Requires improvement

Devon Partnership NHS Trust

Wards for people with learning disabilities or autism

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)
RWVEE	Whipton Hospital	Additional Support Unit	EX1 3RB

This report describes our judgement of the quality of care provided within this core service by Devon Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Devon Partnership NHS Trust and these are brought together to inform our overall judgement of Devon Partnership NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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 the additional support unit at Whipton Hospital as requires improvement because:

- We found that patients were not read their rights under Section 132 of the Mental Health Act and there was a lack of accessible information about how to access an independent mental health advocate.
- Positive behavioural support planning was not embedded into patients' care and support.
- There were no activity schedules on display to show patients the planned activities during the week. Staff on site were not engaging patients in meaningful activities during our visit.
- We heard and saw that patients were not happy about the quality of their food. There were concerns from patients about the nutritional value of the food, the times meals could be eaten and the temperature of the food. We saw that patients were not encouraged to prepare their own food. The raised vegetable patch that had once been used by patients was overgrown and not in use.
- The seclusion room did not have toilet and washing facilities. The extra care area toilet facilities were not adequately ventilated.
- Although patients had their own bedrooms, the ward was noisy with a lack of quiet areas and recreational areas indoors or outdoors.
- There was a disproportionate number of nursing assistants employed, who alongside regular agency staff, did not fulfil the duties required to meet the needs of the patients on the unit.
- The staff were not clear about the recently updated seclusion and segregation policy.
- The managers did not receive enough support from the rest of the multidisciplinary team to share their skills and knowledge throughout the team. For example, the psychiatrist could talk to us about positive behaviour support but the nurses lacked knowledge in this area. The management team could talk to us about the differences between seclusion and segregation but the rest of the team were confused about the difference. There were over 20 nursing assistants employed but they did not have the skills to complete the activities required to meet the needs of the patients.
- The management team had noted the complaints about food provision but had not acted upon them.
- The blanket restrictions in place meant the ward was not set up to promote recovery and independence.

However:

- The wards were very clean and parents and carers of patients told us they believed their family member was in a safe environment.
- Staff regularly assessed and updated risks onto shared data information systems.
- Managers shared learning outcomes from adverse events in staff meetings, which were well documented.
- Mandatory training was at 94% compliance.
- Every patient had a mental capacity assessment which staff regularly reviewed. Staff had a good working knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Records showed staff were supervised every month, and had annual appraisals.
- Staff were caring, kind, respectful and well thought of by parent and carers.
- Patients had their own easy read care plans and the team made good efforts to adapt documents so that they were accessible.
- There were no waiting times for treatment and discharge planning was thorough.
- Staff, patients and families knew how to complain and comments books were easily available.
- Staff talked positively about their manager and the senior management team.

Summary of findings

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

Are services safe?

Good

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

- The unit was very clean and complied with current infection control hygiene standards with clear referencing to good hand washing techniques.
- Staff assessed, discussed, and reviewed ligature risks during staff meetings.
- On call systems were robust and well managed. Staff told us that they could access support in an emergency when required.
- All staff, including long term agency staff, held a high compliance to mandatory training at 94%.
- Each patient had recorded risk assessments, which were detailed and regularly updated.
- Managers shared learning outcomes from adverse events in staff meetings, which were well documented.

However:

- Sickness and absence levels were high at 12%, when the trust's benchmark was 4%. This was due to one member of staff on long term sick leave.
- There were blanket restrictions in place limiting access to the outdoor courtyard area.
- The extra care area was in long-term use and therefore patients who may need to use the seclusion room did not did not have access to toilet and washing facilities.
- Ventilation was not effective in the extra care area toilet facilities.

Are services effective?

Requires improvement

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

- Staff did not explain to patients their rights under Section 132 of the Mental Health Act.
- There was no information on the ward for patients about how to access Independent Mental Health Advocate services.
- Some staff in the team were not aware of National Institute for Health and Care Excellence guidelines around positive behaviour support, and we saw that this was not embedded into patient's care plans.

However:

- All patients had detailed mental capacity assessments, which staff regularly reviewed
- 97% of staff had completed Mental Capacity Act training.

Summary of findings

- Monthly supervisions and annual appraisals were well documented.
- Handovers were person centred, informative and effectively reviewed risks.

Are services caring?

Good

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

- Staff treated patients with dignity and respect.
- Patients had their own easy read version of their care plan. The unit had other accessible documents on display.
- Patients and carers praised the staff team and told us that they were caring, kind and went above and beyond their call of duty.
- Patients felt that they could approach staff for support.
- Patients and their families told us they felt involved in the care planning process right through from admission to discharge.
- We saw that documented care plans detailed the views of the patients.
- We heard from families and carers who told us that staff ask them to attend meetings.
- Patients had their own weekly meetings and comments books so they could feedback about the service they received.

Are services responsive to people's needs?

Requires improvement

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

- Patients were not happy about the quality of their food. Patients were not being encouraged to prepare their own meals. The raised vegetable box outside that had previously been used by patients was overgrown and not in use.
- There were no activity schedules to show patients planned activities during the week. Staff on site were not engaging patients in meaningful activities during our visit.
- Access to indoor and outdoor recreational areas was limited.
- Although patients had their own bedrooms, the environment was noisy throughout with no quiet areas on the wards.

However:

- Discharge planning was thorough and involved patients and their families.
- Families could visit at ease and they told us they had been given information about how to complain.
- The team had developed easy read safeguarding procedures and reports and their risk register was also in an easy read format. Each person had an easy read copy of their care plan.

Summary of findings

- Patients could complain via the comments book and through their weekly patient meetings.

Are services well-led?

Requires improvement

We rated "well-led" as **requires improvement** because:

- The management team were not utilising their complement of nursing assistants and agency staff effectively enough to meet the needs of the patients on the unit.
- There was insufficient evidence of information sharing across the multi-disciplinary team. For example, the psychiatrist could talk to us about positive behaviour support but the nurses lacked knowledge in this area and were therefore not using this recognised approach to promote recovery. The management team could talk to us about the differences between seclusion and segregation but the rest of the team were confused about the difference.
- There were over 20 nursing assistants employed but they were not used effectively to complete the activities required to meet the needs of the patients.
- The management team had noted the numerous complaints about food provision but had not acted upon them.
- The blanket restrictions in place meant the ward was not set up to promote recovery and independence.
- The trust's seclusion and segregation policy had recently been updated and was seen within the service. However, not all of the staff we talked to had read and signed the documents and they were unclear about the definitions within the policy. Although the management team had a good understanding, this information sharing had not filtered down throughout the team.

However:

- Staff talked positively about their management team. When we met the management team they demonstrated knowledge, experience and honesty.
- The management team talked positively about the senior management team and the trust's visions and values were well documented in the unit and seen within personnel portfolios.
- Any learning from incidents was well documented and action taken.
- The management team were involved in quality assurance processes and had accessible versions of how they improved quality and safety within the unit.

Summary of findings

Information about the service

The additional support unit at Whipton Hospital provided assessment and treatment within a hospital setting for individuals with a learning disability and a psychiatric illness, whose needs and risks could not be safely managed in a community or mainstream setting. The service was for adults with a learning disability who live in Devon (excluding Plymouth) presenting with acute psychiatric illness, in a situation where universal mental health or specialist learning disability community services were unable to provide effective and safe interventions.

There were two single sex wards with two beds in the female ward and three beds in the male ward, each providing 24 hour care from qualified staff, seven days a week, 52 weeks a year.

The additional support unit at Whipton Hospital was previously inspected in February 2014 but did not receive a rating as it formed part of our pilot inspection process.

Our inspection team

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 which inspected this core service comprised of a CQC inspector, a clinical psychologist, a mental health act reviewer, an expert by experience, a student social worker and a senior manager from Monitor.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations and local people to share what they knew about the mental health services provided by the trust. We reviewed information that we held about these services and sought feedback from patients, families and carers via our comment card box and by telephone interviews.

During the inspection visit, the inspection team:

- Visited both male and female wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with one person who was using the service and received feedback from three others using comment cards.
- Spoke with the manager, deputy manager and team leader of the wards.

Summary of findings

- Spoke with five other staff members; including doctors, nurses and health care assistants.
- Attended and observed a hand-over meeting.
- Collected feedback from three family members using comment cards.
- Looked at five treatment records of patients.
- Carried out a specific check of the medicines management on both wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Carried out a Mental Health Act monitoring visit of the service.

What people who use the provider's services say

We reviewed three comment cards prior to the inspection and found that all the comments were positive about the service. For example, patients stated:

"staff go above and beyond the call of duty, treated me and my partner very well."

"excellent standard of care, nothing but praise for the service".

However, four out of five patients and one carer commented that they were not happy with the quality of the food.

Good practice

The unit had recruited an expert by experience, who visited the unit once per fortnight to conduct quality assurance audits. The expert by experience talked to staff and patients then fed back any issues to the board of governors.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that people detained under the Mental Health Act are being read their rights under Section 132.
- The trust must make patients aware of their rights to access an independent mental health advocate by providing this information in an accessible format.
- The trust must ensure all staff are following NICE guidelines for 'challenging behaviour and learning disabilities: prevention and interventions for patients with learning disabilities whose behaviour challenges'; published: 28 May 2015. This includes guidelines on positive behaviour support.
- The trust must deliver good quality food that meets the nutritional needs and preferences of the patients.
- The trust must enable local managers to deliver a service in line with current practices specific to enabling patients with learning disabilities to become more independent.

Action the provider SHOULD take to improve

- The trust should take action to fill the qualified nurse vacancies on the unit.
- The trust should consider training requirements for the team on the MHA Code of Practice.
- The trust should engage patients in outcome focused, meaningful activities.
- The trust should delegate nurse led activities to long serving agency nurses and nursing assistants to make sure they can meet people's care and treatment needs.
- The trust should ensure there are toilet and washing facilities in the seclusion room.

Summary of findings

- The trust should check there is adequate ventilation in the toilet facilities in the extra care area.
- The trust should make sure patients have access to quiet areas, indoor and outdoor recreational spaces on site.
- The trust should ensure all the staff working at the additional support unit read and understand the trust's updated seclusion and segregation policy.

Devon Partnership NHS Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Additional Support Unit	Whipton Hospital

Mental Health Act responsibilities

- We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.
- Out of the five patients at Whipton Hospital, four were detained under the Mental Health Act (MHA).
- We saw that there were very good capacity assessments on consent to treatment and admission to hospital and that these had been recently reviewed. Treatment forms (T3) were attached to all prescription charts.
- We found that although all staff had some training in the Mental Health Act, no-one had received training in the recent changes to the code of practice.
- Patients were not having their rights under Section 132 of the MHA explained to them. We found three patients were informed of their rights when detained on Section 2. However, we found no evidence that they were informed of their rights when later detained on Section 3 of the MHA. When we questioned the management team about this, we were told that this was as a result of the lack of qualified nurses on the team and not having the resources to comply with this area of the Act. When we highlighted the requirements to the manager, they rang the mental health central team at the trust immediately to rectify this.
- There was no information on the ward for patients about accessing IMHA services and how to access and support engagement with the IMHA. This impacted on patients who had not been informed of the wider issues of referrals, capacity issues, access to wards/records and re-referral if necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

- 97% of staff had training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- There was one DoLS application made in the last six months. At the time of our inspection, this person was

waiting for their best interest assessor to make an appointment to carry out the assessment. The management team at the additional support unit had been in recent contact with the local DoLS team to chase this up.

- Staff had a good understanding of the Mental Capacity Act 2005, in particular the five statutory principles.
- Staff asked for consent from patients before taking them out and this was documented on each person's progress notes. Where a person did not have capacity the staff undertook a mental capacity assessment following the five statutory principles.
- All staff we spoke to were aware of the Mental Capacity Act and DoLS policy and knew where to locate it.

Good

Are services safe?

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

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Safe and clean environment

- The ward layouts allowed staff to observe all parts of the ward.
- The ward complied with guidance on same-sex accommodation by having two separate areas at opposite ends of the building, clearly labelled secured entrances with a reception area, staff room and site office separating the two areas.
- The contents of the emergency medicine bags were checked regularly by hospital staff. All the contents were in date and they included the expected reversal agents as stated in the trust policy.
- There were no toilet and washing facilities in the seclusion room. The bathroom facilities were situated next door in the extra care unit, meaning patients having to break seclusion if they wanted to use the toilet. At the time of inspection, the extra care area had been in use by another patient for approximately three months.
- There were some ligature points in the wards. These were identified on the site's risk register, risk assessed, regularly updated and most recently shared with the team in the meeting minutes of a staff meeting held in July. These risks were being safely managed through a severity of risk measurement assessment.
- Environmental risk assessments were in place and regularly reviewed. We reviewed documents and reports around a previous serious incident from December 2014 where environmental improvements were made following a root cause analysis report by the trust. The ward had risk assessed and made the recommended changes to the environment and we also saw these risk assessments present in new admission forms. The team had been made aware of these assessments and risks in their staff meetings which we were able to view during our inspection.
- Patient environment action team (PEAT) inspection data showed that the unit scored 2% above the England average for cleanliness with a score of 99.7%. PEAT scores for maintenance, condition and appearance were 1% higher than average at 98%.
- There were notices showing hand washing techniques in all of the toilet facilities, infection control information displayed on communal notice boards and the premises were clean throughout and complied with current infection control standards. However, there was a smell of urine in the extra care area. When we addressed this issue with staff, they explained this was due to a lack of adequate ventilation in that area of the building.
- The fire action plan was up to date, along with relevant risk assessments around fire safety.
- The ward had a safety alarm system. The personal infrared transmission assistance buttons, when activated, sent an alert to every area of the building, to minimise the risk of an alert being missed. There were also pagers on both wards.

Safe staffing

- There was a staffing chart for the unit, updated in July 2015, which represented current established levels of staff. Shifts were assessed to have two Band 5 nurses working both the early and late shifts with one additional member of staff on administrative duties during the day, totalling five qualified nurses on shift every day.
- The established levels of qualified nurses for the additional support unit was 12. At the time of inspection there were 8.7 qualified nurses in post. There was one qualified nurse on long term sick and there was a temporary reduction of one post by 0.4 post due to ill health.
- Qualified nurses shifts were being filled by agency staff. We saw that the use of agency staff was consistent; some were long serving agency staff and they were

Good

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present on most shifts. The number of qualified nurse vacancies on the ward had a negative impact on the number of nurse led activities, nurse prescribers and patient one-to-one time with their named nurse. The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies in a three month period were 115 in February, 86 in March and 72 in April. The number of shifts that had not been filled by bank or agency staff during the same period were: seven in February, two in March and six in April. Feedback from our comment cards stated, "patients seen by a lot of bank staff".

- The staff sickness rate during the 12 month period was high at 12% against the trust's benchmark of 4%. This was due to one member of staff on long term sick leave.
- There was a high number of nursing assistants on the ward. The unit had an established staffing level of 21 nursing assistants with no current vacancies.
- There was immediate medical cover day and night across the road at the main hospital and the unit's on call system comprised of one junior doctor, one consultant, one tier one manager and a band seven nurse on call every day.
- Mandatory training adherence was 94%. The unit's mandatory training records was displayed on the 'ASU team performance board' in the communal staff room. Out of the 437 courses required to complete, staff at the ASU had completed 410. Completion rates were 87% for fire safety, 73% for manual handling and 86% for conflict resolution. Managers were able to view training data and staff were able to book themselves onto required training via the data system (named 'Daisy').
- Although core training was up to date, no-one had received training on the MHA Code of Practice and only one quarter of the team were up to date with medicines management training which was detailed on the site's risk register.

Assessing and managing risk to patients and staff

- We reviewed the seclusion records and monthly reports. Over a three month period, there had been seven incidents of seclusion in March, one in April and one in June. There had also been one incident of long term segregation which resulted in one person being contained in a particular area.
- The unit had recently reviewed their practices around seclusion and segregation following a trust recommendation seen in recent business meeting minutes. However, when we spoke with staff on duty they were unclear about the differences and described different accounts of how each had been applied.
- The updated segregation and seclusion policy was in both files. Twenty-one out of the 33 staff had signed to confirm they had read the seclusion records.
- In the female area patients who required seclusion were kept safe by making a seclusion area in the female area rather than being transferred to the seclusion room which was located in the male ward of the unit.
- In the last six months, there had only been one incident requiring the use of restraint, and this was in the supine position.
- Out of the five records we examined, there were up to date risk assessments in place for each person. Risk assessments were written within the trust's format and risk summaries were updated at least weekly and in some cases daily.
- The manager told us that the referring team update all risk assessments before patients are admitted to the ward. During a staff handover observation, we were able to see that each person had their levels of risk analysed and reported on within the last 12 hours and that this information was projected onto a screen for all staff to see during the handover meeting.
- Within the safeguarding meeting minutes there were risk assessment analyses. High risks were identified, the environment was assessed and there had been a request for a health and safety manager to review the areas of identified risk.
- There were blanket restrictions in place. The door to the back courtyard was locked to protect one patient. When we questioned staff about this, they told us that patients could access the outdoor area with support. The televisions and wardrobes were locked and boxed in as a generic safety measure.
- Staff were trained in safeguarding and knew how to make a safeguarding alert when appropriate. There was

Good

Are services safe?

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an easy read safeguarding printout on the communal notice board which was colour coded to highlight any safeguarding concerns. The team had a 97% compliance rating for updated safeguarding training.

- There were tissue viability checks in five care plans. These were updated. Falls were documented and addressed.
- Staff stored medicines securely. They recorded the temperatures of the medicine refrigerator and the room it was in on a daily basis. These were all within the expected temperature ranges. Staff checked the contents of the emergency medicine bags regularly. All contents were in date and they included the expected reversal agents as stated in their trust policy.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. The standard operating procedures for controlled drugs had been reviewed and updated in 2014. Incidents involving controlled drugs were reported via the incident reporting system. These were investigated by the accountable officer for controlled drugs and records made of the actions taken.
- There was an in-house clinical pharmacy service which included arrangements for medicines reconciliation, the review of prescribing and administration of medicines and the monitoring of medicine incidents.
- All medicines were supplied under service level agreements with neighbouring NHS trusts. The prescribing of medicines against T2 forms, which detailed consent to treatment and T3 forms, which contained details of a second opinion appointed doctor, were checked by the clinical pharmacists, but these forms were not provided to the dispensing pharmacy. All the medicines prescribed were in accordance with the Mental Health Act T2/T3 forms.
- NHS prescription forms were available in case medicines were needed out of hours. These forms were kept securely.
- All the patients had their allergy status recorded. The prescribing of high dose anti-psychotic medicines was monitored and physical health checks were in place.
- The additional support unit did not use rapid tranquillisation.
- Medicine incidents were reported via the trust incident reporting system. The trust had been seen as a low reporter of incidents compared to the national average. The unit had reported 23 medicine incidents in the previous three months.
- The trust had a policy and procedure for the covert administration of medicines.This included how a decision would be made to administer medicines covertly and the associated legal implications. Advice was provided by the pharmacy service on how best to administer these medicines.

Track record on safety

- There had been two serious untoward incidents reported in the last six months relating to fractures following patients falling out of bed.
- Following one serious incident, the unit had conducted a root cause analysis. We were able to see the minutes from this meeting which were also cascaded into recent staff meetings and a safeguarding meeting.
- We could see during the inspection that the two required improvements; i.e. crash mats and bed frame material, following the serious incidents had been rectified and were now risk assessed for new admissions.

Reporting incidents and learning from when things go wrong

- When we spoke to staff, they were able to show us that they knew how to report incidents on the incident reporting tool, Daisy, the trust's internal data system.
- The regular nurses on duty updated the incident reporting tool before the end of the shift.
- Managers shared feedback from the investigation of incidents with the team. These meetings were taking place once a month.
- Evidence of changes having been made following an incident were seen during our inspection in current risk assessments for new patient admissions.

Are services effective?

Requires improvement

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Assessment of needs and planning of care

- We saw guidance from the 'care pathways for learning disability' being used by the qualified nurses. They referred to this guidance for inpatient service admission, patient discharge and also used RiO recording guidance when writing up progress notes. RiO is an electronic care record system used by mental health trusts across the country.
- Nurses worked on care pathways in the office if not needed on the ward. During our inspection, some paper copies were being updated on the unit but most of the information was stored on RIO. For the five patients we observed, all five of their care plans were completed, up to date and reviewed.
- Care records showed that a physical examination had been undertaken and that there was on-going monitoring of physical health problems. Care plans were in place for diabetic patients.
- We found that patients had their views documented clearly in their care plans and we saw that their plans were regularly reviewed and updated.

Best practice in treatment and care

- Staff told us that they followed NICE guidelines, but we didn't see this evidence embedded into patients' care plans.
- When we spoke to patients and their carers, we heard that they had medicine and treatment options, and we saw that the management team conducted monthly audits of medicines. We observed on one patient's notes that they had their prescription for lithium checked and reviewed in July; this was seen in the medicines section.
- The psychiatrist on duty was able to talk us through best practice in treatment and care, detailing work the team did following the Winterbourne view enquiry. Although the psychiatrist was able to talk to us about positive behavioural support around challenging behaviour, we found that the nurses on duty did not have a thorough working knowledge of this guidance. When raised with the manager, we heard that the team do need to look into this practice in more detail. During our inspection, we saw that positive behaviour support was not used with patients when they became distressed on the unit.
- We found care record audits, as part of the trust's accreditation for inpatient mental health services accreditation process, there was evidence of nurses carrying out a self-audit, followed by a peer review in October 2014. Action plans and learning following these audits were seen documented in team meeting minutes.

Skilled staff to deliver care

- The team had input from occupational therapists, physiotherapists, speech and language therapists and psychologists as well as pharmacists and referral to others if needed. We saw in admission notes that this full range of professionals were involved during initial assessments and then later on in six weekly discharge planning meetings.
- Managers held a record of when supervisions and appraisals were due, which was colour coded. When viewing this record, there were at least 10 supervisions in 12 months for each member of the team including long term agency staff. The deputy manager showed us evidence of the knowledge skills framework and how individual training records linked into performance development reviews with evidence of the courses attended. Specialist training included training on autistic spectrum disorder and personality disorders. We found that there were four performance development reviews pending and one overdue due to long term sickness.
- When we spoke to staff we found inconsistency in their understanding and explanation of the trust's seclusion and segregation policy. One person told us they were unsure if the person living in the extra care unit was being segregated and not all of the staff had read and signed the new policy.

Are services effective?

Requires improvement

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

Multi-disciplinary and inter-agency team work

- We were able to view staff meeting minutes that were taking place on a weekly basis. All were dated, people attended noted, and a list of actions with the responsible person were seen at the end of the minutes.
- During our inspection we were able to observe a full staff handover meeting. Each patient using the service was discussed in detail including levels of current observations, sleeping patterns, medicine changes, levels of current detention and Section 17 leave. Levels of risk before Section 17 leave were discussed, reminders about consent to treatment orders that were coming up, blood sugar testing and appointments with multi-disciplinary team members, for example the tissue viability nurse, were discussed.

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

- Out of the five patients at Whipton Hospital, four were detained under the Mental Health Act.
- We saw that there were very good capacity assessments on consent to treatment and admission to hospital and that these had been recently reviewed. Treatment forms (T3) were attached to all prescription charts
- We found that all staff had had some training in the Mental Health Act; no one had received training in the MHA Code of Practice.
- Patients were not having their rights under Section 132 of the MHA explained to them. We found three patients were informed of their rights when detained on Section 2. However, we found no evidence that they were informed of their rights when later detained on Section 3 of the MHA. When we questioned the management team about this, we were told that this was as a result of the lack of qualified nurses on the team and not having the resources to comply with this area of the Act. When we highlighted the requirements to the manager, they rang the mental health central team at the trust immediately to rectify this.
- There was no information on the ward for patients about accessing IMHA services and how to access and support engagement with the IMHA. This impacted on patients who had not been informed of the wider issues of referrals, capacity issues, access to wards/records and re-referral if necessary.

Good practice in applying the Mental Capacity Act

- 97% of staff had training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- There was one DoLS application made in the last six months. At the time of our inspection, this person was awaiting for their best interest assessor to make an appointment to carry out the assessment. The management team at the additional support unit had been in recent contact with the local DoLS team to chase this up.
- Staff had a good understanding of the Mental Capacity Act 2005, in particular the five statutory principles.
- Staff asked for consent from patients before taking them out and this was documented on each person's progress notes. Where a person did not have capacity the staff undertook a mental capacity assessment following the five statutory principles.
- All staff that we spoke to were aware of the Mental Capacity Act and DoLS policy and knew where to locate it.

Good

Are services caring?

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Kindness, dignity, respect and support

- We observed a staff handover during which the staff team discussed the patients with respect and thoughtfulness.
- We analysed comment cards prior to the inspection and found that comments from patients, families and carers were positive. For example, one stated, “staff go above and beyond the call of duty, treated me and my partner very well”, “excellent standard of care, nothing but praise for the service”.
- One patient spoke of an incident with a member of night staff when they felt the staff were invading his personal space and he had felt threatened and scared. When we looked into this incident we saw it had been resolved and learning was shared amongst the team.
- We spoke with three family members of the patients using this service, who told us that the permanent staff were very good, helpful and caring, also that the service was a very good unit which promoted recovery and was very clean. One family member we spoke to described how they had seen an improvement in their recovery and that they thought the staff understood their family member and their condition very well. One family member said that the staff go over and above their duties and make time to meet with families. Another family member described the staff as “super staff, very professional and caring” and said that they were extremely happy and satisfied with the level of care and support their family member received.

The involvement of people in the care that they receive

- Families told us that they had received information packs on admission to the ward. One parent informed us that when their family member was admitted, the psychiatrist explained the service, the care and treatment the person would expect to receive and discussed future planning around the person.
- We were told that if patients did not wish to attend a multi-disciplinary meeting, there was an easy read form that could be filled out beforehand to make sure every issue was covered. We were able to see these forms and check that they were accessible and in an easy read format. We heard that this practice allowed the patients time to think of questions they might like to ask. We saw that following any MDT meeting, the content was discussed with the person using services in a one-to-one setting so the person understood what had been discussed. We saw that learning logs had been filled in with patients; for example, “what you said and what we did”. We viewed six learning logs with evidence of involvement, feedback and action.
- One of the parents we talked to told us that they contributed to their family member’s care plan and they had copies of recent reports. Family members told us they attended meetings at the ASU every fortnight and received the minutes from these meetings. They felt actively involved and were kept very much up to date with lots of opportunities to feed back to the service.
- Family members told us that they were aware of discharge dates and some felt actively involved in the process. One family member told us that they had raised concerns about some safety issues in the accommodation and these had been listened and responded to.
- We found one poster relating to advocacy in the male ward, in very small print and not in easy read format. We did not see any information relating to independent mental health advocates.
- We saw samples from four comments books where the patients had inputted feedback about their service. Feedback was collated under the titles of ‘what you said’ and ‘date action took place’.
- We saw some easy read information around the service. We saw photo boards of staff members, posters on some doors; for example, office, meeting room and lounge were in picture format. We saw the date displayed, easy read information about the patient’s weekly meeting, what to do if you suspect abuse, information about medicines and information about the cleanliness of the unit.
- There was evidence on the unit of weekly patient meetings and we saw these cross referenced in staff

Good

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meeting minutes from July. During these meetings we saw documentation of patients being asked if they're happy at ASU. We also saw detailed parents/carers feedback being responded to.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Access and discharge

- Average bed occupancy over the last six months was 100%. However there were no of out of area placements attributed to this core service in the last six months.
- Care records showed there had been no delays for patients on the unit from referral to initial assessment or from initial assessment to the onset of treatment.
- Patients on home leave had their bed allocated to them and this remained available to them throughout their absence from the unit, this provided flexibility and reassurance for them and their families if they needed to return early from home leave.
- We spoke to family members and carers who told us that when they needed access to a psychiatrist, they responded very quickly and concerns could be addressed quickly. This information was corroborated when we inspected patient's progress notes on RiO.
- We found detailed and person centred discharge plans for each person using the service. The team held discharge planning meetings every six weeks. One patient's care plan showed after care plans and arrangements detailing their views on their discharge, the views of the multi-disciplinary team involved and the names and roles of the people involved. When we spoke to family members and carers, they were all aware of their family member's discharge date and had been involved in the planning around discharge.
- We saw that there was evidence of two delayed discharges at the service. One was due to the lack of a suitable provider and the other was as a result of lack of funding from the local authority to provide a placement. The team maintained continued communication with the funding authorities to manage the time delay. Patients were kept informed of the process.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards were very clean but sparse in decoration. Some patients had posters in their rooms which had been recently purchased.
- Although patients had their own bedrooms, during our inspection, we found the environment to be noisy with limited access to quiet areas.
- There was a room where patients could meet visitors. Visiting hours were not restricted and patients had good access to their family members.
- Patients were able to use mobile phones for personal calls. Access to smart phones was risk assessed.
- We saw that the back door to the courtyard was locked which limited patients' access to outside space. This was a blanket restriction to ensure the safety of one patient. When we questioned staff about this, they told us patients could access the outside area with staff support.
- We heard that patients complained about the quality of the food. At the ASU, food was brought in from an internal caterer using a cook/freeze approach, in response to previous complaints about the food on the ward. The trust had responded to one person's complaint who told us they now had a weekly allowance to buy their own food. One family member we spoke to described the food as 'horrible' and expressed concerns that their family member was losing weight as a result. When we spoke to one patient using the service, they described the food as 'abysmal' and they expressed concerns about the lack of nutritional value.
- One patient told us there was little flexibility about the time they wanted to eat as they had been told food could not be reheated. We saw in the comments book that one patient had described the food as 'disgusting'. We saw that the team had responded by saying they would action this complaint by contacting the nutritional group for further advice. However, we did not see any evidence of results around this.
- We found feedback from our comment cards stating, "staff mentioned food has been an issue."

Are services responsive to people's needs?

Requires improvement

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

- The raised vegetable box outside that had once been used by patients was overgrown and not in use.
- Access to hot drinks was not restricted.
- We spoke to parents and carers who told us about specific activities their family members had been involved in, such as a fishing trip and trips to the tea rooms to meet up with family. Staff told us about activities patients took part in, such as tennis and football on site. However, when we observed both wards, we found that patients were not being engaged in activities, there were no activity planners and schedules and a lack of nurse-led activities. There were timetables for staffing but these did not include activities. When we talked to the team about this, we were told that this was due to the lack of qualified nurses at the moment.

Meeting the needs of all people who use the service

- Easy read information was displayed around the unit and each person had an easy read copy of their care plan.
- Easy read colour coded red, amber and green rated safeguarding posters were in place for patients.
- If a patient required an interpreter, they were able to access one through the trust.

Listening to and learning from concerns and complaints

- The trust had recorded that there had been no formal complaints for the ASU in the last 12 months. However, we were able to view the comments books on the unit where we found six complaints, each with an action detailed by the team. We also spoke to one person using the service who had raised a complaint about a member of staff. When cross referenced we found that the complaint had been resolved. The staff appeared to address complaints and concerns locally and without escalating concerns through a formal process, allowing them to resolve issues quickly.
- We saw that patients could complain via the comments book and through their weekly patient meetings. When we spoke to family members and carers, they told us that they knew how to complain and had seen positive results following a complaint.
- Some of the easy read information we saw was printed in small font, making it difficult to read easily and there was a lack of information about patients' rights.
- There was a debrief file which enabled staff to record their views on what improvements could be made on the ward, this provided an opportunity for feedback within the team. Topics covered included 'identify what went well', staff could 'express their views and feelings' and 'identify what could have been done better'. There were issues raised about parking and better quality food.
- Improvements were being planned for the garden areas, staff were invited to contribute to the planning of this. There were 'proposed works to improve the garden areas' maps on the walls in the communal staff area, where staff could draw on the map a design for the garden works.

Are services well-led?

Requires improvement

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

Summary of findings

Please see summary at the beginning of this report.

Our findings

Vision and values

- The team were able to tell us about the trust's vision and values and we saw print outs of these in each staff member's professional portfolio.
- We observed the trust's 'is it good enough for my family' posters displayed round the unit. We saw three samples of recent performance development review records where we found objectives to 'promote and review services which are good enough for my family'. This does not reflect the change in the trust values.
- The team spoke positively about the senior management team. The manager showed us evidence of their last visit a few months ago and told us that they do visit the unit to familiarise themselves with patients and staff there. We were told about nursing forums that the trust organises where nurses could meet to discuss current issues and future plans.

Good governance

- The management team were on site, available to the team and visible on the ward. The management structure was clearly defined. There was a manager, deputy and nurse manager well established within the team.
- Staff spoke positively about the senior management team and confirmed they had adequate support from the trust.
- The team's administrative support was on reduced hours. However, the management team supplemented their provision from another administrative support worker so adequate support was provided to the management team.
- Staff demonstrated positive morale at work and we observed a person centred attitude during the team handover.
- Ward systems and procedures at the ASU seem to be effective based on evidence from 94% staff compliance with mandatory training, 97% compliance with regular supervision and 85% compliance with appraisals (PDRs).
- The team's training records were monitored on 'Daisy'; the trust's internal data system, and staff were prompted using colour coding red, amber and green ratings if their training was about to become out of date.
- Incidents were reported and we found evidence of debriefing packs, staff meeting minutes, comments books and supervision records when staff learnt from incidents, complaints and feedback from patients.
- The provider used key performance indicators to monitor sickness and absence levels which were higher than the trust's benchmark of 4%. At 12% this was due to one member of staff being on long term sick leave. KPIs were also shared on the ASU's team performance board which was visible to all staff in the communal staff room.
- Two examples of delayed discharges and staff sickness levels were highlighted on this board, demonstrating a duty of candour that showed where things needed to be improved.
- The team's risk register was discussed at every staff and governance meeting and was reviewed monthly. We were able to view an easy read version of the team's risk register. We saw three medium risks around medicine errors due to unqualified nurses on shift, level of staff completing medicines management training and the lack of use of rapid tranquilisation.
- The medicine management policy had been reviewed in April 2015 and was supported by procedures which were all in date.
- Medicine supply problems were monitored through the incident reporting system and there were regular meetings to review any issues. There was a service level agreement annual meeting for the pharmacy supply services.
- A medicines management dashboard was completed weekly. This included medicine storage, allergy status,

Are services well-led?

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medicines reconciliation completed and prescription charts checked by a pharmacist. Gaps in the administration records on prescription charts were monitored and recorded as medicine incidents.

Leadership, morale and staff engagement

- Shifts were covered by a sufficient number of staff but clinical administrative tasks were not being carried out and on the day of our visit patients were not engaged in activities.
- We were concerned that the manager did not ensure the whole team were trained and aware of the positive behaviour support guidance.
- The management team had noted the complaints made about the food but had not actioned them.
- Managers and the psychologist did not share their knowledge and skills with the nursing team around current best practice supporting patients with learning difficulties and the updated segregation and seclusion policy.
- Staff talked positively about the manager. Staff said they felt listened to and were able to raise concerns safely. They felt that their staff morale and commitment to the job was high despite experiencing qualified nurse vacancies.
- When we spoke to the manager, they told us that they adopted an open practice and felt safe to raise concerns with the senior management team. The manager told us that they had no issues around stress.
- We learnt about a bullying and harassment issue that had occurred on the ward. We saw that the staff had met with the manager who had explained that the behaviour demonstrated was unacceptable, and had addressed the issue according to the trust's policy. We saw details of a follow up meeting one month later which detailed the resolution, performance measures and expectations from the trust.
- We spoke to staff about their levels of involvement in service provision and redesign. Some staff told us they felt involved in decisions about the service and any concerns were always raised at MDT meetings, although one member of staff told us they had no opportunity to contribute to recent service redesigns.

Commitment to quality improvement and innovation

- The manager informed us that the team were part of the accreditation for inpatient mental health services AIMS network, which helped embed changes in practice into the team and ensured they were adhering to set standards. We were able to observe a quarter one (Q1) plan from the previous week discussed in a governance meeting. The plan included areas for improvement around care planning for patients with autism which was followed up by a workshop led by the manager. The manager told us about team building events they had organised, safeguarding information and training for patients and we saw evidence of a carers forum/ network.
- The manager told us about their expert by experience, who visited the unit once a fortnight to conduct quality assurance audits. Whilst conducting their visit, the expert by experience talked to staff and patients then fed back any issues to the board of governors. We were able to see this evidenced in the service's feedback file.
- We were able to see the ASU's easy read version of improving quality and safety at ASU, which covered areas such as respecting patients, agreeing to care and treatment, working with others, safety and having the right staff and medicines. Each topic had an easy read symbol next to it and the team detailed, 'what they have done so far' to action any improvements. We saw that this was completed from January to July of this year.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not having their rights under Section 132 of the MHA explained to them. There was no information on the ward for patients about accessing IMHA services and how to access and support engagement with the IMHA. The provider must ensure that people detained under the Mental Health Act are being read their rights under Section 132. The provider must make patients aware of their rights to access an IMHA by providing this information in an accessible format. This is a breach of Regulation 9 (1)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff were not aware of positive behavioural support planning and did not demonstrate that they followed these required guidelines in practice. The provider must ensure all staff are following NICE guidelines for 'challenging behaviour and learning disabilities: prevention and interventions for patients with learning disabilities whose behaviour challenges'; published: 28 May 2015. This includes positive behaviour support planning. This is a breach of Regulation 12(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Patients were not happy about the quality of their food. The provider must deliver good quality food that meets the nutritional needs and preferences of the patients. This was a breach of Regulation 14(4)(c)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must enable local managers to deliver a service in line with current practices specific to enabling patients with learning disabilities to become more independent. This was a breach of Regulation 9(3)(b)