act responsibilities

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

- MHA training was not a mandatory training requirement. Data showed that 121 out of 173 staff were up to date with their level one MHA training in July 2015 and there was a plan in place to increase attendance with MHA training for nursing staff across the trust. However, all

staff that we spoke to demonstrated a good understanding of their responsibilities under the MHA. They had a good working knowledge of the MHA and the relevant sections relating to the patient group.

- All medication cards had copies of consent to treatment forms appropriately attached.
- There was good evidence of a full and thorough system for checking that Section 132 rights were regularly discussed with patients.

Detailed findings

- There was a MHA administrator based within the hospital and staff felt confident they could approach them with any issues relating to the MHA or the MCA.
- All detention paperwork was up to date. It was held electronically and could be accessed freely by staff across the site. Section 17 leave forms were electronically completed and the responsible clinician granted authorisation by signing the document electronically. There was a risk that the leave authorisation could be amended by other staff, not only the responsible clinician. However, all amendments could be tracked and audited in the event of an error. Ward staff checked the electronic system for up to date leave plans but also recorded patient leave on whiteboards in the offices. Some staff said they used the whiteboard as their reference because it was quicker than looking it up on the electronic records system (RIO). We saw one incidence of staff not cross-referencing the whiteboard with the leave care plan and found that the leave on the whiteboard was not the same as that recorded in the leave care plan. Using two systems concurrently posed a risk of patients taking the wrong leave because both systems were not being updated at the same time.
- Patients had access to generic advocacy, independent mental health advocates and independent mental capacity advocates. Information pertaining to detention under the MHA was available on all the wards. Records showed that patients were informed of their rights of appeal against their detention under the MHA section 132 MHA.
- Patients had access to mental health review tribunals and hospital managers meetings.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with showed a good awareness of the Mental Capacity Act (MCA) and the guiding principles. One person told us they were aware of how the MCA impacted on the client group and another described how the MCA could help when supporting a patient to manage their finances. The staff told us they received regular updates and training in the MCA and this was evident in the quality of the capacity assessments we observed in the patient care notes, particularly in relation to the use of e-cigarettes as a way of reducing smoking. Staff knew how to access the MCA policy and additional information about the act on the trust intranet.
- Mental capacity was discussed in clinical reviews and recorded throughout care and treatment records. Staff were aware when mental capacity assessments had taken place and where to locate them. Mental capacity and best interest meetings were held.
- All patients within the service were detained under the Mental Health Act and there were no DoLS applications required.

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 refer to the summary at the beginning of this report.

Our findings

Safe and clean ward environment

- At the purpose built Dewnans centre, all wards had clear lines of sight for observing patients. Convex mirrors were used in areas where full easy sight was not possible. Staff also said they regularly checked corridors and would discretely follow a patient if they moved out of view. There were systems in place for staff providing patient observations and for this to be documented.
- Avon house, Connelly house and Owen house were old buildings spread over two floors. Staff had to go upstairs to observe patients because there were no clear lines of sight.
- There were multiple ligature points on the low secure wards. However, staff told us they were able to manage these risks effectively. Ligature points were identified using the trust's screening tool and environmental ligature assessments were completed annually. We examined a sample of these and saw that identified risks were either eliminated or managed using individual patient risk assessments. Staff were aware of the ligature audits and told us they felt able to manage individual patient risks. Ligature cutters were easily accessible. They were stored safely and staff were able to tell us where they would get them if needed.
- The service was commissioned to provide care and treatment for men only, so was fully compliant with the Department of Health guidance on same sex accommodation.
- All wards had medication dispensing rooms. Patients did not access these rooms as they were used solely for the dispensing of medication.
- Resuscitation and emergency equipment was available on all wards and this was regularly checked. Emergency medication and maintenance schedules were in date. Each ward carried out its own checks but there was no central audit of the check process. Clinic rooms were clean and well stocked. Stock items were in date and facilities were available for safe disposal of sharps and waste.
- Each ward carried out regular supportive checks, observing where patients were and what they were doing. Each ward also carried out environmental security checks to make sure the ward was a safe environment for patients and staff and these were consistently completed.
- The Dewnans centre had two seclusion rooms and two extra care areas that were used for patients who needed to be nursed away from the wards. Seclusion is the supervised confinement of a patient to contain severely disturbed behaviour which is likely to cause harm to others. Patients in the seclusion rooms could see a clock to keep them oriented to the time of day and had some natural daylight. They could communicate with staff outside the rooms with a two-way intercom and staff could see them clearly to make sure they were safe. However, the seclusion rooms did not have an en suite shower, so bathing arrangements for secluded patients were problematic because they had to share the same shower facilities as the patients who were placed in the extra care areas. Moving secluded patients could pose a risk to staff and other patients who were using the same area. There was an incident in June 2015 when a member of staff was badly hurt while moving a patient.
- The seclusion rooms at Avon house and Chichester house did not have toilet facilities. If patients needed to use the toilet, staff had to escort them out of the seclusion room to use a nearby toilet, where we identified ligature points. Alternatively, staff said they could offer the patient a disposable receptacle. This option would be less dignified and less comfortable for the patient. Additionally, staff would either have to remain with the waste until a colleague relieved them or leave their observation post to dispose of it. This could pose a risk to patient safety.
- At the time of our visit, a patient from Warren ward was using the extra care area (ECA) at the Dewnans centre. The documentation for the long-term segregation and attempted re-integration of this patient was checked and found to have been completed fully. It displayed a clear rationale for the long-term segregation and a clear

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plan to support the patient to return to the ward environment safely. The patient was sleeping in one of the seclusion rooms and using one of the ECA lounges during the day. This meant that the use of the ECA impacted negatively on the other seclusion room and access to the shower room because they were both located in the ECA corridor.

- The ward areas were visibly clean and well maintained. We looked at the ward cleaning schedules and saw that regular audits for cleanliness were undertaken by the housekeeping department and the trust infection prevention and control team. This meant that the ward environments were clean and infection prevention was being managed. We looked at Patient Led Assessment of the Care Environment (PLACE) scores. Langdon hospital scored 99.6% for cleanliness and 97.5% for condition, appearance and maintenance of the environment. This meant that the hospital scored higher than the England average score and Connelly house was assessed separately and scored 100% for cleanliness and 94.3% for condition, maintenance and appearance, which was also higher than the England average. Patients told us that their wards were cleaned regularly and well. Most patients cleaned their own rooms with some support from the housekeepers. We spoke with members of the housekeeping team who were very proud of their ability to keep the wards clean and felt they were an important part of the team. In line with the hospital water checking procedure, there was a system in place to ensure that the showers and taps in vacant bedrooms were regularly audited and fresh water flushed through the system.
- There were hand-washing signs in communal toilets and we observed that staff followed correct hand washing procedures during the dispensing and administration of medication.
- Environmental risk audits were completed across the hospital site. These considered structural aspects of the buildings. Between audits, staff were able to report any structural defects to the estates team to be rectified.
- Patients on Warren, Cofton and Holcombe told us that they had wrist fobs to enable them access to their bedrooms. However, the service deemed it was not appropriate for patients to have unrestricted access to their bedrooms on Ashcombe ward due to the risks associated with their presentation. When we spoke to the staff and patients on the wards, it became apparent that not all patients had a fob for their rooms. This was

not based upon risk assessments but was because some fobs had been lost or broken. We were told that the fobs enabled staff to track the wearer anywhere within the hospital building and an alarm was triggered if the fob was removed from the wearer. This was being managed in a supportive way, empowering the patients to access different areas of the hospital. However, it was not clear if the patients had been fully informed that the fob system tracked their movements. The wards did not have a policy on the operational use of the fobs and patients did not have individual contracts for their usage.

- All staff carried personal alarms and a member of staff on each ward was identified at the start of the shift to be the first responder in the event of an incident across the hospital site. We heard the system being tested and saw the auditing process used. The system used a voice call alarm at the Dewnans centre and an alarm across the rest of the site. Some staff told us that the regular alarm testing on the low secure wards was distracting and unpleasant for both patients and staff, particularly when there was a fault with the system that meant the alarm sounded more often and longer than usual. We were present when there was a fault with the system and there were repeated loud alarm sounds.

Safe staffing

- Clinical team managers told us that staffing levels were determined by the trust, using a “safer staffing tool” but we were not shown the methodology for how this was worked out. Trust data showed that in April 2015 the service had an agreed establishment of 95.7 whole time equivalent qualified nurses (WTE) and 112.8 nursing assistants. There were 29.3 vacancies for qualified nurses and 5.3 vacancies for nursing assistants across the service. The staffing establishment of nurses and nursing assistants had increased in April 2015. The highest vacancy rate was at Owen house with 8.6 nurse and 5.1 nursing assistant vacancies. Ashcombe ward had 4.1 more than their agreed establishment of nursing assistant posts. The vacancy rate was placed on the service risk register and the trust was actively recruiting to their vacancies. Senior managers noted there was a national shortage of these nurses and their situation in Devon was not unique. However, they were positive about the way they were addressing their recruitment and they were employing long-term agency staff in the interim to ensure consistency of care for patients. The

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service had also increased incentives for staff by introducing new developmental opportunities for both nurses and health care assistants. Trust data showed that between February and March 2015 all wards in the Dewnans centre had over 100% fill rate for qualified nurses, which meant that they had more nurses at work than they had planned for. However, on Ashcombe ward the average shift fill rate for qualified nurses was 84% during this period, which meant that 16% of shifts ran without a second qualified nurse, the minimum requirement for safer staffing. All shifts were run by at least one qualified nurse and support workers were used to backfill short falls and ensure safe care. When nursing shifts are not filled, there is a risk that not all patients will get the care they require at the time they need it so the service tried to mitigate against this by increasing the numbers of health care assistants if there were nurse shortages. No shifts went uncovered at Owen house and Chichester house during April 2015 but both Connolly house and Avon house had one shift each that could not be covered by bank or agency staff during the period. Trust data showing sickness rates across the service showed 10.4% sickness levels on Holcombe ward compared to a rate of 4.9% for mental health and learning disability services nationally (Health and Social Care Information Centre Jan-Mar 2015).

- The service had a high reliance upon regular agency staff but some agency staff had been deployed on specific wards for over a year. There were systems in place to properly induct and support these staff. We spoke with an agency nurse who told us they very much felt part of the team and were supported in their role. Some patients at the Dewnans centre told us they felt the agency nurses “knew what they were doing”.
- The clinical team managers were able to adjust staffing levels to take account of patient needs. They told us they had the autonomy to make these decisions and were supported by their managers. Staff were moved around the service if needed. The service had introduced a “pool” of health care assistants that worked in a peripatetic style. They were managed by the clinical team manager at Avon house but were deployed to the wards with the greatest need for increased staffing or to cover for staff absence. We also saw that the clinical team managers held a daily conference

telephone call with each other in order to resolve staffing issues and the senior nurse manager was involved in this. Issues could be escalated to senior managers if necessary.

- The service used long-term agency nurses to cover for some staff vacancies. This meant that every patient had an allocated nurse. When we looked at care records, we saw evidence that one-to-one support time was taking place with the patients but this was not always recorded on a weekly basis. Patients told us they received their one-to-one time with staff but several told us that staff were too busy to find time to talk to them at other times. Patients told us there was always a qualified nurse present on the wards.
- Four patients told us there were not enough staff to support their Section 17 leave. We looked at the Section 17 leave records and found that patients with corresponding leave entitlement did leave the wards to go into the community at least once a week if they were assessed as safe to do so. One patient at Chichester house said their leave was cancelled three or four times a month and that their activities were cancelled or delayed every two weeks. However, the vast majority of patients said their leave or activities were not cancelled or delayed due to staff shortages and records showed that on the morning of the inspection visit six leaves were facilitated from Chichester house and 12 had taken place the day before.
- Each ward allocated a member of staff from every shift to respond to emergencies. Staff from across the hospital site worked together to respond as a team when the emergency alarm was sounded. This meant that the hospital provided enough staff to respond to emergencies, in order to protect both patients and staff. Staff told us they felt safe on the wards and felt supported by their colleagues in the event of an incident. However, an anonymous letter said wards were not safe but it did not explain why. One member of staff at Avon house said that having a team of just three staff working on nights meant that when the emergency responder left the ward, if one member of staff was providing direct patient observations there was only one member of staff to care for the rest of the patients. However, no other staff reported this was a problem and there was no evidence that patient need or staff safety was compromised at night.
- During office hours, there was adequate cover for medical staff to attend the wards in an emergency. Out

Are services safe?

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of normal office hours, the consultants operated a 1:7 on call rota which included working one weekend in every seven. During their on call weekend, the consultants were on site at Langdon Hospital for 6 hours on a Saturday and Sunday. They were on call for the rest of the weekend, so there was daily consultant cover at the hospital. There was a junior doctor on call rota, provided by senior house officers, which was based in Exeter, about 20-30 minutes away by car. The junior doctor on call rota supported the on call consultant. Some staff told us that this could be problematic for reviewing patients in seclusion during out of hours. However, when we checked a sample of the seclusion review documentation, there were no recorded problems with the timeframe for face-to-face reviews and there was no evidence of delays for patients.

- Trust data showed that very high levels of staff were up to date with their mandatory training. Even the wards with the lowest compliance (Holcombe and Cofton) had 91% of staff who were up to date with their mandatory training requirements. The service was exceeding the trust target of 90% compliance with mandatory training.
- Staff were responsible for serving food and snacks to patients. Staff across the service told us there was no longer any training for food hygiene because the trainer had retired. Staff at ward level told us that all those who served food to patients were currently in date with their food hygiene training and that senior managers were aware that there was no longer a training programme in place. Senior managers confirmed that there had been a gap in providing this training but they were in the process of arranging a new training programme for staff responsible for handling patient food.

Assessing and managing risk to patients and staff

- There was clear evidence that patients were risk assessed on admission and had up to date risk assessments, which were linked to their care plans. The service used the detailed historical clinical risk management tool (HCR-20 v.2) for violence risk and these were updated regularly at ward review and CPA meetings. We attended two CPA meetings across the service and saw that staff used the HCR 20 with the patient to develop their care plans.

- We saw that audits carried out by the infection prevention and control team highlighted the need for all patients to receive an infection assessment within 72 hours of admission to the service and for this to be documented in the electronic patient records system.
- There were blanket restrictions in place but these were clinically appropriate for the secure services environment. Restrictions included access to mobile telephones at night and how much money patients should have access to when on unescorted leave. However, on Ashcombe ward patients were not allowed access to televisions in their rooms. This meant that, regardless of their individual risks, patients had no individual entertainment within their personal room space.
- The trust had a policy on the management of patient observations and the service followed this. There was a planned system for ensuring that all patients were allocated individual staff members to observe them on a shift-by-shift rotation. The policy relating to the management of ligatures identified the individual clinical risk indicators of patients and factored this into a risk score for each patient in each room, in order to reduce risks.
- All the staff we interviewed told us that restraint was only ever used as a last resort. They told us that de-escalation techniques would always be tried before physical intervention techniques. Data from the trust showed that Ashcombe ward had the highest level of restraint recorded for the service between November 2014 and May 2015, with 40 incidences involving 13 patients. Across the service, there were 87 incidents of restraint during the period, eight of which were in the prone position (seven on Ashcombe ward and one at Avon house). There were 28 patients involved in the 87 incidents of restraint. Staff explained that the ethos of the clinical team was to use de-escalation primarily, with physical intervention as the last resort rather than medication and rapid tranquilisation. Data confirmed that there was no use of rapid tranquilisation during the period. We looked at a snapshot of mandatory training data for 30th April 2015 and found that Owen house, Avon house, Coften ward and Chichester house were all 100% compliant with their personal intervention / restraint training. The lowest compliance was Connolly house at 90.9% followed by Holcombe ward with 92% but this was still above the trust target of 90%.

Are services safe?

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- We inspected seclusion records and found that between November 2014 and May 2015, there were 37 incidents of seclusion across the service. Twenty-four were on Ashcombe ward, six at Avon house, three at Chichester house, three on Holcombe ward and one on Coften ward. The Dawnans centre recorded nine incidents of long-term segregation during the same period. Six of these were on Ashcombe ward, one at Avon house, one at Chichester house and one on Holcombe ward. Rationales for long-term segregation, over 72 hours, were available to inspect and we judged all these to be appropriate.
- Seclusion records were initially recorded on paper and then transferred to the electronic record system by administrators. Managers ensured that the electronic patient records system held copies of the paper documents, so staff could easily access them when they needed to. We were shown “grab packs” of paperwork that were prepared to support the process by ensuring staff had easy access to the correct documentation in an emergency. The use of restraint, seclusion and long-term segregation was discussed and closely monitored at patient safety meetings.
- All staff undertook basic safeguarding training as part of their mandatory training. Trust records showed that in April 2015, 100% of staff on all wards had undertaken this training except for Ashcombe ward where the rate was 97.2%. All staff we spoke with were clear about their safeguarding responsibilities and knew how to identify and make a safeguarding referral within office hours and during the evening / weekend. Staff were able to identify their local safeguarding leads and knew how to seek support if they needed it. Seven safeguarding referrals had been made between January 2014 and June 2015 and 8 alerts or concerns had been raised since May 2015.
- We observed a sample of shift handover meetings. These were thorough and effective. Risk, support, physical health care and leave were all discussed in the handover meetings.
- There was good medication management at the hospital. Safe but flexible dispensing was used and there were no institutionalised practices such as patients queuing for their medication. Managers had a system in place to monitor reported medication and administration errors. Incidents were recorded and analysed with actions set so that staff could minimise the risk of reoccurrence. Wards at the Dawnans centre had CCTV installed in the clinic rooms so that staff could monitor the risks associated with the management of medication in order to protect both staff and patients. Pharmacists were based on site and each ward received regular weekly visits from a pharmacist and a technician. We looked in detail at medication management at Connelly house. The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and associated regulations. Pharmacy technicians made weekly checks of medicines storage. All medicines were supplied under service level agreements from the neighbouring NHS trust. The prescribing of medicines against T2/T3 forms was checked by the clinical pharmacists. (T2 forms record that patients have consented to their treatment. T3 forms record that treatment has been properly authorised for patients who were unable or unwilling to consent.) NHS prescription forms were available in case medicines were needed out of hours; these forms were kept securely. Training in medication reconciliation, storage of medicines and administration was available from onsite nursing and pharmacy staff. We looked at 64 medication charts across the service and found if there was prescribing of high dosage antipsychotics physical health checks were carried out for patients. Patient allergies were clearly recorded. The prescribing of “as required” (PRN) medication and sleep medication was regularly reviewed. Patients at Connelly house were supported to manage their own medication as part of the discharge preparation process. We found that good systems were in place to manage these risks such as risk assessments, regular checks and storage in locked cupboards. One patient told us how proud he was of managing his own medication effectively.
- Children were not permitted entry to the ward areas at the Dawnans centre. However, the trust did have a child visiting policy, which the service followed. Visits from accompanied children were permitted following suitable risk assessments. A family room was available to accommodate visits and alternative venues off site could be accommodated if this was required. The service was part of the Royal College of Psychiatrists’ quality network for forensic mental health services. Members of the network regularly reviewed each other’s service and provided a report with recommendations. The latest peer review provided by the quality network noted that there were no toys available for children to

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play with because Langdon staff felt this would introduce an infection risk. The peer review report suggested that the service might wish to review this policy in the interests of making the visiting area more comfortable for child visits to take place.

Track record on safety

- Between January 2014 and February 2015, there were two reported serious incidents, both of which occurred on Ashcombe ward. Staff were able to describe changes to the service that had taken place as a result of these incidents. Simulation exercises had been introduced to reflect learning from incidents and staff had received information about the incidents.
- In June 2015, a member of staff sustained significant injury following assault by a patient in the Ashcombe ward extra care area. Following the incident and subsequent investigation, the service decided they would no longer routinely deploy agency staff to Ashcombe ward unless they had undergone physical intervention training.

Reporting incidents and learning from when things go wrong

- There was a governance framework in place, which encouraged and supported staff to report incidents. Almost all staff were able to explain confidently how they reported incidents using the electronic reporting system. Managers demonstrated how they reviewed incident reporting in their teams. Following incidents, investigations and analysis had taken place and the learning had been shared with staff. All the permanent nursing staff we spoke to felt confident using the electronic incident reporting system. However, short-term agency staff were unable to access the electronic system and some health care assistants told us that they did not use it but they reported incidents to their senior colleagues who completed the electronic recording system for them. Other health care assistants told us that they did use the electronic incident reporting system. As there was some confusion about whether health care assistants could use the electronic reporting system and because short-term agency staff could not access the system, this meant that incidents might not be recorded effectively.
- Managers were able to capture information about incidents, near misses and never events. The service analysed the information and shared it with staff.

Clinical team managers held weekly meetings that enabled them to discuss issues and then feedback to their staff teams. Regular staff team meetings were held and incidents were discussed. Staff also told us they discussed incidents in their supervision and information about incidents was also shared in emails. Trust data showed that between January 2014 and February 2015, there were no serious incidents that required reporting under the serious incident framework (NHS England, March 2015). There were 312 incidents reported in the service between April 2014 and March 2015. One was reported as severe, six as moderate, 131 as low harm and 174 as no harm.

- Post incident debriefing was available for patients and staff to reflect on incidents and identify actions. Most staff told us they had been involved in debriefs following incidents. We looked at the safe and therapeutic management of violence and aggression report dated March 2015. The report illustrated an audit from June 2014 that showed two out of five restraint incidents involved the staff in a debrief. One member of staff told us the de-briefs were not structured but another told us that they had improved. Most staff told us that they received feedback from investigations but one member of staff told us that the staff were usually the last to know any outcomes.
- Staff were able to explain how learning from incidents was shared in team meetings, emails and staff newsletters. Staff also explained that they had developed simulation exercises in order to effectively learn and share information. Managers and staff were able to give us examples of how changes were made following serious incidents, such as decisions not to deploy agency staff unless they had undertaken training in physical interventions (control and restraint). We looked at supervision audits and saw that incidents, restraint and safeguarding were included in supervision.
- Staff were open and transparent with patients when things had gone wrong. We were told that a patient had missed a community hospital appointment because staff had forgotten to arrange enough cover to facilitate the leave. The patient had been given both a verbal and a written apology.
- The service listened to staff and patient feedback and made changes to the way the service was delivered. Examples of changes included alterations to patient menus and the inclusion of additional patient activities.

Are services effective?

Good 

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

Summary of findings

Please refer to the summary at the beginning of this report.

Our findings

Assessment of needs and planning of care

- Almost all patient records showed that a physical examination had been completed when the patient had been admitted to the hospital. All patients had support and encouragement to attend to their physical health care needs. There were two sets of care plans that did not indicate the need for the ongoing monitoring of a physical health issue. However, the inspection team found evidence in the daily care records that these two patients were receiving physical health care when required. There were examples of patients with very specific physical health needs having well developed and thorough individualised care plans.
- There were detailed and thorough care plans that supported patients but also addressed risk to others in a safe and effective way. We randomly sampled care plans back to 2013 and saw that the practice of updating them regularly was embedded within the service. We found the care plans were recovery focussed and had adopted the widely used "my shared pathway" approach toward care planning. They were person centred and holistic.
- Some patients told us they needed support with managing their weight. Staff outlined ways in which they supported patients to manage their weight and promote healthy eating and healthy lifestyles. For example, weight and body mass index were regularly checked, healthy living advice and attendance at health promotion groups was offered. Shift handover meetings and clinical review meetings showed how staff encouraged healthy eating, offered support to patients and monitored food portion sizes and requests for second helpings. Patients' mental capacity to make decisions regarding their eating and weight was assessed and recorded. Specialist advice from the dietician and physical activity instructors was available to patients and was routinely used. Additionally, the physiotherapist and physical activity staff were fully integrated in to the multidisciplinary team.

- Staff used electronic records and some paper records. Patient progress was monitored and recorded in care records. The management of section 17 leave was via a section 17 leave care plan rather than via a signed copy of an authorisation held on the ward. This meant that prior to a patient taking section 17 leave, the care plan had to be checked for the most up to date version. Staff told us that this could sometimes lead to delays supporting patients to access leave. We observed patients being supported to take section 17 Leave without the electronic care plan being checked as the staff were confident that the leave arrangements had not been changed and were relying on the information on the whiteboard to be correct. In one case, we requested staff check the leave care plan and they found that the care plan had not been changed. Therefore, staff were not always following the section 17 leave protocol and there was the potential for risk to patients and others if patients took leave that was not authorised.

Best practice in treatment and care

- Access to psychological therapy had been varied across the service due to a shortage of psychologists. At the time of the inspection, there were no psychology led groups running and patient access to one to one psychology had been limited on some wards. We met with the newly appointed lead psychologist who confirmed that new psychologists had been appointed and were waiting to start work. There had been a recent investment and commitment to psychological services and newly appointed staff were due to start in September and October 2015.
- The hospital had a service level agreement with a local GP surgery. A GP visited on a weekly basis. Patients had access to the visiting GP when required. The wards also had access to a practice nurse from the local GP surgery. We looked at patient records and saw that patients were receiving appropriate health care when they needed it. We observed all wards had well equipped treatment rooms and access to dental care with a specific dental care suite allocated to Holcombe ward. This dental suite enabled the visiting dentist access to all the equipment required to carry out routine dental treatment. Patients could see their own dentist in the community if they preferred and if they had appropriate section 17 leave.
- Assessments took place using nationally recognised tools including the health of the nation outcome scales

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and historical clinical risk management. These were regularly updated at clinical review and CPA meetings. Occupational therapy staff used the model of human occupation tool. Recovery star was routinely used. This is a nationally recognised evidence-based tool for supporting and measuring change in adults who are managing their mental health or recovering from mental illness.

- Ward-based audits took place of, for example, hand hygiene, care planning, carer involvement, record keeping, medicines management and infection prevention control. Recommendations from audits were carried out.

Skilled staff to deliver care

- The teams included nurses, nursing assistants, nurse managers, consultants, speciality doctors, psychologists and therapy staff, occupational therapists, social workers, approved mental health professionals, pharmacists and technicians, a physiotherapist, physio sports-activity staff, administrators, housekeepers, and there was a vacant part time dietician post. However, at Chichester house and Avon house there had been a vacant psychology post, which had meant that a number of patients who were assessed as requiring psychological therapy had not been provided with it. A temporary psychologist had been deployed to cover the vacancy but one family member told us that they were only there for a short time and left without preparing the patient for their departure, which had left the patient feeling vulnerable and unhappy. However, new staff had since been recruited to the psychology team and we were assured that patients would receive the therapy they were assessed as requiring.
- New staff had both a suitable trust and local induction programme prior to working on the wards.
- Staff and managers told us that regular clinical and managerial supervision was provided. Trust audits showed that in July 2015, 85.8% of staff had received supervision within the previous 60 days. We also saw that 89% of staff had received an appraisal within the previous 12 months.
- Managers told us checks were in place to ensure that any agency staff had received the required training prior to being booked to work at the hospital. Contracted agency staff had completed an induction programme and were subject to the same supervision mechanisms as established staff.

- Staff gave examples of specialist training they had been offered, such as support to undertake university degree pathways and vocational qualifications. We were also told about the two new pathway programmes for supporting band four nursing assistants into advanced practitioner roles and activity workers into the occupational therapy pathway toward advanced practitioner roles.
- Regular team meetings took place and staff told us that they felt supported by colleagues and managers and had supervision and appraisals. Additionally, reflective practice learning sessions led by the psychologist were available at the Dewnans centre. Appraisals and supervision data we looked at confirmed this. However, on some wards we found gaps in the recording of supervision sessions. Staff said this was because supervision was recorded as having taken place on one system but the notes were either hand written or recorded into another system. The two systems were not compatible indicating the trust data extracted might not always be accurate. Managers and supervisors told us this was being monitored and actions taken to improve the quality of data capture.
- Staff told us that they felt performance issues would be dealt with promptly via the line management structure. Managers felt supported by the human resources and administration teams because information was made available to them when they needed it and there were trust policies to guide them. Systems were in place to support managers with risk assessments and alternative working environments for pregnant women.

Multi-disciplinary and inter-agency team work

- The wards had weekly clinical review and multi-disciplinary (MDT) meetings. There was a programme for all patients to be reviewed, this information was shared with the patients so they were aware in advance of when they were due to meet with their clinical team. We also saw there were regular Care Programme Approach meetings. We observed very thorough MDT meetings with full patient involvement and support from the whole MDT. Where the housekeeper had been identified as having a good relationship with some patients, they were able to provide information into the handover and MDT meetings in order to support the patient and the MDT process.

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- We observed five handover meetings between shifts and found they were all well-structured and effective. The wards used a handover framework tool, which meant that clinical and risk information was handed over to colleagues in detail.
- Managers informed us that the care-coordinators from the local teams could be hard to engage with when they needed to discuss moving patients on from the service.

Adherence to the Mental Health Act and the Code of Practice

- Trust data showed a low level of staff trained in the Mental Health Act (MHA) across all wards. MHA training was not a mandatory training requirement. Data showed that 121 staff out of 173 were up to date with their level one MHA training in July 2015 and there was a plan in place to increase attendance with MHA training for nursing staff across the Trust. However, all staff demonstrated a good understanding of their responsibilities under the Act. Staff we spoke with had a good working knowledge of the MHA and the relevant sections relating to the patient group.
- Medication cards had copies of consent to treatment forms appropriately attached.
- There was good evidence of a full and thorough system for checking that Section 132 rights were regularly discussed with patients.
- There was a MHA administrator based within the hospital and staff felt confident they could approach them with any issues relating to the MHA or the MCA.
- All detention paperwork was up to date. It was held electronically and could be accessed freely by staff across the site. Section 17 leave forms were electronically completed and the responsible clinician granted authorisation by signing the document electronically. There was a risk that the leave authorisation could be amended by other staff, not only the responsible clinician.
- Ward staff checked the electronic system for up to date leave plans but also recorded patient leave on whiteboards in the offices. Some staff said they used the whiteboard as their reference because it was quicker than looking it up on the RIO electronic records system. We saw one incidence of staff not cross-referencing the whiteboard with the leave care plan and found that the leave on the whiteboard was not the same as that

recorded in the leave care plan. Using two systems concurrently posed a risk of patients taking the wrong leave because both systems were not being updated at the same time.

- Patients had access to generic advocacy, independent mental health advocates and independent mental capacity advocates. Information pertaining to detention under the MHA was available on all the wards. Records showed that patients were informed of their rights of appeal against their detention under the MHA section 132.
- Patients had access to mental health review tribunals and hospital managers meetings.

Good Practice in applying the Mental Capacity Act

- The staff we spoke with showed a good awareness of the Mental Capacity Act (MCA) and the guiding principles, one person told us they were aware of how the MCA affected the client group and another described how the MCA could help when supporting a patient to manage their finances. The staff told us they received regular updates and training in the MCA and this was evident in the quality of the capacity assessments we observed in the patient care notes, particularly in relation to the use of e-cigarettes as a way of reducing smoking. Staff knew how to access the MCA policy and additional information about the act on the Trust intranet.
- Mental capacity was discussed in clinical reviews and recorded throughout care and treatment records. Staff were aware when mental capacity assessments had taken place and where to locate them. Mental capacity and best interest meetings were held.
- All patients within the service were detained under the Mental Health Act and there were no DoLS applications required.
- The staff we spoke with showed a good awareness of the MCA and the guiding principles, one person told us they were aware of how the MCA affected the client group and another described how the MCA could help when supporting a patient to manage their finances. The staff told us they received regular updates and training in the MCA and this was evident in the quality of the capacity assessments we observed in the patient care notes, particularly in relation to the use of e-cigarettes as a way of reducing smoking. Staff knew how to access the MCA policy and additional information about the act on the Trust intranet.

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Are services caring?

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

Summary of findings

Please refer to the summary at the beginning of this report.

Our findings

Kindness, dignity, respect and support

- All the care plans we looked at showed evidence of patient involvement. They contained detailed patient views and comments about their care pathway. Care plans were specific to patient need and showed clear evidence that the patients' thoughts and feelings had been addressed throughout the planning and evaluation of their care plan. Care plans were holistic, person centred and recovery focused.
- Staff showed a good understanding of their patients' individual needs and we observed good rapport between patients and staff.
- Patients told us that they liked the staff and many said that they were better than the staff in their previous hospitals. Patients told us that the staff treated them fairly and almost all comments were positive. Most patients were positive about the support they received on the ward. Where they had concerns, we found that staff had fully investigated their complaints.
- We saw many very warm and caring interactions between staff and patients and humour was used appropriately.
- Bedrooms could be personalised with pictures, photographs and personal items if patients wanted.
- All except three patients said they felt staff respected their privacy and dignity and showed this by knocking the door before entering their rooms.
- Patients were supported to undertake vocational training qualifications with a local college if they wanted to. Patients were also supported to develop their employment opportunities.
- Staff maintained good confidentiality on the wards but there were whiteboards in the offices that contained confidential patient information and these could be seen through the office windows. This meant that patients were able to identify what MHA section and risk levels were recorded for other patients.

- We looked at Patient Led Assessment of the Care Environment (PLACE) scores for 2014 and saw that the hospital achieved 92.2% for privacy, dignity and wellbeing. Connelly house was assessed separately and it scored 90.7%. These scores were higher than the average for England. The score for food was 92.6%, which was higher than the trust average and higher than the England average.

The involvement of people in the care they receive

- The wards had a clear admission process. New patients were given an introduction to the environment and there were information booklets available for patients and carers. Staff told us they followed the formal process for welcoming new patients, which included showing them around and supporting them to attend the morning meetings so that they could introduce themselves to other patients.
- The patients had daily meetings and weekly community meetings on the wards. There were also patient forum meetings and patient council meetings. Patients were active in attending these meetings and minutes of meetings showed that patients were confident to raise issues with staff in these fora. Patients had been involved in service developments such as the smoke free environment changes.
- Most patients said they had a copy of their care plan but a number chose to keep it in the ward office. Patients told us they could request a copy of their care plan if they wanted to look at it. There was consistent evidence of collaborative working between patients and staff to develop their care plans. The care plans were written in a way that was person-centred and gave full meaning to the patients' goals.
- Carers and families were routinely involved in patients' CPA meetings. Risk assessments were developed and openly discussed with patients.
- Patients could develop advanced directives alongside their care plans, in order to indicate how they would like to be supported in the event of deterioration in their mental health. Some patients chose to develop advanced directives and were supported by staff to do this.
- We attended a recovery star meeting and found that the patients were positively involved in the process of their recovery and felt able to discuss and support each

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other. Recovery star is an evidence-based tool for supporting and measuring change with adults who are managing their mental health or recovering from mental illness.

- The service had a clear strategy for engaging with carers and held six monthly carers' events. Warren ward had a family and carer specific area where information and surveys were carried out to gather family views of the care their family member was receiving from the ward. The service provided a positive and pro-active opportunity for family members and carers to engage with the ward management team. Avon house had held carers events. Family members and carers spoke positively about the staff on all wards and had been supported to make a complaint if they felt they needed to. However, one relative told us that there was no toilet available for visitors near the room where they held visits at Chichester house so they had to be escorted from the visitor's area by staff if they needed to use a toilet.
- All wards had access to the local advocacy service. Contact details were clearly displayed and the advocates regularly attended the wards to support patients in CPA meetings and clinical review meetings. Staff understood the role of the independent mental health advocate and could refer patients to the service if required. We observed effective and positive interactions between the advocates and patients and staff.
- "You said, We Did" boards were used on the wards. These were used by staff and patients to record feedback. We saw examples of patients asking for trips to specific markets, which had been booked.
- Patients were not routinely involved in the staff recruitment process. However, we were told that this was something the service was committed to doing and they were exploring ways of involving patients.

Are services responsive to people's needs?

Outstanding



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

Summary of findings

Please refer to the summary at the beginning of this report.

Our findings

Access and discharge

- Average bed occupancy across the service in the six months leading up to the inspection was 94.6%. All eight wards had a bed occupancy rate of more than 85%, with Avon house having 100%. There was a waiting list for admissions to the Dawnans centre and one patient was waiting for a transfer to the low secure service. The service did not accept unplanned admissions; all were planned, involving pre-admission assessment. In July 2015, the average length of stay in the medium secure service was 369 days and 538 days in the low secure service. There were no recorded readmissions within 90 days.
- We saw no evidence that patients were moved between wards during an admission for non-clinical reasons. When patients were moved, this occurred at an appropriate time of day. Staff told us that if a patient required intensive psychiatric nursing care a bed could be located on a psychiatric intensive care unit ward.
- Data showed that between 1st November 2014 and 30th April 2015 there were four delayed patient discharges – one each at Chichester house, Cofton ward, Connelly house and Owen house. Staff told us that patient discharge could be delayed due to reasons beyond the control of the service, such as no “move on” placement being available. However, there was good liaison between commissioners and the service, which enabled them to have a wider view of vacancies nationally and locally.
- The hospital held a weekly bed management meeting, which considered admission and discharge planning. NHS England commissioners were involved in this meeting along with ward doctors and managers. We observed that all wards were systematically reviewed and all potential discharges and admissions were considered during this meeting. Local and national vacancies were discussed.

- The service accepted admissions from high secure services, other secure units, adult mental health services, prison and the courts.

The facilities promote recovery, comfort and dignity and confidentiality

- All wards had excellent access to occupational therapy, sports activity and equipment. We observed that sessions for yoga, cricket and access to the gym took place. Patients were clear what their activity plans were and what services were available to them. There was a patient run café, a car valeting service and clothes shop on site where patients could engage in meaningful activity and gain work experience. Patients could also learn motor cycle maintenance. Educational certificates such as NVQs were available for patients to access. The therapy area at the Dawnans centre enabled patient to access a variety of therapeutic and learning activities, which included a heavy and light workshop, a library and a computer workshop. Patients on the low secure wards had greater access to leisure activities, which included fishing, mountain biking, surfing, swimming; and tai chi. Fun activities were also arranged by staff and these included BBQs, crab-catching competitions, movie nights and music. Some staff shared their music interests and involved patients in things like playing the guitar.
- At the Dawnans centre, the wrist fob system enabled patients to have a wide range of access around the unit based upon their assessed level of risk. They could manage their own access within the unit without requiring escorting by staff. The door entry system allowed all patients wearing fobs to be located easily if they needed to be contacted in an emergency.
- All wards had a well-equipped treatment area for patients to be able to see visiting clinicians. The local GP visited the hospital every week, as did the practice nurse. Patients with appropriate levels of Section 17 leave could also visit the local surgery.
- All wards had open communal lounges with access to televisions. A galley drinks area on wards at the Dawnans centre enabled patients to make hot and cold drinks 24 hours a day. Patients bought their own snacks. If they had leave, they did this at the local shops. Patients on the low secure wards could ask staff for drinks after 11pm but could not make them themselves. Patients at the Dawnans centre could book small TV rooms to watch programmes of their choice. All wards

Are services responsive to people's needs?

Outstanding



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

had a quiet area. The ward areas were appropriately personalised. Communal areas were painted in vibrant colours with differentiation of colours between the different zones of the wards at the Dewnans centre. The wards were as homely as possible with personalised bedrooms and welcoming communal spaces. Warren ward displayed a number of collaborative pieces of artwork, one of which was a collective mural depicting the different interest of the patients and staff. This was a striking piece and patients were particularly proud of their involvement in its production. Some patients told us that they had been involved in the decorating of communal areas on the low secure wards and in the choosing of furniture.

- Most wards had telephones for patients to use, which were situated in private areas. Owen house only had a phone in the communal area but staff said patients could be taken to an office to make a call in private. However, as the office was a restricted area, the staff member would have to remain with them. Most patients had their own mobile phones but there was a policy that these were kept in the staff office overnight.
- Patients were supported to manage their finances but there were blanket restrictions with regard to how much money they could keep on their person and in the staff office. Patients with limited Section 17 leave arrangements, who would otherwise have difficulty accessing their money, used the onsite cashier facility. However, even the patients with extensive Section 17 leave arrangements used the onsite cashier facility. Access to money from the cashier's office was at set times only but the opening times were clearly displayed.
- Patients at the Dewnans centre had ensuite bathrooms but patients on the low secure wards mostly had to share a limited number of bathrooms and toilets.
- All patients had access to suitable outdoor garden space. At the Dewnans centre, there was an internal courtyard garden on each of the wards. That area of the hospital site was designated as non-smoking and patients were enabled to use their e-cigarettes in the garden area. The outside spaces were well maintained and there were many examples of patients involved in horticulture. Patients could grow vegetables and flowers. There were poly tunnels and widespread gardening projects on the low secure wards. The hospital was within a 111-acre site overlooking the sea and included a wild flower garden, a formal garden, a cricket field, tennis court and quiet reflection space. Patients with

agreed Section 17 Leave could walk and sit in the extensive grounds. Some patients walked in the grounds with their visitors. Seating was available for patients to rest and enjoy the views.

- Almost all patients said the quality of food served was good although some said that the portion sizes were not big enough. Extensive work had been done around the development and involvement of patients with respect to menus. The service had listened to CQC and to patients by making improvements in the provision of food. PLACE scores for ward food were 98.1%, which above the trust average of 92% and the England average of 93.6%. Patients at Connelly house were supported to shop and cook their own meals so they could develop skills that would build their confidence and independence in preparation for discharge. The housekeeper told us how she provided recipe and cooking tips to the patients.
- We looked at a sample of patient bedrooms and saw that patients could personalise their rooms if they wanted to. There was evidence of positive risk taking so patients could have personal items in their rooms and their risk assessments were clearly linked to this.
- Patients at the Dewnans centre had a lockable space in their room to store toiletries. However, staff held the keys to this space. Patients on the other wards could lock their rooms and carried their own room keys.
- Patients had activity timetables, which they were clear about. Some patients told us there were fewer activities available at evenings and weekends.
- There was excellent signage around the wards, identifying the function of the rooms and the location of patient bedrooms.
- Noticeboards contained information about primary nurses and the care team. At Connelly house there was a display where patients and staff shared some information about themselves in order to get to know and understand each other.

Meeting the needs of all people who use the service

- The Dewnans centre had full access for people with restricted mobility. The low secure wards, apart from Chichester house, were old buildings and bedrooms were on the first floor. There were no patient lifts and access was via narrow steep stairs. The low secure wards would not easily meet the needs of patients with restricted mobility.

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- Information was available in other languages if needed. Interpreters were used and patients told us that their care plans could be translated for them to read.
- Patients' individual needs were met, including cultural, language and religious needs. The hospital had a multi-faith room which was in use at the time of the inspection. Patients gave examples of their cultural needs being met such as access to culturally appropriate food and visits to local faith building or visits from faith leaders. Contact details for representatives from different faiths were available. The Chaplains were key in facilitating this contact.

Listening to and learning from concerns and complaints

- Staff encouraged patients to complain and helped them to resolve complaints. Details of the local Patient Advice and Liaison (PALS) service and CQC were visible on the wards. Trust data showed that there were 17 complaints

received for the service between April 2014 and March 2015. Of these, nine complaints were upheld. PALS were involved in managing complaints for the trust. We heard from one relative that they had waited around six months before receiving a response to their complaint. When the response arrived, the relative was disappointed to see that the responder had spelt the patient's name incorrectly. The trust were aware that their response times to complaints had not been as fast as they would like and senior managers in the service told us they were working to improve their performance with responding to complaints.

- We saw staff make concerted efforts to arrange transport at short notice for a patient to attend their voluntary work placement after a mix-up had meant their transport was no longer available. The patient was kept informed throughout the process, given an apology and staff ensured that they also liaised with the work placement staff.

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 refer to the summary at the beginning of this report.

Our findings

Vision and values

- All the wards we visited had the trust vision and values clearly displayed for patients and staff to see. Many of the wards had adapted the trust vision posters to enable the staff and patients to make their own comment on how they were focussing on particular domains of the organisational values. We were told how these comments were then fed into the governance structure and trust review. Staff we spoke with felt that the operational objectives were positive and told us they felt connected to the objectives and were involved with the developments.
- The ward teams had clearly defined objectives and we saw ward level operational plans to develop strengths and manage risks identified for each of the wards.

Good governance

- Staff told us they were receiving regular clinical supervision and managerial supervision on the wards and were also having ad-hoc supervision. Staff in their probationary period were having regular probationary meetings. In July 2015, supervision rates within the service stood at 85.8% of staff having received supervision within the last 60 days and 89% had received an appraisal within the last year. At Chichester house and Owen house 100% of staff had received an appraisal within the last 12 months. There was one instance of ongoing disciplinary action involving a member of staff within the service. 91% of doctors within the service had been revalidated.
- The trust had governance processes in place to manage quality and safety within the service. Managers attended local meetings such as accident incident review meetings, quality and risk meetings and patient safety meetings where issues, audits and incidents were discussed. The information was then discussed with staff at team meetings and in supervision sessions to ensure consistency and improve the service. A

medicines management dashboard was completed weekly. This included medicines storage, allergy status, medicines reconciliation completed and prescription charts checked by pharmacist. Gaps on the administration records on prescription charts were monitored and recorded as medicine incidents.

- Regular audits were undertaken throughout the service, including audits of infection prevention and control, mattress condition, cleaning, relational security, buildings condition, ligature risks, and safe and therapeutic management of violence and aggression. Patient records were randomly and routinely audited each month and these audits were effective in ensuring that important information was updated.
- Staff told us they were actively involved in clinical audits and could confidently discuss these.
- There was no evidence that the staff on the ward were formally recording data for a key performance indicator process. Senior staff informed us that they used the clinical governance process to inform the senior management team of key issues.
- Wards had appointed staff champions to lead and monitor areas such as safeguarding and resuscitation.
- All ward managers felt supported within their line management structure to affect change within their clinical environment. Staff and patients told us that the new appointments to clinical team manager roles were bringing about positive change and the hospital was progressing and improving.

Leadership, morale and staff engagement

- There were systems in place to monitor staff sickness and staff turnover. Some staff were on long-term sickness due to physical illness. However, some staff were on sick leave as a result of injuries sustained at work. Managers outlined systems for giving staff support including letters from senior managers in the trust.
- The service was appointing a manager to lead a pilot project aimed at reducing the incidents of patient violence and aggression on the wards.
- Staff had opportunities for support from independent employee assistance services, human resources and occupational health services.
- Staff with “lived experience”, that is experience of living with a mental health issue, were employed and valued by the service. We spoke to one member of staff with

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lived experience who told us that the service was supportive and accommodating of their condition and they were encouraged to develop their skills within the service.

- Apart from an anonymous letter, no staff told us that they were experiencing bullying or harassment at work.
- Senior managers told us that exit interviews and feedback were sought from staff leaving the service and the process was being reviewed to ensure it was more robust and could capture themes.
- Managers were able to identify and deal with staff performance issues. There were a number of newly appointed managers in the service and they were confident that they could access support to enable them to perform their roles effectively. They gave examples of leadership support, human resources support and managerial support available to them.
- Clinical team managers supported each other. They held weekly meetings and had daily conference calls to discuss staffing arrangements. They provided management cover for each other when necessary and said they felt supported by their line managers. They were provided with regular up to date information so that they could bench mark their wards within the service. Senior managers explained that they accepted fluctuations in supervision or appraisal rates and allowed their nurse managers the autonomy to deal with these without being criticised or overly scrutinised.
- Senior managers told us that despite the staffing shortages, they would not appoint staff unless they demonstrated good values and could assure them they were able to operate within an environment where compassionate care was a driving force.
- Staff morale was mostly high across all the wards we visited. However, two staff told us that morale was not good and staff were demotivated because of staff shortages and because long-term agency staff earned a lot more money than they did. The staff teams at the Dewnans centre felt that their voice was heard by managers and that the service had been through a significant period of change, from which they could see the benefits. They described joined up teams with a collaborative approach.
- All staff members staff told us they felt that the senior management of the service was forward thinking and pro-active in hearing their voice and the voice of the patient group. Apart from one anonymous letter, staff

were all positive about their managers. All staff knew who the managers of the service were and most could describe visits to their wards from their leaders. They described the senior management of the hospital as being “approachable”. Staff told us they had not seen members of the senior executive team.

- One senior manager showed strong commitment and leadership to the service. They had been due to retire but the service had been unable to recruit a replacement so they decided to remain in post in order to provide consistency and leadership while further recruitment took place.
- When planning changes within the service, senior managers considered the impact upon patients, staff and the running of the service. This was demonstrated by the research and planning that the service undertook in preparation for becoming a smoke free zone. The service had considered a wealth of data and implemented the changes in a planned and staged way in order to reduce the impact and manage the needs of patients and the service. Patients and staff were informed of plans in advance of any change taking place.
- Staff could provide feedback into the service and one member of staff told us about the “rumour mill”, a system where they could provide anonymous feedback.
- Staff told us they felt confident to use the whistleblowing procedure and to raise concerns with their colleagues and line managers. We saw evidence that staff had raised concerns and used the whistleblowing procedure. Investigations had taken place as a result of this and positive changes had occurred within the service, such as no longer deploying agency staff who had not received training in physical intervention.

Commitment to quality improvement and innovation

- The service demonstrated a commitment to quality improvement and innovation. They planned to participate in a violence reduction pilot programme alongside South London and Maudsley NHS Foundation Trust. The pilot was due to commence in September 2015 and aimed to reduce incidents of violence and aggression by 25% within two years.

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- The service had introduced additional career pathways for nurses, occupational therapists and nursing assistants. The aim was to improve recruitment and retention of staff and provide good career opportunities.
- The service participated in the Royal College of Psychiatrists quality network for forensic mental health services, carrying out self-assessments and peer reviews with other members of the network.
- The fire intervention programme used at the hospital had been formally evaluated as part of research undertaken by the University of Kent.
- The service actively participated in research projects in collaborations with academic partners. They were in the process of setting up participation for a new study into: attitudes towards sexual expression in secure forensic settings. Hospital patients were also involved in a molecular genetics of adverse drug reactions study and had recently concluded involvement in a non-interventional European research project. Participation in two other long-term clinical studies were ongoing.