Devon Partnership NHS Trust

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

Wonford House Hospital
Dryden Road
Exeter
Devon
EX2 5AF
Tel: 01392403433
www.dpt.nhs.uk

Date of inspection visit: 10 June to 11 June and 15 June 2020
Date of publication: 25/08/2020

Ratings

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

Summary of findings

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

Requires improvement 

Summary of this service

We carried out a focused inspection of wards for adults of working age and psychiatric intensive care units run by Devon Partnership NHS Trust. This was a focussed inspection, so we did not rate the service during this inspection. The requires improvement rating relates to the rating awarded at the previous inspection.

The wards are registered to provide the following regulated activities;

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.

We visited Delderfield ward and Moorland View ward. Delderfield is one of two 16-bedded wards at The Cedars in Exeter. Moorland View is one of two 16-bedded wards at North Devon District Hospital. Both wards are acute inpatient wards that provide assessment, care and treatment for adults with mental health needs.

At the time of our inspection Ocean View, the neighbouring acute adult inpatient ward to Moorland View ward, was being used as a ward for a small number of patients who were being tested for Covid-19 prior to admission as part of the trust's infection prevention and control strategy.

Ocean View ward was suspended in early June 2019. Ocean View and Moorland View staff teams merged to become one 24-bedded ward to support safe staffing.This was due to difficulties recruiting staff, especially registered nurses. On 30 November, the bed numbers on the merged ward were further reduced to 16 beds following the death of a patient to support safe staffing and manage patient acuity.

We visited Delderfield ward and Moorland View ward due to concerns about patient safety incidents involving ligature incidents and patient deaths. There had been a number of patient safety incidents involving ligature incidents and patient deaths including a patient death on Delderfield ward in March 2020 and two patient deaths on Moorland View ward in September 2019 and November 2019. These were in addition to other serious incidents involving patients self-harming.

On 18 June 2020, following this inspection, we sent the trust a letter of intent under section 31 of the Health and Social Care Act 2008 identifying our serious concerns about the safety of patients on Delderfield ward and requesting the trust submit information to explain how it would make immediate improvement. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. A letter of intent sets out our intention to take urgent action if the provider does not assure us that it will make the required improvements urgently. The trust responded to the letter of intent on 22 June 2020 with an action plan. However, we did not feel it set out clearly enough what action would be taken so asked for further assurance. The trust responded on 1 July 2020 setting out further immediate actions it was taking/would take to ensure the safety of patients.

Summary of findings

In the Section 31 letter of intent we told the trust we were concerned about the management of environmental risks including ligature risks. The environmental ligature risk assessment shown to us on Delderfield ward was not the latest version as the interim manager told us they did not have access to it. This version had not been updated following recent serious incidents.

We told the trust we were concerned that on Delderfield ward, patient's observations and intentional rounding were not sufficient to keep patients safe. Staff only randomised formal patient observations if they determined that the patient was at particular risk. This was contrary to the Trust's engagement and observation policy which stated observations should not be predictable or entirely regular. The predictability of observations exposed patients with self-harming behaviours to a risk of having the opportunity to hurt themselves.

We told the trust we were concerned about the quality, recording, oversight and effectiveness of observations and intentional rounding on Delderfield ward. There was a lack of oversight of observations, despite incidents taking place when observations were missed, or when observation levels had not been sufficient to prevent self-harm.

We asked the trust to tell us how it would improve the quality and oversight of observations and intentional rounding to improve its ongoing assessment and understanding of patients' well-being, progress and fluctuating risks and in order to appropriately care for patients.

We told the trust we were concerned about a lack of response to audits and a lack of learning from serious incidents. There had been a delay in completing the investigations into recent serious incidents, including the patient deaths. There was evidence of learning from serious incidents on Moorland View ward. However, on Delderfield ward, minimal local learning had taken place following a death in March 2020 and staff said they were waiting for the outcome of the root cause analysis or simply did not know if there was any learning from the death that took place in March.

We had no concerns about the induction process on Moorland View ward where agency staff were monitored during their shift. However, we told the trust we were concerned about the lack of a robust system to ensure agency staff were inducted to the Delderfield ward. An induction checklist was in place, however if staff said they had worked shifts on the ward before, this was not checked to ensure their induction and training was up to date.

We told the trust we were concerned about staff training because staff on both wards told us they had not been formally trained in ligature risk assessment and management. The inspection team reviewed an audit that showed staff felt under skilled in risk assessment. Staff did not receive formal training in patient observations and there was no formal process on Delderfield ward for checking patient observations had been completed.

Delderfield ward had implemented a daily security check on Delderfield ward three weeks prior to the inspection. The daily security check helped raise staff's awareness of ligature risks on the ward and staff generally found it useful. There was a lack of action to rectify risks because works had been delayed due to the Covid-19 pandemic. In response to the pandemic, in early March, contractors were removed from site by their firm management teams. The Trust advised us it had no involvement in or control over this decision.

In the Trust's response to our letter on 22 June 2020, the Trust assured us that the Director of Nursing and Professions had visited Delderfield ward to discuss the initial findings and immediate actions with the staff and leadership on the ward. The Trust provided us with an action plan on 22 June 2020 to address our initial findings. The trust provided us with an up to date copy of the ligature risk assessment for Delderfield ward that had been updated in April 2020. However, the environmental ligature risk assessment lacked details of actions taken to mitigate risks so we asked for further assurance. The trust confirmed wards were now ensuring observations were unpredictable for all patients. The trust told us it had briefed staff on the use of the engagement and observation policy, reminding staff to complete observations at variable intervals. The trust told us it had introduced measures to ensure induction was more robust, reviewing the local induction checklist for all agency staff workers on all shifts, regardless of whether or not they had previously worked on the ward. The Trust advised that simulation training in ligature risk assessment and management was being developed for roll out at the end of July 2020.

Summary of findings

We wrote to the trust again on 26 June 2020 to request further assurances. We asked for confirmation that the interim manager on Delderfield ward had access to the environmental risk assessment. We asked for more detail about reviewing and auditing of engagement and observation and for confirmation that patients were receiving unpredictable and irregular observations. We noted that Delderfield ward had introduced a weekly audit of engagement and observation. However, this audit was happening daily on Moorland view and we asked the trust to assure us that a robust and regular review of engagement and observation was taking place. We asked the trust to confirm that agency and bank staff on Delderfield ward were being provided with individual supervision and being included in discussions about changes to the observation levels of patients. We asked for further clarification on the risk training being provided to staff and to tell us how it would ensure staff were sufficiently trained, competent and confident in intentional rounding, observation and the assessment and management of patient risk. We asked for more detail about how the trust ensure learning is discussed and disseminated effectively on Delderfield ward. We asked for an update on the expected completion date for the root cause analyses for each of the deaths on Moorland view and Delderfield ward. We told the trust that the risk register they had provided to us for Delderfield ward did not appear to be an active document and that it lacked detail. We asked for assurance of the trust seeking a permanent manager for Delderfield ward. We asked for assurances about the timeframes of the work being conducted by the trust's 'preventing and managing ligature events in inpatient settings group'.

The trust wrote to us again on 1 July 2020 and it advised the interim manager had had access to the environmental risk register but had now left the ward. It provided us with its audits of observations for Delderfield ward. These showed that comprehensive observations were taking place in line with trust policy. The trust advised it would be ensuring all staff feel engaged, understand and participate in clinical discussions and decision making. The trust told us it had introduced a three times daily audit of the recording of observations on Delderfield ward. The trust provided Delderfield ward's updated risk register and it was comprehensive. The trust confirmed that temporary bank and agency staff were being offered supervision. The trust provided confirmation of the governance process for ensuring learning from incidents and audits is discussed and disseminated.

However;

We found positive and proactive leadership on Moorland View and that risks were being managed well.

Staffing levels were safe on both wards. The trust had an active recruitment programme and it was supporting existing staff to undergo nurse training.

Handover were effective on both wards. Handovers were detailed and covered dynamics between patients, physical health risks and patients' risk.

All patients and carers that we spoke with said staff enabled them to have contact with one another. This was particularly welcomed during the Covid Pandemic lockdown period. Patients, families and carers gave good feedback about staff, describing them as helpful, approachable, supportive, caring, and respectful.

All patients said they were involved in planning about their discharge and families and carers said they were suitably involved in discharge planning.

Patients on both wards talked about enjoying being able to use the gardens which were well maintained, spacious and offered a calming environment

Staff felt the culture on both wards was good and that staff were caring for each other and towards patients. Staff felt respected, supported and valued.

As this was a focussed inspection, specifically to follow up on issues of concern about patient safety, therefore did not rate the service and the rating from the previous inspection still applies.

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

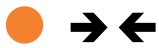
Summary of findings

- Is it safe?
- Is it well led?

During this inspection, the inspection team:

- Visited Delderfield ward and Moorland View ward
- spoke with the ward managers
- spoke with 16 staff including registered nurses, healthcare assistants, support workers and student nurses
- spoke with patients
- spoke with carers
- spoke with stakeholders of the service
- looked at 14 care and treatment records of patients
- attended a handover meeting on Delderfield ward
- looked at a range of policies, procedures and other documents relating to the running of the wards.

Is the service safe?

Requires improvement 

This was a focussed inspection, so we did not rate this key question during this inspection. The requires improvement rating relates to the rating awarded at the previous inspection. We found that:

- Although staff completed regular risk assessments of the ward environment, there were environmental risks that had not been addressed. The ligature assessment for Delderfield ward did not contain sufficient detail of risks or mitigation and the ward was not able to explain the scoring system used or what the scores meant. The trust had planned to install sensors to doors on bedrooms and en suite bathrooms on all its wards to mitigate the risk of patients using the tops of doors as ligature points. There had been lengthy delays in completing these works on adult inpatient wards and on Delderfield ward the risk was not sufficiently mitigated to ensure the safety of patients. Staff were worried about this risk and they were not being kept informed about when the work might take place.
- At the time of our inspection there was no formal training for staff in the management of ligature or environmental risks although they did receive general risk management training. Following our Section 31 letter of intent, the Trust confirmed simulation training was being developed for roll out at the end of July 2020.
- The process for ensuring temporary staff were familiar with the ward was not robust. There was a lack of a robust process for ensuring temporary staff working on Delderfield ward were sufficiently familiar with the ward and the tasks expected of them. There was a lack of a robust process to ensure temporary staff were up to date with training and they were not provided with supervision with the rest of the staff team. Following our Section 31 letter of intent, the trust confirmed a series of measures to ensure temporary staff were sufficiently briefed and that their induction record was reviewed on each shift.
- Delderfield ward was using bank and agency staff to fill shifts due to staff leaving, to fill gaps in the rota and to respond to changing patient acuity levels. We noted that staffing levels on the ward was safe. However, patients told us they did not always know the staff and staff were not always familiar with the ward and with patient's individual care.

Summary of findings

- On both wards staff completed a risk assessment of every patient on admission and updated it regularly. However, there was a lack of detail in some risk assessments and risk management plans about specific risks. Staff completed observations of patients so they could monitor their ongoing risk and wellbeing. Staff completed these observations at exact time intervals, and this was contrary to the trust engagement and observation policy which states staff should ensure that observations are neither predictable or entirely regular. In its second letter in response to our Section 31 letter of intent, the Trust provided us with its audits of observations. These showed that comprehensive observations were taking place. However, on one of the nights, observation records showed observations were missed during an incident. In response to the Section 31 letter of intent, the Trust confirmed that all patients were receiving unpredictable and irregular observations within the timeframe required for their risk.
- Moorland view patients said staff asked them how they were feeling and asked if they needed anything. On Delderfield ward, staff completing checks on patients were not doing so in a therapeutic or engaging manner. There was no process in place for ensuring observations took place and that they were of benefit to patients. Following our Section 31 letter of intent, the Trust introduced an audit of observation records that ensured staff were appropriately engaging with patients.
- Some staff on Delderfield ward told us they were not always included in discussions about changes to patient's observation levels. The trust addressed this in its second response to our Section 31 letter. The trust said it would be ensuring all staff feel engaged, understand and participate in clinical discussions and decision making.
- Some staff on Delderfield ward told us they were not always informed of changes to observations levels in a timely manner.The trust addressed this in its second response to our Section 31 letter by ensuring all staff feel engaged, understand and participate in clinical discussions and decision making.
- The trust had not yet completed its investigation and analysis of the deaths of three patients on these wards or identified learning from these incidents. Staff on both wards told us they were waiting for this learning or simply said they did not know if there was any learning identified following these incidents. Delderfield ward staff told us the ward had not changed since the death of a patient in March 2020. In its response to our Section 31 letter, the Trust advised the investigations into the three deaths on these two wards were due for completion at the end of July 2020.

However

- Staffing levels were safe on both wards. The trust had an active recruitment programme and it was supporting existing staff to undergo nurse training.
- Moorland view ward had a comprehensive ligature assessment that listed risks on the wards.
- Following our section 31 letter to the trust, personality disorder training would be provided on Delderfield ward in the week commencing Monday 22 June 2020. Simulation training to teach staff about managing ligature risks was in development with a plan to roll it out at the end of July 2020.This training would be mandatory for all staff.
- Handover was effective on both wards. Handovers were detailed and covered dynamics between patients, physical health risks and patients' risk.

Is the service effective?

Requires improvement 

We did not have any concerns which related to this key question and did not inspect against it. The requires improvement rating relates to the rating awarded at the previous inspection.

Summary of findings

Is the service caring?

Good  

This was a focussed inspection, so we did not rate this key question during this inspection. The good rating relates to the rating awarded at the previous inspection.

We spoke with patients, families and carers from both wards and we found that:

- All patients and carers said staff enabled them to have contact with one another.
- All patients said they were involved in planning about their discharge and families and carers said they were suitably involved in discharge planning.
- Patients, carers and families said they could feedback about the ward and knew how to complain.
- Half of the patients on Delderfield ward said there were enough staff to facilitate activities and one-to-one time.
- Patients, families and carers gave good feedback about staff, describing them as helpful, approachable, supportive, caring, and respectful.
- Patients on both wards talked about being able to use the gardens which they enjoyed.

However:

- Four patients on Delderfield ward said they often did not know the staff because they were not regular staff. Three of the carers and families we spoke to mentioned staffing being stretched or there being a lack of continuity.
- Half of the patients on Delderfield ward said there were not enough staff to facilitate activities and one to one time.

Is the service responsive?

Requires improvement  

We did not have any concerns which related to this key question and did not inspect against it. The requires improvement rating relates to the rating awarded at the previous inspection.

Is the service well-led?

Requires improvement  

This was a focussed inspection, so we did not rate this key question during this inspection. The requires improvement rating relates to the rating awarded at the previous inspection. We found that:

- Delderfield ward had inconsistent leadership including the lack of a consistent consultant psychiatrist on the ward. The ward manager post was vacant and being covered by an interim manager.
- On Delderfield ward there was a lack of oversight of patient observations, despite incidents that had shown that observations were missed or observation levels had not been sufficient to prevent serious harm. The trust introduced audits of observations on Delderfield ward following our Section 31 letter of intent.

Summary of findings

- Staff on both wards were still waiting to receive learning from the outcomes of the trust investigation into the patients' deaths and the investigations had been delayed. The trust advised the investigations were due for completion at the end of July 2020.
- Staff were frustrated by the significant delay in the trust installing door sensors and staff were worried about the risk that they were required to manage.
- Delderfield ward's risk register was incomplete and was not being kept up to date. It did not provide assurances regarding mitigation of known risks. In the Trust's second response to our Section 31 letter of intent it was confirmed Delderfield ward's risk register had been updated and provided a copy.

However

- Managers on both wards were experienced and approachable. Staff had confidence in the managers and they were positive about the leadership on both wards. Staff we spoke to were confident in the interim ward manager on Delderfield, despite them being in the role just three months.
- Staff felt the culture on both wards was good and that staff were caring for each other and towards patients. Staff felt respected, supported and valued.
- Staff on both wards felt able to raise concerns. Staff knew how to find information about the whistle-blowing process and the role of the speak up guardian.
- Staff on both wards were supported and supervised.

Detailed findings from this inspection

Is the service safe?

Safe and clean environment

Safety of the ward layout

We were concerned about the environmental risks on both wards. There was a risk caused by patients using the tops of doors as ligature points and this had resulted in serious incidents on both wards. The trust decided to mitigate this risk by installing sensors to patient bedroom and bathroom doors across all of its acute in patient wards. However, there were significant delays to the installation of door sensors. The trust had planned to install the sensors following a serious incident on another ward in 2017. Door sensors had been installed in the trust's mother and baby unit and psychiatric intensive care unit in 2018 but technical issues were identified that resulted in a pause and review of the programme of door sensors being installed across the trust in line with emerging national evidence about alternative technical solutions and the effectiveness of current door sensors in reducing ligature harm. The review resulted in a revision to the door sensor programme. There was a plan for the trust's board to review the door sensor capital plan for approval on 14 July 2020 with a view to starting work in October 2020 for 56 weeks.

Seven of the staff we spoke with from both wards expressed their concern about the risk of doors being used as ligature points. On Moorland view ward, the ligature risk assessment stated that the mitigation for the risk of bathroom doors being used as ligature points was to fit door sensors but there was still no confirmed date for the installation of the sensors. Moorland view ward managers told us that if individual risk assessments indicated it, en-suite bathroom doors were locked so patients could not access them.

Both wards had ligature anchor points and comprehensive lists of these. Ligature anchor points are features of an environment that can be used to secure an item that can be used for self-strangulation. Following the death in March 2020 on Delderfield ward, a full environmental risk assessment was completed on 3 April 2020 but the interim manager told us they did not have access to this document.

On Delderfield, there was a lack of action and awareness of environmental risks. The interim ward manager was unaware of where the blind spots were on the ward. The risk posed by the blind spots had not been identified on the ward's environmental risk assessment. Delderfield ward's environmental risk assessment stated that three bathrooms did not have anti-barricade doors and that bedroom furniture had been identified as unsafe but there was no evidence to show that there was a plan to purchase new furniture.

The garden on Delderfield ward was an unsupervised area but the environmental ligature assessment identified several high risk items. There was no action against these risks other than to say the garden was anti-ligature as far as was practicably possible.

Some ligature works had been carried out. For example, Moorland view ward had trialled saloon doors on en-suite bathrooms, but they had not worked effectively. Bathrooms had anti-ligature sinks installed. Following installation, it was discovered that in other trusts there had been a small number of isolated ligature incidents involving the sinks and staff were advised to be mindful of this.

During the three weeks prior to our inspection visit, Delderfield ward staff had been completing a daily security checklist to identify ligature anchor points and raise newly identify ligature points with the estates team to be resolved. This approach also enabled staff to become more aware and familiar with ligature risks on the ward.

Detailed findings from this inspection

The trust had an active anti-ligature programme. However, during the COVID-19 pandemic, the contractors' firms removed the contractors from site to protect their staff from risk of infection. This decision was made by independent contractors and was therefore outside the Trust's control. The trust advised that the estates internal and contracting works rebegan as soon as was safe and possible to do so. This delayed the works planned, including an upgrade of patient toilets and bathrooms to a ligature-free standard on both wards.

Ward managers provided monthly reports to the trust's directorate governance board. The May 2020 report for Delderfield ward included environmental risks as a "hot issue". It stated some actions taken to mitigate risks arising from serious incidents in the form of three initiatives: the daily ligature check and business and supervision agenda had been adapted to include prompts to ensure ligature risks were discussed. In addition, work was being done to prioritise work that needed to be completed by estates.

Safe Staffing

All ward managers held a daily call together to check staffing levels and share staff if needed. On the day of the inspection staff on both wards told us they were happy with staffing levels. However there had been staffing changes on Delderfield ward due to staff leaving and new staff joining the ward.

Delderfield ward had three registered nurse vacancies and five health care support worker vacancies. Delderfield ward was using bank and agency staff to fill shifts and patients told us they did not always know the staff. Patients told us temporary staff were not always familiar with the ward or with patient's individual care. Staff on Delderfield ward told us the level of patient acuity on the ward could sometimes make it feel unsafe, depending on whether the staff on duty were experienced. Staff told us that although staffing levels on the ward could be increased if needed, the ward could not always get cover.

Moorland View's neighbouring ward Ocean View ward was suspended in June 2019 due to a difficulty recruiting adequate numbers of experienced staff. The ward staff were combined and worked on Moorland View ward. Managers told us it was rare for Moorland view ward to use agency staff that were not known to the ward. On Moorland view ward there were two managers due to Ocean View ward being closed.

The trust had a programme of supporting staff to access nurse education. This programme aimed to ensure the trust would have enough registered nurses in future. Moorland View ward was supporting three staff with practitioner courses. There was a plan to reopen Ocean View ward once current preceptees had completed their preceptorship. There were no trainee nurses on Delderfield ward.

Mandatory training

The trust was not providing any face to face training because of the restrictions in place during the Covid-19 pandemic.

Following our Section 31 letter of intent, the trust advised that personality disorder training would be provided on Delderfield ward. This training would be mandatory for all staff. Following the inspection, the trust advised us that work had been underway for some time to develop this critical training for the Trust. A programme of development for Delderfield Ward was already underway, including the preparatory meeting with the simulation trainer that had had to be delayed due to COVID-19 and ward visiting restrictions.

At the time of our inspection staff told us they had not been formally trained in the management of ligature risks or patient observation. Staff instead had the opportunity for learning via staff supervision, discussion and briefing sheets. Staff did complete two levels of clinical risk training: level one was online and level two was a more in depth, face to face

training but it was suspended due to the Covid-19 pandemic. Following our Section 31 letter of intent, the trust told us staff on Delderfield ward were repeating level one clinical risk training. Moorland view was providing simulation training for its staff to teach them to manage self-harm incidents. Following our Section 31 letter of intent the trust told us it would provide the simulation training to staff on Delderfield ward.

On Moorland View ward, agency and bank staff had access to the same training, ligature briefings and supervision as substantive staff. Moorland View ward's temporary staff attended handover and substantive staff supervised their practice throughout the shift. In addition, on Moorland View ward, regular agency and bank staff were provided with supervision and training alongside substantive staff. This was not the case on Delderfield ward. However, in its second letter in response to our Section 31 letter, the trust confirmed that temporary bank and agency staff were being offered supervision as well as substantive staff. Supervision, including that which was overdue, was planned to take place in July and August 2020.

We were concerned about the induction process on Delderfield ward. There was a lack of a robust process for ensuring temporary staff who had previously worked on the ward, were sufficiently familiar with the ward and the tasks expected of them. There was a lack of a robust process of ensuring temporary staff were up to date with training. In addition, temporary staff were not provided with supervision with the rest of the staff team.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at 10 care records on Delderfield ward and four care records on Moorland View ward.

At our previous inspection we found staff did not always develop detailed, robust risk management plans in response to identified needs and changing risks. At this inspection, on both wards, staff completed a risk assessment of every patient on admission and updated it regularly. Of the 10 records we looked at on Delderfield ward, eight had an up to date risk assessment. All the patient risk assessments on Moorland View ward were up to date.

However, the level of detail in care records was varied. There was sometimes a lack of detail about how patients were feeling and about specific risks such as assessment of access to restricted items that could be used as ligatures. For example, On Delderfield ward we saw a care record for a patient with a specific physical health risk that had not been documented on their risk assessment or care plan. All other Delderfield ward care records showed patient's psychiatric risks but physical health risks were not identified or care planned.

On Delderfield ward we found there was a lack of detail in some risk assessments and risk management plans. There was a lack of detail of engagement with patients during observations and intentional rounding in care records on both wards.

We found during our previous inspection that staff did not consistently review risk assessments and management plans in response to untoward incidents. At this inspection we saw examples of risk assessments being updated following incidents on both Delderfield and Moorland View wards.

Following our inspection visit, Delderfield ward held a business meeting with the staff. Staff were asked to rectify the issues with documentation and staff were offered support to achieve this. The ward managers said they will continue to monitor and audit documentation to support staff and discuss in supervision.

Management of patient risk

Patient risks on both wards were mitigated by observations of patients and intentional rounding using the trust's 'four steps to safety' approach. Intentional rounding was a process for holding conversations between patients and staff to

support them with early signs of frustration to reduce the risk of potential violence or aggression. Staff also spoke about intentional rounding as a way of managing self harm risk. This was a proactive approach to engaging with patients to make wards safer and increase interactions between staff and patients. The aim was to identify potential problems and prevent them from escalating.

In addition to intentional rounding, trust staff completed observations of patients at a frequency determined by their level of risk. Staff increased or decreased the frequency of observations of patients flexibly and in response to changes in risk. On Moorland View ward, if a patient's observation levels changed, a member of staff took responsibility for informing all the staff on the ward. On Delderfield ward, staff told us they did not always find out about changes to observations straight away. Although staff were not all directly involved in observing a particular patient at the same time, staff felt it would be helpful for them all to be aware of increased risks to patients so they could be mindful and make extra checks if the opportunity arose. Two staff from Delderfield ward said all staff could contribute to discussions about risk and observation levels but two staff disagreed. The trust addressed this in its second response to our Section 31 letter by ensuring all staff feel engaged, understand and participate in clinical discussions and decision making. If changes to observation levels were made during ward round, then the team was excluded from taking part in the discussions. Moorland view ward had a policy of automatically increasing the level of patients' observations for patients if they were involved in a ligature incident, until their risk could be formally reviewed.

We were concerned about the quality of patient observations and intentional rounding on Delderfield ward. On Delderfield ward, staff completing checks on patients were not doing so in a therapeutic or engaging manner. For example, we saw a member of staff who was completing intentional rounding, simply ask if a patient was ok and then move on. When we spoke to patients from Delderfield ward they said observations were brief and often did not include any conversation with staff. We observed that if patients wanted something it was up to them to approach staff. Moorland view patients said staff asked them how they were feeling and asked if they needed anything. We observed the staff completing a tick-box form during intentional rounding on Delderfield ward. The form did not collect information about the interaction with the patient and how they were feeling.

There was a lack of a process for ensuring the quality of observations on Delderfield ward. Moorland View had a system for ensuring important tasks were completed. Each shift, a member of staff was allocated to doing audits, rotas and making sure thorough observations and intentional rounding were taking place. Following our Section 31 follow up letter, the trust provided us with its recent audits of observations. These showed that comprehensive observations were now taking place. However, on one of the nights, observation records showed observations were not taking place during an incident as they were not being covered. Moorland View ward ensured at least one intentional rounding per patient per day included a one to one session with each patient.

On Delderfield ward, ligature management had been added to the standard supervision agenda prior to our visit and this was to trigger a conversation that ensures staff were familiar with ligature risks. However, the form had not yet been used. In its second letter in response to our Section 31 letter, the trust told us that the self-strangulation policy and the engagement and observation policy had also been added to the supervision agenda.

We reviewed the minutes of a 'preventing and managing ligature events in inpatient settings' group that was held on 6 December 2019. The group had talked about the need to encourage staff to engage patients rather than just observing them. The group noted an example of staff reading newspapers and using laptops while conducting level three observations. Level three observations are where the patient is under constant supervision because of concerns about their risk. The minutes of the 'preventing and managing ligature events in inpatient settings' group stated staff needed to consider what they could be doing to engage with patients and provide them with activities.

On Moorland View ward staff approached patients regularly and we saw good interactions between patients and staff on Moorland View. However, we were concerned that on both wards, formal observations were conducted by staff at exact time intervals. This was contrary to the trust engagement and observation policy which states staff should ensure that observations are neither predictable or entirely regular. This meant patients could predict when they would be checked

and know how long they would be left alone for. This was a risk for patients who self-harmed on Delderfield ward as patient interactions were minimal. A serious incident took place on Delderfield ward three days before our inspection visit where a patient had self-harmed and an agency member of staff failed to complete a scheduled observation of a patient. The patient was known to be at increased risk at the time of the incident. This incident is being investigated by the trust. In its second letter in response to our Section 31 letter, the trust, following audits, confirmed that all patients were now receiving unpredictable and irregular observations within the timeframe required for their risk.

In our Section 31 letter to the trust on 18 June 2020, we asked the trust to ensure patients observations and intentional rounding were robust, in line with trust policy and keeping patients safe. Staff did not receive training on completing observations and there was no formal process for checking patient observations had been completed. Following our letter, the trust advised us that staff were implementing an engagement and observation form for staff to complete to confirm that good quality observations were taking place. The forms would be audited weekly and the findings addressed in individual staff supervision and at all business meetings.

Handovers were thorough and effective on both wards. Handovers were detailed and covered dynamics between patients, physical health risks and patients' risk. During the handover on Delderfield ward, the importance of engaging with the particular patient during observations rather than just 'eyes on' was discussed in the handover we attended. Both wards told us that patient risks and observations were communicated through handover and ward rounds.

Track record on safety

Our inspection of the wards followed the deaths of two patients on Moorland View ward in September and November 2019 and one on Delderfield ward in March 2020. These deaths were all associated with environmental ligature risks.

Reporting incidents and learning from when things go wrong

The trust had not yet completed its investigation and analysis of the deaths of three patients on these wards and staff on both wards told us they were waiting for this learning or simply said they did not know if there was any learning from these incidents. Delderfield ward staff told us the ward had not changed since the death of a patient in March 2020.

However, we noted that Delderfield ward was increasing staff awareness of ligature risks in the ward environment with a daily check. The interim ward manager on Delderfield ward had introduced weekly business meetings for staff that included discussion of incidents and any learning or actions taken. This was a new meeting and one meeting had taken place. Moorland view ward held a monthly learning from the experience meeting for all staff to talk about risks and how they could be mitigated.

On Delderfield ward, following the serious incident of self-harm three days prior to our inspection visit where a patient's observation check was missed, no action had been taken to ensure Delderfield ward staff were completing all required observation checks for all patients.

Moorland View managers had reflected on the deaths in 2019 and recognised that the ward environment was difficult to manage. This risk had been mitigated by the closure of Ocean View ward. Ward managers had been raising concerns about the environments of Ocean View and Moorland View wards for some time prior to the deaths.

A programme of self-strangulation simulation training was being developed and was due to be rolled out to the adult inpatient wards from the end of July 2020. This training would include ligature risks, engagement and observations.

Following our Section 31 letter of intent to the trust on 18 June, the trust told us that learning from incidents and emerging themes and trends would be discussed in the Delderfield ward huddle meeting and The Cedars business meeting. The huddle would review how the team was learning from incidents and how learning was being embedded. In addition, a ward-based facilitator would attend debriefs from serious incidents and report to the ward manager on any learning. This was to ensure issues were addressed in a timely manner.

Detailed findings from this inspection

The trust said it would also implement safety briefings in response to learning from serious incidents and these would be cascaded organisation wide.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with five patients and four families and carers of patients on Delderfield ward. We spoke with six patients and four families and carers of patients on Moorland view ward.

Patients on Delderfield ward described the staff as brilliant, helpful, friendly and very good. Patients on Moorland View ward described staff as lovely, approachable and supportive, respectful and caring.

The majority of patients on Delderfield ward said that they often did not know the staff because they were not regular staff. The majority of patients on Delderfield ward said there were enough staff to facilitate activities and one-to-one time with patients. Patients on Delderfield ward were satisfied with activities except for on Sundays when two patients said there was nothing to do.

The majority of patients on Moorland View ward said staff talked to them about how they were feeling and asked if they need anything. All the patients on Moorland View ward said there were enough staff and that staff were familiar to them. Patients on Moorland View ward said there were enough activities although one patient said there were fewer things to do at weekends

All patients said staff enabled them to have contact with their family and friends and carers.

Patients on both wards talked about being able to use the gardens which they enjoyed.

Involvement in care

Involvement of patients

Two patients on Delderfield ward said staff reviewed risk with them and two said they did not. Three of the patients on Delderfield ward said their observations were often just someone looking at them but not talking to them.

All the patients said they were involved in planning about their discharge.

All but one of the patients said they knew how to give feedback and complaint about the ward.

Involvement of families and carers

Families and carers of patients on Moorland View ward described staff as respectful, warm, polite, brilliant, supportive. Families and carers on Delderfield ward described staff as patient, friendly, kind, polite and nice.

Moorland View ward families and carers told us they could contact the ward to find out how their loved one was doing and they said they felt suitably involved in the loved one's care. However, they told us there was no proactive process in place for the wards to let them know how patients were doing. Two carers on Delderfield ward said they had attended ward rounds by video link and they appreciated this.

Three families and carers of patients on Delderfield ward we spoke to said they were not involved in patient's discharge. All families and carers of Moorland View patients said they were suitably involved in discharge planning

All families and carers of Moorland View patients we spoke to knew how to complain. Two patients and three families and carers of patients of Delderfield ward patients said they did not know how to complain.

Three of the carers and families on Delderfield ward we spoke to mentioned staffing being stretched or there being a lack of continuity.

Detailed findings from this inspection

Is the service well-led?

Leadership

Managers on both wards were experienced. Staff said managers on both wards were approachable and they had confidence in them. Managers provided good leadership and were respected by the teams.

However, Delderfield ward had experienced a lack of consistent leadership including the lack of a consistent consultant psychiatrist on the ward and the ward manager post was vacant and being covered by an interim manager. There was a senior nurse manager who was supporting the new interim manager as they became more familiar with the ward. Staff did not know how long the interim manager was staying. The trust advised us in its second letter in response to our letter of intent that the manager of the neighbouring Coombehaven ward was now the interim manager, supported by the senior nurse manager. A recruitment process was underway to fill the vacant ward manager post and a new consultant had been appointed to commence in post in August 2020.

Culture

Staff we spoke with generally felt the culture on both wards was good and that staff were caring for each other and towards patients. Staff told us they had been affected by the patient deaths on their wards although they said they felt well supported. They had received debriefs from the clinical psychologists that visited the ward each week.

Staff told us teams supported each other. Staff on Delderfield ward said the team had struggled because of the lack of a consistent, substantive ward consultant psychiatrist and the vacant manager post.

Staff on both wards felt able to raise concerns. Staff knew how to find information about the whistle-blowing process and the role of the speak up guardian.

Governance

The trust had an active recruitment programme, but it was unable to staff Ocean View ward so the ward had been suspended. Delderfield ward was having to use agency staff on a regular basis due to ongoing shortages in substantive staff. Despite this, there were enough staff on the wards, and substantive staff were supported and supervised.

The trust was not ensuring risk was managed well on Delderfield ward. There was a lack of a robust system in place to enable the oversight of patient observations on Delderfield ward, despite incidents that showed that observations were missed, or observation levels had not been sufficient to prevent serious harm. On Moorland View, a member of staff was allocated to ensuring observations were completed appropriately on each shift. However, on Delderfield ward, there was a lack of a mechanism for ensuring observations were completed. On Delderfield ward, managers were not ensuring that meaningful conversations were taking place with patients and this meant opportunities could be missed to meet patients' needs and monitor patient safety.

There was a lack of responsiveness from the trust to environmental risks raised by the wards. The trust was considering installing door sensors to make bedroom and en-suite doors on the wards safer. However, ward staff were frustrated by the delay in the trust actioning this and they were worried about the residual risk. Staff reported raising issues, such as the risk of doors being used as ligature points, with the trust and experiencing long delays in any response from the trust.

Mechanisms that were in place were not always effective in reducing risks at ward level. Wards submitted a monthly report to the adult directorate governance board, detailing challenges on the ward such as environmental risks. The interim manager on Delderfield ward was unclear of the purpose of this report and had not received feedback from the meeting on how the challenges would be addressed.

There was evidence that the trust had not kept an up to date risk register for Delderfield ward. Following our inspection visit the trust provided an updated risk register for Delderfield ward. The item on ligature risks on the ward was created on 18 June 2020, eight days after our inspection. In addition, the risk register for Delderfield ward was minimal with five risks documented on it. In its second response to our Section 31 letter, the trust confirmed Delderfield ward's risk register had been completed and provided a copy. However, there was no control for patient access to hot water on the updated risk register.

The risk register for Moorland view was comprehensive with 26 items all of which were standard and transferable risks that would apply to most inpatient wards.

Managers were not ensuring learning and development was taking place effectively on Delderfield ward following incidents of serious self-harm and a patient death. Staff on both wards were waiting for the outcomes of trust investigations into the patients' deaths and these had been significantly delayed by the trust. In its response to our Section 31 letter, the trust advised that the investigations into the three patient deaths were due for completion by the end of July 2020. Some improvements had recently been implemented, for example, the daily ligature check on Delderfield ward.

Learning, continuous improvement and innovation

The trust was making attempts to reduce the risks associated with adult inpatient wards. We looked at an analysis of ligature attempts over the past five years and it showed that the highest number of incidents took place on Delderfield ward (30% of incidents across the whole trust). The trust told us after the inspection that this was largely due to the high levels of patient acuity on Delderfield Ward in addition to the wards in Exeter having the higher rates of admission of patients with emotionally unstable personality disorder (EUPD).'

Fifteen percent of ligature attempts took place on Moorland View ward. The trust had a safer in suicide team and they had completed an audit that showed a significant spike in ligature incidents from October to December 2019. A high percentage (98%) of incidents involved a low number of patients with a diagnosis of emotionally unstable personality disorder. There was a plan to pilot a new approach to high risk patients. However, this work had been interrupted by the Covid-19 pandemic.

The safer in suicide team was looking at clinical pathways for people with a primary diagnosis of emotionally unstable personality disorder. It was noted that Delderfield ward was an outlier for length of stay (it being longer than on other wards). It referred to lengthy and non-therapeutic admissions in which the risk to self can actually be greater. The team had also arranged for weekly training sessions for all staff in working with people in an acute setting with a diagnosis of personality disorder to start in 2020 and this was being rolled out.

The trust also had a preventing and managing ligature events in inpatient settings group. The group recognised there had been an escalation in the number of events and that it was causing great risk to individuals, distress to families and that it was affecting morale and well-being of staff. It also recognised that the risks were impacting on staffing numbers, raising staff turnover and making the environment unsafe. The group was looking at ways to reduce ligature events on wards. The group had recognised that patients diagnosed with personality disorders were admitted to inpatient beds in Devon more frequently than in other areas of the country and they were questioning the wider mental health system's approach to managing serious risk. The group recognised that patients with emotionally unstable personality disorder may not benefit from admission to hospital because their self-harm behaviour often escalates.

The trust had a steering group for personality disorders that was driving quality improvement using the framework of the January 2018 Consensus Statement on Personality Disorder by the Royal College Psychiatrists. The personality disorders programme aimed to reduce unnecessary and unhelpful admissions by supporting patients in the community. The group also aimed to increase access to psychological therapies

Detailed findings from this inspection

The steering group for personality disorders had led the implementation of the personality disorders training programme to support staff in management of patients with emotionally unstable personality disorder on acute wards. Six staff on Delderfield ward had completed a training in Dialectic behavioural therapy. Dialectic behavioural therapy is a recommended intervention for patients with personality disorders. The ward had an ambition to provide this training for all staff.

The trust had developed a new clinical protocol with district general hospitals to manage the physical health monitoring aspects of self-strangulation. This protocol had not yet been implemented.

Areas for improvement

The trust must ensure environmental risk assessments are updated, including following serious incidents and that robust mitigation is in place. It must ensure environmental risks, once identified, are reduced in a timely manner.

The trust must ensure patient observations and intentional rounding are robust, comprehensive, completed in line with trust policy and keep patients safe. It must ensure mechanisms are in place to prevent patient observations being missed during incidents on the wards that might divert the attention of staff.

The trust must ensure staff are sufficiently trained, competent and confident in intentional rounding, observation and the assessment and management of patient risk.

The trust must ensure there is a robust system to ensure all staff, including temporary staff have been inducted and are familiar with the ward and the tasks required.

The trust must ensure improvement in the quality and oversight of the ward. It must ensure staff are completing their duties to a high standard. It must ensure staff robustly complete ongoing assessment of patients' well-being, progress and fluctuating risks.

The trust must ensure the findings of audits and serious incidents are responded to and learned from in a robust and timely manner. It must ensure learning is shared with staff without delay.

The trust must ensure risk registers are comprehensive, reviewed and updated regularly.

Our inspection team

Our inspection team consisted of a Head of Hospital Inspection, an Inspection Manager, two inspectors, one specialist advisor who was a registered nurse with experience of working in acute mental health services and an expert by experience.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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 17 HSCA (RA) Regulations 2014 Good governance