Outstanding ☆

Cornwall Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

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)
RJ866	Bodmin Hospital	Fettle Ward	PL31 2QT

This report describes our judgement of the quality of care provided within this core service by Cornwall Partnership NHS Foundation 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 Cornwall Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cornwall Partnership NHS Foundation 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Good ●

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Long stay/rehabilitation mental health wards for working age adult as outstanding because:

- Staff focused on ensuring the safety of patients through assessing the patients, and the environment. These risk assessments were comprehensive and updated regularly to help staff provide safe care. If things did go wrong, staff would give patients a sincere and prompt apology and keep them informed on steps taken to prevent it from happening again.
- Systems were in place to ensure that the ward had adequate staffing. Staff were skilled and experienced at delivering care in that environment. Although there was some difficulty in obtaining places on training courses, staff demonstrated knowledge that meant patients could receive high quality care.
- Patients and staff co-created care plans that were holistic and recovery centred. Staff supported patients to set goals to help them reach their objectives, and provided a range of activities and nationally recommended therapies to help them to do this. Staff had continued to use the protocols for patients to self-administer their medicines safely that we had seen on the last inspection. This was still working well in helping patients to become more independent and prepare them for living in the community. They worked to ensure that patients' wishes about their care were taken into account and were valued.
- Staff had strong links with local services, and had social inclusion workers that helped patients to access training and activities in the community. We saw examples of patients volunteering, gaining employment and entering higher education.
- Patients were only transferred from the ward when they needed care that could be better provided in another setting. The ward was full at the time of inspection and there was one person waiting for a bed. Staff would only discharge patients when there was a suitable placement for them and worked hard to find somewhere where patients could move to without their health deteriorating. The average length of stay was 538 days.
- Throughout our inspection, patients told us that staff were caring and kind and we saw that staff were truly dedicated to giving high quality, person centred care in a respectful way. They had made changes to the ward environment to help protect patients' privacy, as well as ensuring that the communal areas were well decorated and there were plenty of things for patients to do while they were on the ward.
- Staff benefitted from stable leadership from the ward manager; staff of all levels said that they felt the team was supportive and cohesive. They had a team vision of recovery and the way the they should deliver care that echoed the values of the trust.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff focused on patient safety. They assessed clinical risk using recognised tools and updated these assessments regularly. If things did go wrong, staff would give patients a sincere and prompt apology and keep patients updated on steps to prevent it from happening again.
- Staff also were aware of when and how to safeguard vulnerable adults and children and had information on the ward to help them do this. Patients also had access to this information.
- The ward had a sufficient number of staff to provide safe care, and there were systems in place to manage absences and sickness. If the ward used agency or bank staff, they were staff that were aware of the ward and staff would give them an induction and orientation at the start of their shift. The manager had started recruiting for upcoming vacancies.
- There were systems in place to ensure that staff kept the ward clean, and checked emergency equipment. These systems also ensured that staff stored and managed medicines safely.

Are services effective?

Outstanding

We rated effective as outstanding because:

- Staff used a holistic approach to assessing patients. They co-created care plans with patients and worked as a team to ensure that patients received care and treatment that allowed them to reach their recovery goals. Staff used recognised and recommended treatments, as well as continuing to use the self-administration of medicines protocols we had highlighted on our last inspection.
- There was a culture of continuing improvement and staff took part in audits. Staff used these audits to help improve practice on the ward. Staff were preparing for a visit from the Royal College of Psychiatrists as part of their national accreditation scheme. The ward had previously received accreditation but this had lapsed before another visit could be arranged.
- While there were sometimes issues with booking places on mandatory training, staff were knowledgeable and skilled. They routinely held internal training events and focused on group development.

Summary of findings

- There was a strong relationship between the staff and local services. This meant that patients benefitted from courses at the local college and were enabled to integrate with the local community in a meaningful way as part of their recovery.
- From the point of admission, patients' recovery was central to their care. Staff helped patients plan goals towards this and used recognised tools to help them do this, such as the recovery star.
- We saw that staff worked in line with the legal frameworks such as the Mental Health Act and the Mental Capacity Act. They were knowledgeable about their obligations under this framework and worked to ensure that they sought consent and worked to ensure patients received treatment in the least restrictive way.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- We saw a strong culture of enablement and involvement of patients in their care. Patients were continually positive about the way staff treated them and we saw much evidence that staff worked in a truly compassionate way.
- Staff considered that patients would have a range of needs, including cultural, social and religious needs and worked to ensure that these needs were met. They put measures in place to protect the dignity and privacy of patients and improve the environment of the ward. For example, playing local radio throughout the ward to help ensure private conversations could not be overheard.
- We saw that staff involved patients in their care planning, and respected their wishes when delivering care to patients. They showed a determination to deliver care following patient's wishes even when this needed creativity and compassion to overcome any obstacles.
- Patients were active partners in their care. Staff had the facilities and training to include patients in every aspect of their care and this was reflected in patients comments about the ward. There were many opportunities for patients to have their voice heard and staff helped them realise their potential. Staff truly valued patients emotional and social needs and were committed to helping them recover in a meaningful way.

Are services responsive to people's needs?

Good ●

We rated responsive as good because:

Summary of findings

- Once admitted to the ward, staff only transferred patients to other services based on their needs. If they were ready to be discharged then staff would work hard to find an appropriate placement for them to be discharged to and if they required more intensive treatment, then staff would transfer them to a ward that could meet their needs.
- There was only one patient waiting for a bed on the ward and the average length of stay (538 days) varied depending on patient needs.
- The facilities on the ward allowed patients to access a range of activities throughout their treatment. Staff worked hard to offer meaningful and worthwhile activities, including courses delivered by the local college. There were facilities to allow disabled access and staff could meet patient's cultural and religious needs as required.
- Staff gathered patient feedback and displayed the results of this feedback in the communal areas of the ward. This included steps they were taking to improve things. Patients were aware of how to raise complaints and had multiple opportunities to bring these up as a group, with staff. There was a structure for raising complaints individually.
- The ward was in part decorated by patients, and patients could decorate their room. Staff had tried to make the ward as homely as possible, and there was a variety of games and books that patients could access.

Are services well-led?

Good

We rated well-led as good because:

- There was strong local leadership from the ward manager. This was clear in the interactions we saw while on the ward and staff reported that this leadership was echoed in the senior management team. This style of leadership had a positive effect on staff morale and we saw that morale was high among the staff on the ward.
- There was a defined vision for the service that worked towards a set definition of recovery when patients achieved their best level of functioning. This fit with the trusts core values.
- Staff had opportunities to raise concerns and being involved in service development through team meetings and away days. All staff could put risks on the local risk register. Staff said they felt comfortable raising any concerns they might have.

However:

Summary of findings

- There were governance systems in place to help the manager track key performance indicators within the service. While these systems worked well, the trust could not provide us with accurate information on the percentage of staff that had received clinical supervision in line with their policy and staff told us there was difficulty accessing mandatory training because of the number of places on courses.

Summary of findings

Information about the service

Fettle ward is located at Bodmin hospital in Cornwall. It has 18 beds and can accept male and female patients for long stay, rehabilitative care. A patient had been discharged on the day of inspection and another was due to be admitted, the ward was full apart from this. The ward is classed as a 'community rehabilitation ward' this means that it predominantly takes patients from acute inpatient services that would benefit from a longer term, rehabilitative care before they return to the community. Often these patients have had multiple admissions for the treatment of psychosis.

The location has been inspected six times, twice in 2011 and 2012, once in 2013 and once in 2015. We rated the service outstanding overall. We rated caring and responsive as outstanding, and safe, effective and well led as good. There were no requirement notices associated with this service at the time of this inspection.

Our inspection team

The team that inspected this core service comprised a Care Quality Commission (CQC) inspector and three specialised professional advisors with experience in long stay rehabilitation services (including a clinical psychologist and two mental health nurses).

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive inspection programme.

The trust merged with Peninsula Community Healthcare NHS Trust in April 2016 and as such we always undertake a comprehensive inspection at an appropriate time following a merger.

How we carried out this inspection

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

? Is it safe?

? Is it effective?

? Is it caring?

? Is it responsive to people's needs?

? Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

? visited Fettle ward and looked at the quality of the ward environment and observed how staff were caring for patients

? spoke with eight patients

? spoke with the managers for the ward

? spoke with seven other staff members; including registered nurses, unregistered nursing staff and a psychologist

? attended a multidisciplinary meeting and a handover

Summary of findings

? collected feedback from five patients using comment cards

? looked at 13 treatment records of patients and eight medicines records

? carried out a specific check of the medicines management on the ward

?looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients were consistently positive about the service. They said that staff were kind, treated them with respect and worked hard to ensure that they received the care that they needed. Patients told us that they felt safe and cared for, and that this was in part because staff worked to engage them in their care, and where they wished it, involving their relatives as well. They said that the ward was always clean and tidy and that staff encouraged them to take part in activities that would help them to recover.

Good practice

Staff had continued to use the procedure for patients to safely self-administer their medicines. This allowed for greater autonomy and helped to prepare patients for living more independently in the community.

Staff included patients in all aspects of their care and worked hard to ensure that patients were enabled and supported to reintegrate with the community. The caring attitude of the staff was evident and patients comments to us reflected this.

Cornwall Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fettle Ward	Bodmin 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.

Staff had completed legal documentation in line with the Mental Health Act appropriately and the trust's Mental Health Act office audited this.

Staff were knowledgeable about the Act and 91% of them were up to date on their training on it. This was against a target of 85%. If they needed advice then they could seek it from the Mental Health Act office.

Patients had access to advocacy and staff clearly documented consent to treatment and capacity documentation where appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were knowledgeable about the principles of the Mental Capacity Act (MCA) and worked within its guidelines. Almost all staff (91%) were up to date with their training on the MCA. This was against a target of 85%.

There had been no applications under the deprivation of liberty safeguards within six months of this inspection but we saw a good example of where staff had considered a patient's best interests and their capacity to ensure that they received good care and had a better quality of life.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- The ward was open, and airy. There were multiple windows into communal areas across the ward courtyard that helped staff to observe the ward. Staff prioritised being in clinical areas, supporting patients.
- Staff completed ligature point audits (ligature points are points that can be used to tie a rope or cord for the use of self-strangulation). These points were either managed through clinical observations, risk assessments of the patients, or by maintenance work to remove them. We saw examples where staff had raised the necessary building works with the company that ran the building.
- The ward had two main bedroom corridors, and one slightly separate bedroom corridor (that staff and patients called the bungalow). These could be separated off to allow for male and female bedroom areas, depending on the needs of the patients. The ward had facilities to allow for separate lounges and bathing areas for different genders and each bedroom had an en-suite toilet and shower. The ward was laid out in accordance with same sex accommodation guidance.
- We found that the clinic room was well cleaned, stocked with appropriate and maintained equipment and that staff checked the emergency equipment to ensure it was fit for use. Patients had their own separate medicines drawers and there was signage to prompt staff about proper medicines management.
- The ward had a dedicated housekeeper who kept the ward clean and tidy. We saw that furnishings were in a good state of repair, and on the day of inspection, maintenance staff were repairing a pipe that had broken the day before. Staff told us that the company that owned the facilities was mostly responsive to repairs, although there were some occasions where there had been delays.
- Bodmin Hospital scored worse than the England average on their PLACE assessment for all categories. PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). Their lowest scores were for Disability (61.1%) and Dementia Friendly (69%). These reports cover all the wards on the site, not just Fettle ward.
- Staff carried hand gel to help prevent the spread of infection and we saw prompts around the ward displaying techniques for infection control as well as for flu vaccinations.
- The building was a private finance initiative. However, staff had access to the regular reports for checks on the fire alarm system and for other environmental safety checks such as for legionella.
- There was a personal alarm system in place which staff checked. We saw that when these alarms were used, there was a timely and appropriate response.

Safe staffing

- The ward had an established level of seven whole time equivalent (WTE) nurses and 14 non-registered nursing assistants. At the time of this inspection there was a 0.8WTE vacancy for an occupational therapist. There were upcoming vacancies for two nurses, a programme of recruitment was in place.
- The staffing levels were two registered and four non-registered nursing staff in the day, one or two non-registered nursing assistants in the twilight shift and one registered and two non-registered nursing staff at night. The ward manager, social inclusion workers, deputy manager and ward clerk were not included in these figures and usually worked 9-5 during the working week. The manager had the authority to increase these numbers if there was a clinical need.
- The ward used either bank or agency to fill any shifts not covered by the staff team. However, the ward had been unable to fill one qualified and four nursing assistant shifts during the day in the past two months. One of these unfilled unregistered nursing shifts was at night. During the day, there were other staff available (such as the manager, deputy manager, social inclusion workers, and a psychologist) who could give support. At night, other staff could be summoned from wards on site if needed. Between June 2016 and May 2017, bank and agency covered 7% of registered nursing shifts and could not cover 0.7% of registered nursing shifts. For non-registered shifts in the same period, bank and

Good

Are services safe?

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

agency covered 8.5% of shifts, and could not cover 0.7% of shifts. Staff sickness was 6.6% and turnover was 5.2%. The turnover rate was much lower than the trust average which was 12.5%. However, the sickness rate was higher than the trust average which was 5%.

- The ward displayed their staffing for the day in a display case, with pictures and names of the staff on duty, as well as some information about their interests. The ward mainly used regular agency and bank staff, and so their pictures were also available for patients.
- Ward staff gave bank and agency staff an induction and orientation to the ward when they arrived.
- Patients had named staff members from each profession on the ward, and could access regular 1:1 time with them.
- Both staff and patients told us that leave and activities were very rarely cancelled or postponed.
- Medical doctors were available on call if there was a need. Staff said they were responsive and could quickly attend in an emergency.
- Mandatory training rates were variable. Overall, 85% of staff were up to date with mandatory training. However, there were 16 out of 49 training topics where staff were below 75%. These included: fire training (67% for inpatient, 63% for settings that were not inpatient wards), moving and handling(48%), care planning (73%), clinical risk training (82%), record keeping (73%), physical health observations (67%), slips and falls (67%), learning disabilities and mental health (61%), safeguarding and managing aggression level one (56%), airway management (52%), basic life support (50%), managing aggression and violence (MAV) inpatient (50%), MAV community (50%), and safeguarding level three (none of the staff had received this although this training was only applicable for two members of staff).

Assessing and managing risk to patients and staff

- The staff did not use seclusion, neither had there been any incidents of prone (face down) restraint or rapid tranquilisation (the emergency administering of medicine to reduce violence or aggression).
- We reviewed 11 care records and saw that staff had used recognised risk tools. For example, the HCR-20 (a risk of violence tool) and STORM (a self-harm mitigation tool). Staff regularly reviewed these risk assessments and updated appropriately.
- Restrictions on the ward (such as not allowing energy drinks, alcohol or illegal drugs) were appropriate and patients were informed of them. We saw signage prompting patients about the restrictions on the ward.
- Staff were aware of how and when to submit a safeguarding alert and they had put posters and information in their office, and in the ward corridors to help ensure staff and patients were aware what constituted abuse and how to report it. Staff had raised two safeguarding alerts between May 2016 and April 2017.
- Staff stored and dispensed medicines in an appropriate way and we saw policies in place to support them in this.
- The ward had several private meeting rooms that could be used for patient visits, including for when children visited.

Track record on safety

- Between 1 June 2016 and 31 May 2017, trust staff reported one serious incident (SI). This incident was classed as 'Substance misuse whilst inpatient meeting SI criteria'.

Reporting incidents and learning from when things go wrong

- Staff were confident on what an incident was and how to report it. Staff reviewed these incidents according to the trust policy. Staff were open and transparent when things went wrong.
- We saw how the ward manager could check incidents and review them for learning. The manger shared this learning with staff in handovers, and team meetings.
- Staff told us that the trust gave support to them after a serious incident in the past.

Are services effective?

Outstanding ☆

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

Our findings

Assessment of needs and planning of care

- We reviewed 13 out of 18 patient care records (72%). We saw that staff completed comprehensive and appropriate care plans. Staff had access to mobile desks so that they could complete these with patients collaboratively. Staff had completed recognised recovery tools (the recovery star) where this fitted with the patients' goal for their rehabilitation.
- Patients received regular physical health checks while on the ward, and we saw evidence that staff completed physical observations when appropriate. Staff had received additional training to conduct these checks without using physical contact, should patients not wish to be touched.
- We saw that staff designed care plans with an aim for recovery. To the staff on the ward, this meant achieving the best level of functioning for that patient. These plans covered a wide variety of areas, such as voluntary work, therapeutic goals and daily living skills.
- Staff used electronic records, but did supply patients with their care plans in a paper form. The information we reviewed was securely stored and up to date.

Best practice in treatment and care

- We reviewed eight medicines records. We saw that staff were following guidance on prescribing antipsychotic medicines (i.e. not prescribing high doses of multiple medicines). We also saw that staff had developed care plans for patients to ensure that they were not at risk of withdrawal symptoms.
- Staff had continued with the policy of enabling patients to self-administer their medicines that we noted on our last inspection. This process was facilitated through individual medicine drawers, risk assessments and facilities in patient's rooms to allow them to store some medicines there.
- There was a clinical psychologist on the ward. We saw that the psychologist had included psychological therapies into the daily activities of the ward. These therapies included motivational work, dialectical behavioural therapy and cognitive behavioural interventions for people with psychosis. The National Institute for Health and Care Excellence recommends these treatments.
- Patients had access to healthcare specialists and staff supported them to access these services where appropriate.
- Staff used recognised tools to measure the clinical outcomes of patients care while they were on the ward. These included the model of human occupation screening tool, the recovery star as well as other measures as appropriate.
- We saw evidence of routine audits of the care provided. Staff told us that they completed these routinely to ensure that they could give the care that patients wanted and needed to meet their recovery goals.
- We saw that there was a wide range of activities to help patients to gain skills for use outside the ward. The ward had social inclusion workers that helped patients to build links in the local community through attending courses and volunteering. Staff told us there had been patients before that had gained employment while on the ward.

Skilled staff to deliver care

- The staff team comprised a full complement of mental health professionals, including staff from the nursing, psychology, psychiatry and occupational therapy professions. The team also had imbedded social inclusion workers. These staff helped to link patients into local charities and amenities. During our visit, we saw that they were arranging for a patient to attend courses in partnership with a local college.
- The staff we spoke with were all very experienced in working in rehabilitative care. We spoke to a regular bank worker that had been filling bank shifts on the ward for four years who demonstrated an in-depth knowledge of patients on the ward.
- Existing staff gave an orientation and induction to staff that were new to the ward. We saw a daily handover and a new member of staff said they found it very helpful.
- The trust was unable to give figures to allow us to measure the percentage of staff that had received formal supervision in line with trust guidance (four to six weeks). The ward manager had some information on whether staff had received supervision in a given month. However, we saw that staff had multiple opportunities for informal supervision outside these sessions and that they used them appropriately.

Are services effective?

Outstanding ☆

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.

- At the time of inspection, the majority (93%) of non-medical staff had received an annual appraisal. There was a plan in place for all staff to receive an appraisal and staff told us that this lapse was due to the time period for these appraisals changing.
- Staff told us that training within the trust was sometimes difficult to book onto due to availability. However, staff within the team had received specialist training to help them give better care. For example, training on refeeding syndrome (health complications caused by feeding people that had not eaten in some time) and making non-contact physical observations.

Multi-disciplinary and inter-agency team work

- Staff met as a multidisciplinary team daily. In the morning they met for handover, and later in the day for a 'safety huddle'. All available staff attended these meetings, the regular cleaning staff member also attended. Staff also held patient reviews weekly (patients could book a review, as well as there being a routine schedule of reviews).
- We saw that the handover meetings were effective, comprehensive and prepared staff for caring for the patients that day. We also saw a discharge meeting that showed the working relationships between the inpatient and community mental health teams to help provide seamless transition from hospital.
- The care plans we reviewed showed that the team worked together to help ensure that all the patient's goals could be met. We saw examples of where staff had supported patients to gain skills to enter higher education, and to volunteer and gain employment. The multidisciplinary team also worked together to help patients meet their therapeutic goals around their mental health.
- Staff told us of the working links that they had built with other services in the local area. The social inclusion team had completed a lot of the work which had led to a local college providing two courses to patients, within the ward environment. One of these courses was teaching patients gardening skills.

Adherence to the MHA and the MHA Code of Practice

- We reviewed 13 care records and saw that, staff had completed Mental Health Act documentation appropriately. Staff reviewed the documentation on a regular basis as part of an audit.
- Staff said that if they had any questions or concerns, they could seek advice from the trusts Mental Health Act office.
- Staff stored patients leave documentation appropriately and used a standardised form that included a description of patients, in case they did not return from leave.
- Almost all staff had received training in the Mental Health Act (10 out of 11, 91%).
- We saw that staff had attached consent and capacity documentation to medicines charts where appropriate.
- There were posters on the ward for patients that gave information about the advocacy services available. These included Independent Mental Health Act Advocates.

Good practice in applying the MCA

- Almost all staff had received training in the Mental Capacity Act (60 out of 66, 91%).
- There were no applications under the deprivation of liberty safeguards (DoLS) made within the six months before this inspection.
- Staff could accurately describe the principles of the Mental Capacity Act. The care we saw followed these principles and offered patients the least restrictive care possible and supported them to make decisions around their care on the ward. There was a policy to help guide staff and they could seek advice from the Mental Health Act office as well.
- We saw a good example where staff had considered a patient's best interests and their capacity to make the decision to take medicine as well as other aspects of their care. We saw that staff had followed this plan to make sure that the patient had a better quality of life.
- Staff knew what constituted restraint, and were committed to using least restrictive practice.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- It was obvious from the care that we saw that staff worked hard to build meaningful therapeutic relationships with patients. We saw that this was not limited to direct care staff, but also the ward clerk and cleaner on the ward. Staff treated patients with kindness and dignity to help them reach their goals and support them to move on from the ward. This was clear in every aspect of care we saw, from discharge meetings, to the environment itself.
- Staff had encouraged and involved patients in the decoration of the communal ward areas. This included displaying the staffing numbers in a different way. Staffing for the day was displayed on a picture board with staff names, pictures and interests to help patients engage with staff. Staff had also provided each patient with a list of the staff that would care for them as named members of staff so that they could form a therapeutic team.
- Staff worked with the limitations of the building to provide confidential care. The meeting areas and some of the staff offices were in places where it was possible to overhear conversation. To minimise the risk of sensitive information being overheard, staff played local radio stations in communal areas.
- We spoke with eight patients individually, and a group at lunch. The overwhelming majority of comments were praising staff and their attitude in caring for them on the ward. Patients said that staff were dedicated, friendly and thoughtful to their needs. We saw five comment cards completed by patients, all of which echoed the comments patients made to us in person.
- In relation to privacy, dignity and wellbeing, the 2016 PLACE score for Bodmin Hospital (across the whole hospital) was 73.8%, which was below the England average of 89.7%. PLACE assessments are self-assessments undertaken by teams of NHS and private/ independent health care providers, and include at least 50 per cent members of the public (known as patient assessors).

The involvement of people in the care they receive

- The manager carefully considered all admissions to the ward. Staff invited patients to tour the environment and meet staff and patients before they were admitted so that it would not be completely new to them upon admission. Staff gave new patients a tour of the ward, as well as information about their named staff members.
- Staff engaged patients at every opportunity of their care, including typing up their care plans with patients so that it could be a collaborative process. Staff supported patients in building links with local services in line with the patients' interests. We saw that some had engaged in voluntary work while living on the ward.
- Patients had the contact details of their advocate, and could get these from multiple posters around the ward should they lose them.
- Staff proudly displayed the feedback from patients outside the staff office. This display included a breakdown of the areas they were improving to help give the service that patients wanted. We also saw that patients had regular meetings as a group with staff, and community meetings on Sundays where they could give feedback and pass on any concerns.
- We saw examples of patients making advance decisions about their care, and staff including these in the patients care plan. For example, how they wished staff to give medicine.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The average bed occupancy ranged from 82% to 99% between April 2016 and March 2017. The ward was full at the time of this inspection, apart from a patient that was being discharged that day with another ready to be admitted. The average length of stay was 372 days. The trust reported no re-admissions within 28 days in this period.
- There were no out of area placements to rehabilitation units in the six months before this inspection (March 2017- September 2017).
- At the time of the inspection, there was one person waiting for a bed on the ward.
- Staff kept patients' beds for them while the patient was using leave.
- If patients needed more intensive care, then staff arranged a transfer to a more appropriate setting. For example, to a psychiatric intensive care unit, or acute inpatient ward. When patients were ready to be discharged from the ward, staff agreed an appropriate time of day for this with the patient.
- The staff team discharged patients as soon as they were clinically ready, and there was appropriate housing available for them. Although trust reported no delayed discharges in the year before inspection, staff told us that there was a shortage of appropriate placements for patients. Staff cared for these patients until an appropriate setting was available.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a range of facilities on the ward. These included an open art room, communal kitchen, computer area, multiple lounges (to allow single sex lounges) and a room for staff to hold meetings in. Staff said that they would have liked more rooms, but they worked well within the limits of the building. The ward also had a well-kept courtyard and garden area. Patients helped to maintain the garden.
- Patients had access to quiet areas to meet with visitors, and there were facilities for them to make phone calls in private.
- Patients had access to the courtyard and garden throughout the day. Staff had placed clear signage that they would lock the front door at night, but that patients could ask staff to open it for them. This was for the safety of patients. The front door was open during the day.
- Patients said that the food offered was of good quality. There were also facilities for patients to store and cook their own food. These were available day and night. Staff said that they would have preferred more fridges and freezers for patients, but the ward building was too small. We saw that they had used the available space effectively to help make the ward more homely and suitable for patients.
- Patients could customise and decorate their rooms, and all rooms had a safe that patients could use to store private belongings. Each room also had a lockable storage cupboard for medicines so that patients could self-administer their medicine.

Meeting the needs of all people who use the service

- The ward had facilities for people needing disabled access, including bathing facilities.
- Staff had access to a range of information leaflets on a variety of topics. They told us that the local population were predominantly English speaking, but they could access information in different languages and translators. These leaflets included information about how to complain, local services, treatments, stopping smoking and mental health issues.
- Patients could request meals to meet their dietary requirements and there was a ward chaplain that visited weekly that could help meet patients' spiritual needs (or arrange for a local faith leader to meet with patients).

Listening to and learning from concerns and complaints

- The trust received no complaints between 1 June 2016 and 31 May 2017 for this service. However, the trust did receive one compliment for this ward in this time.
- Patients said they had multiple ways of bringing their concerns to staff. Staff had also put information in the communal areas of the ward on how to complain, as well as operating their own suggestion box.
- Staff were aware of how to appropriately handle complaints and of the trusts complaints process.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff were aware of and worked in line with the organisations values. These worked in line with the wards vision of recovery for each patient, we saw this vision reflected throughout the ward in the care given and the ward environment.
- Staff were aware of the local senior management in the trust, and knew the senior members of the wider trust.

Good governance

- We saw good use of local governance structures by staff. These included monitoring training records, completing audits of the care and gathering patient feedback. The structures were in place for managers and staff to monitor their training. However, they said that the limiting factor was the availability of training for them to attend.
- Staff said that there had recently been a change in the way supervision was carried out. This made it difficult for the trust to report supervision figures to us. However, we saw that there were a range of opportunities for staff to obtain informal supervision.
- We saw that staffing across the previous two months before the inspection had safe levels. Where there were gaps that the ward could not fill with agency or bank, there were other mitigations in place such as supernumerary qualified staff available.
- We saw evidence that staff used structured audit processes to monitor the quality of care they provided, and these results were on display. For example, gathering patient feedback.
- The ward manager had monitored various key performance indicators. However, they made it clear that they were monitoring to ensure high quality care and that there was not a punitive target driven culture on the ward.
- We saw that the manager was well respected by staff and patients alike on the ward. The manager's office was situated in a part of the main ward lounge and we saw that staff and patients were comfortable seeking advice and support from the manager. The ward also benefited from a ward clerk to assist with administrative tasks.
- Staff said they had the opportunity to raise their comments on the service development and have an input on the future of the service.

Leadership, morale and staff engagement

- We saw that the ward had benefited from a dedicated manager. The manager had stayed in post for a long time and showed strong leadership within the ward team.
- Staff said there were no cases of bullying or harassment in the team at the time of this inspection.
- Staff reported good morale and put this down to their cohesive and supportive team. They said they were aware of how to raise concerns or whistle blow if they needed too.
- There were opportunities for staff to complete leadership training, and staff told us they had undertaken these.
- There was signage to help staff follow trust process under their responsibilities of duty of candour if things went wrong. Staff were aware of their duties and the processes they should follow.

Commitment to quality improvement and innovation

- The ward had achieved accreditation for inpatient mental health services (AIMS-Rehab) in the last inspection. However, this had lapsed before the re-inspection could take place and the ward were awaiting another visit shortly after this inspection for this quality programme.