Outstanding ☆

Cornwall Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

Fettle House, Bodmin Hospital Site
PL31 2QT
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Date of inspection visit: 13 – 17 April 2015
Date of publication: 09/09/2015

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 House	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?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Overall summary

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

- Medicine management was very good. The ward provided a well-structured support system for people to look after and self-administer their medicines and ensured people understood medicine safety. Detailed risk assessments were undertaken to identify the risks posed to each individual. There was on-going support and assessments of the person at each stage to ensure they were safe to continue on the scheme. Of particular note was the continued support given to a person when they left the service. An outreach system was in place to check that people continued to take their medicines safely at home and any concerns were dealt with immediately to ensure the safety of the person at all times.
- The ward had a policy for admission to the unit which required all patients to have a risk assessment. We looked at patients' electronic records and saw updated risk assessments with risk ratings. Incidents relating to individual patients could be accessed from the electronic records. Incidents and risk were discussed each day at the morning business meeting
- Multi-disciplinary assessments were carried out prior to admission to assess suitability for rehabilitation. On the ward there was a structured assessment process using a variety of standardised assessments. We saw that validated research tools were being used such as Model of Human Occupation (MOHO), Assessment of Motor and Process Skills (AMPS) and REHAB. Physical health care checks were evident in records.
- There was a team of social inclusion workers whose role was to help patients bridge the gap between hospital and community by using a wide range of services and facilities in the local community. This team was integrated into the ward staff group and provided a graded reintroduction to community involvement for patients. They were involved in quarterly inter-agency network meetings which were attended by a range of community services including; 6 district councils, housing providers, colleges, community centres, specialist employment support, volunteer services, the job centre and citizens advice bureau.
- Throughout the inspection we observed warm and kind interactions by staff towards patients. Staff demonstrated respect when telling us about the care of people on the ward. We observed lunch and saw lots of friendly chatter and laughter with staff being proactive in talking to quieter patients so that they felt involved. We observed staff being flexible and adapting scheduled activities when a patient requested this.
- The ward had effective leadership with staff and patients speaking highly of the ward manager.

However:

- A previous Mental Health Act Review on 31 July 2014 had identified that assessments of capacity were difficult to find at the point of admission and first administration of medication. This had still not been addressed.
- We found that Mental Health Act section 17 leave of absence (s17 leave) paperwork did not have end dates on it. We were told that s17 leave was reviewed monthly and at the three-monthly Care Programme Approach (CPA) meetings, however it would be best practice to have end dates clearly defined.
- The ward had been unsuccessful in recruiting to the vacant psychologist post and there was limited availability of psychotherapy for psychosis.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The ward had a policy for admission which required all patients to have a risk assessment. We looked at patients electronic records and saw updated risk assessments with risk ratings. Incidents relating to individual patients could be accessed from the electronic records. Incidents and risk were discussed each day at the morning business meeting
- Staff showed a good understanding of safeguarding and could explain how and when they would make a safeguarding alert. The ward manager was the lead for safeguarding and any member of staff could make a referral. We saw a flow chart on the office wall to assist staff to follow the safeguarding process correctly.
- Medicine management was very good. The ward provided a well-structured support system for people to look after and self-administer their medicines. This was very well established and ensured people understood medicine safety. Detailed risk assessments were undertaken to identify the risks posed to that individual and consent documentation was signed by the person agreeing to ensure their medicines would be kept safe and secure. There was on-going support and assessments of the person at each stage to ensure they were safe to continue on the scheme. Of particular note was the continued support given to a person when they left the service

Are services effective?

Good

We rated effective as **good** because:

- Multi-disciplinary assessments were carried out prior to admission to assess suitability for rehabilitation. On the ward there was a structured assessment process using a variety of standardised assessments. We saw that validated research tools were being used such as Model of Human Occupation (MOHO), Assessment of Motor and Process Skills (AMPS) and REHAB. Physical health care checks were evident in records.
- There was a holistic approach with staff using a bio-psycho-social model of care with integration of medication. The ward consultant was trained in rehabilitiation. National Institute for Clinical Excellence (NICE) guidelines were being followed, for

Summary of findings

example clozapine was available to patients who might benefit from it. Evidence based social interventions were being used and patients were accessing education and specialist employment support. Pharmacy support was very good

- There was an assistant psychologist and an art therapist on the ward. Staff and patients told us that the assistant psychologist did group work and 1:1 sessions. Psychological interventions such as Cognitive Behavioural Therapy (CBT) formulation were being used and one patient was receiving Cognitive Analytic Therapy (CAT).

Are services caring?

Outstanding ☆

We rated caring as **outstanding** because:

- Throughout our inspection we observed warm and kind interactions by staff towards patients. Staff demonstrated respect when telling us about the care of people on the ward. We observed lunch and saw lots of friendly chatter and laughter with staff being proactive in talking to quieter patients so that they felt involved. We observed staff being flexible and adapting scheduled activities when a patient requested this.
- We spoke to 5 patients on the ward and got consistently positive feedback about how staff treated people. One patient rated staff as 10/10, and another said that they go above and beyond. Everyone we spoke to said that they felt they could trust staff and one person said “they made me feel like I count”. Another patient told us “I think the staff are outstanding and they give far more than they are paid for”
- We saw evidence in care plans of patients being actively encouraged to develop their independence through planned activites and observed interactions between staff and patients that demonstrated that this was embedded in the running of the ward. We saw that staff were flexible when a patient wanted to do something different to their planned activity.
- There was carer’s information pack. We spoke to a carer who told us that she had been involved when her relative’s care plan was being written and had opportunities to feedback about the service. She told us that the staff are proactive in contacting her each week to keep her informed and that she found this reassuring. Staff told us they had been trying to arrange care planning meetings in the evening for a newly admitted patient so that family could attend.

Are services responsive to people's needs?

Outstanding ☆

We rated responsive as **outstanding** because:

Summary of findings

- Plans for accommodation were identified in discharge care plans with clear actions documented. Patients were assisted with bidding for council properties when appropriate.
- There was access to pleasant, well kept outdoor space. An enclosed courtyard had seating and planting that made it a relaxing space to use and we saw patients make use of the garden during our visit. Grassy areas around the building could be accessed easily. The outside spaces were clean and attractive.
- Two twilight workers were on shift each day so that activites could be facilitated in the evenings. Patients told us that there were activities at weekends and that there were always enough staff to be able to support them.

Are services well-led?

Good

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

- Staff and patients spoke highly of the ward manager
- There was evidence of learning from feedback and complaints, appropriate audits were undertaken and staff knew what types of incidents to report and how to report them.
- Morale amongst the staff we spoke to was high, and staff appeared motivated.

Summary of findings

Information about the service

Long stay/rehabilitation mental health wards are for patients who have complex and enduring mental health problems, which cannot be met by general adult mental health services. Fettle House inpatient rehabilitation service is an 18 bedded unit on the Bodmin Hospital site. One bedroom had previously been used as a s136 place of safety suite. This was no longer the case, but the room was due for refurbishment and not available for rehabilitation patients. Therefore the ward could accommodate a maximum of 17 patients at the time of this inspection. It caters for men and women over the age of 18 who have a primary diagnosis of severe and enduring mental illness and have a need for rehabilitation.

The location has been inspected 5 times, twice in 2011 and 2012 and once in 2013. There were no compliance actions associated with this service at the time of this inspection

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt, Independent Consultant

Head of Inspection: Pauline Carpenter, Head of Hospital Inspection, CQC

Team Leader: Serena Allen, Inspection Manager, CQC

The team that inspected long stay/rehabilitation mental health wards for working age adults included a CQC inspector and a variety of specialist advisors including an expert by experience, a registered mental health nurse, a consultant psychiatrist and a pharmacist. A Mental Health Act Reviewer visited to carry out a Mental Health Act monitoring visit and a Second Opinion Appointed Doctor (SOAD) carried out an unannounced visit.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service, including feedback from stakeholders.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 6 patients who were using the service and one carer of a patient using the service
- spoke with the manager of the ward and interim associate director
- spoke with 15 other staff members; including doctors, nurses, psychologists, occupational therapists and social inclusion workers
- attended a daily business meeting

We also:

- looked at 8 electronic treatment records of patients.

Summary of findings

- carried out a specific check of the medication management on the ward.
- looked at a range of policies, procedures and other documents relating to the running of the service
- carried out a Mental Health Act monitoring visit

What people who use the provider's services say

We spoke to patients on the ward and a carer of a patient. Everyone we spoke with was very positive about the care provided on the ward. We were told that staff go the extra mile to help patients. Patients told us they feel safe on the ward, and that there were sufficient staff. Most people told us that they were involved in writing their care plans and that there were a range of activities and that escorted leave is never cancelled.

Good practice

- Medicine management was very good.. The ward provided a well-structured support system for patientsto look after and self-administer their medicines. This was very well established and ensured people understood medicine safety. Detailed risk assessments were undertaken to identify the risks posed to that individual. Consent documentation was signed by the person agreeing to ensure their medicines would be kept safe and secure. There was ongoing support and assessments of the person at each stage to ensure they were safe to continue on the scheme. The ward staff commented that there was good support of the scheme from the pharmacy team. Of particular note was the continued support given to a person when they left the service. An outreach system was in place to check that people continued to take their medicines safely at home. Any concerns were dealt with immediately to ensure the safety of the person at all times
- There was a team of social inclusion workers whose role was to help patients bridge the gap between hospital and community by using a wide range of services and facilities in the local community. This team was integrated into the ward staff group and provided a graded reintroduction to community involvement for patients. They were involved in quarterly inter-agency network meetings which were attended by a range of community services including; 6 district councils, housing providers, colleges, community centres, specialist employment support, volunteer services, the job centre and citizens advice bureau.

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 House	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.

A Mental Health Act Review visit took place as part of the inspection of Fettle House which will be reported separately. Patients at Fettle House were assessed and treated in line with the Mental Health Act 1983. Mental Health Act documentation was clearly recorded and up to date and records showed that patients' rights and status under the Act were explained to them.

We found that Mental Health Act section 17 leave of absence (s17 leave) paperwork did not have end dates on it. We were told that s17 leave was reviewed monthly and at the three-monthly CPA meetings, however it would be best practice to have end dates clearly defined.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were no patients on the ward that were subject to Deprivation of Liberty Safeguards (DoLS). We saw patients care records which showed recent capacity assessments regarding consent to treatment. There were notices around the ward that provided patients with information about the ward's independent mental capacity act worker (IMCA). Staff had completed the trust's e-learning module for the Mental Capacity Act (MCA), and we saw evidence of continual professional development (CPD) training about independent mental capacity advocates (IMCAs). However,

a previous Mental Health Act review visit had identified that assessments of capacity were difficult to find at the point of admission and first administration of medication. This had still not been addressed.

Good

Are services safe?

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

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

Summary of findings

Please see summary at beginning of report.

Our findings

Safe and clean environment

- The main part of the ward was a quadrangle around a courtyard garden. This part of the building was being used for male patients' rooms and had a mixed lounge with a kitchen and a separate men's lounge. There was an L-shaped corridor that contained women's bedrooms and women's lounge with a kitchen. There was good visibility from inside the building into the enclosed garden. All bedroom doors had observation panels. Some areas of the building could be seen from the nursing station but this level of observation was not necessary on an open rehabilitation ward because patients on this type of ward need to be well enough to move out of an acute setting and prepare for more independence.
- We saw that there was a comprehensive ligature risk assessment and there was an action plan in place to mitigate the risks. Identified ligature risks had been placed on the risk register so that the trust could be fully informed and was checked regularly. The ward had an admission policy that said that it could only accept people who do not need high levels of observation to maintain their own safety.
- All bedrooms were en-suite. The ward had separate areas for men's and women's bedrooms, and a separate lounge for women, although at the time of our vist a male patient was having to store some food in the women's kitchen as there was not enough storage space elsewhere
- We checked the equipment in the clinic room. The fridge temperature was checked daily and emergency medication was in place and in date. No controlled drugs were being kept on the ward but there was a controlled drug cupboard in case they were needed. Emergency equipment was checked weekly and we saw that the records were up to date.
- The ward did not have a seclusion room.
- The ward was clean and furnishing was of a good standard in most of the ward. The sofas in the women's lounge were very hard and uncomfortable and we were told these were due to be replaced. Patients told us that the ward was always clean unless someone had done their own cooking and not cleaned up afterwards.
- We saw that there were weekly environmental risk assessments undertaken. Some minor repairs needed to be done, for example, a ceiling light cover needed to be replaced. We were told that repairs can take a long time because of the private finance initiative (PFI) contract that covers the building.
- Staff had alarms and there were nurse call systems. Alarms were linked to other wards for additional support.

Safe staffing

- The ward manager was able to show us the establishment levels of staffing. At least one qualified nurse was available for every shift. There were 2 qualified nurses and 4 unqualified nurses on the ward during the day. There was a twilight shift, staffed by two unqualified nurses and the night shift was made up of one qualified nurse and two unqualified staff.
- We saw that the number of estimated nurses matched the actual numbers that were working. There was a white board in the corridor with the names of the staff for that day written on it. Patients told us that there were always plenty of staff on duty.
- Staff and patients told us that use of agency and bank staff was low. The rotas we looked at confirmed this. There had been two months ealier in the year when bank or agency staff had been used to cover sickness but this was unusual. When bank and agency had been used it was mainly to cover unqualified staff's shifts.
- The ward manager told us that he was able to get extra staff clinically needed by getting authorisation from a senior manager
- A qualified member of staff was always available in communal area although this was not always a nurse. Patients told us that staffing levels levels were good on the ward.

Good

Are services safe?

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

- Patients had 1:1 time, this included time with nursing staff, the ward's assistant psychologist and the social inclusion team members. 1:1 time happened on and off the ward depending on which staff member it was with and the purpose it was being used for.
- Most patients were able to have unescorted leave to help them increase their independence. Patients told us that escorted leave never had to be cancelled, although occasionally the timing might be changed
- There were enough staff to carry out physical interventions and we saw that training was up to date
- During the day there was access to either the consultant psychiatrist or the associate specialist, and an on-call system over-night for medical cover. The location of the ward on the Bodmin Hospital site made access to medical cover easier. Patients could also access the local minor injuries unit if necessary.

Assessing and managing risk to patients and staff

- There was an admission policy which required all patients to have a risk assessment before coming to the ward. We looked at patients' electronic records and saw updated risk assessments with risk ratings. Previous incidents relating to individual patients could be accessed from the electronic records to add to the understanding of each patients risk pattern. Incidents and risk were dicussed each day at the morning business meeting
- Nobody was allowed to bring energy drinks on to the ward. This was explained on a notice at the door. which explained that recent studies had shown these drinks could have a negative effect on physical and mental health. There were no other blanket restrictions.
- The door of the ward was not locked, except at night. Informal patients knew that they could ask staff to open the door at night if they wanted to go out, and there was a notice by the door to remind patients about this.
- All patients were on hourly observations when we visited, and we were told the nurse in charge had authority to put people on high levels of observation if needed. Observation levels were discussed daily at MDT meetings. The manager told us that the ward tried to keep patients on the ward who required temporary increases in observation levels if safe to do so, but would arrange transfer to the acute unit if clinically required.
- Staff and patients told us that restraint is very rarely used. Eleven restraints had been recorded in the previous six months and these had all related to one patient who had been transferred to a more appropriate setting. Staff told us that low level hand holds were the form of restraint that was usually used.
- There had not been any situations that had required the use of rapid tranquillisation on the ward in over a year
- 100% of new staff had completed corporate induction. We saw records that showed variations in attendance at mandatory training. For example 100% of eligible staff had undertaken medication administration training but only 16 out of 26 staff had attended the annual update for managing aggression and violence (MAV) training. The trust had a system for recording mandatory training which allowed the manager to monitor this for each staff member
- We saw training records that showed eight different types of safeguarding training and variations in the numbers of staff completion for the rehab ward. For example domestic violence training had only been attended by 25% of staff but 100% had completed safeguarding adults level 2 training. The ward manager told us other teams had been rated as higher priority for domestic violence training so places had not been available for rehab staff. The method of delivering safeguarding training had changed recently so that therewould be fewer modules for staff to complete which would increase the numbers attending training. Staff we spoke to showed a good understanding of safeguarding and could explain how and when they would make a safeguarding alert. The ward manager was the lead for safeguarding and any member of staff could make a referral. We saw a flow chart on the office wall to assist staff to follow the safeguarding process correctly.
- Medicine management was very good. The ward provided a well-structured support system for patientsto look after and self-administer their medicines. This was very well established and ensured people understood medicine safety. Detailed risk assessments were undertaken to identify the risks posed to that individual. Consent documentation was signed by the person agreeing to ensure their medicines would be kept safe and secure. There was ongoing support and assessments of the person at each stage to ensure they were safe to continue on the scheme. The

Good

Are services safe?

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

ward staff commented that there was good support of the scheme from the pharmacy team. Of particular note was the continued support given to a person when they left the service. An outreach system was in place to check that people continued to take their medicines safely at home. Any concerns were dealt with immediately to ensure the safety of the person at all times

- Rooms were available that were suitable for children to visit the ward. Staff told us that patients who are being visited by children could use the café on the main Bodmin Hospital site as an alternative to visiting on the ward if it was safe and appropriate to do.

Track record on safety

- There were no serious incidents in the last year associated with this core service.
- There were no specific safety improvements managers could make us aware of relating to the ward in the past year.

Reporting incidents and learning from when things go wrong

- The trust used the Safeguard incident reporting system. Staff told us it was straightforward to use. The team received feedback through the ward manager and incidents were discussed in team meetings. The consultant psychiatrist had recently completed a dissertation on reporting incidents.
- Staff were able to explain the types of incidents that need reporting.
- Staff told us that they receive feedback via the ward manager and it is discussed at team meetings. We saw that incidents were discussed as part of the daily business meeting
- The ward manager and staff told us that debrief was always given to the staff involved in any incident and sometimes they had a wider team de-brief and lessons-learnt session.

Are services effective?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

- Multi-disciplinary assessments were carried out before admission to assess suitability for rehabilitation. On the ward there was a structured assessment process with a variety of standardised assessment tools. Staff used validated research tools such as model of human occupation (MOHO), assessment of motor and process skills (AMPS) and REHAB.
- We looked at 8 electronic care records and saw that physical health checks were being done regularly. Patients told us that their physical health needs were met.
- Care records were written in plain english without jargon. They were clear, succinct and information was up-to-date. They included goals for occupation, physical health, social and psychological needs. The recovery star tool was being used with some patients for collaborative recovery-focussed care planning
- The trust uses the RIO electronic records system. Computers were available in the office for staff to access and complete computerised records.

Best practice in treatment and care

- Patients were treated with a holistic approach using a bio-psycho-social model of care with integration of medication. The ward consultant was trained in rehabilitiation. NICE guidelines were being followed, for example clozapine was available to patients who might benefit from it. Evidence based social interventions were being used and patients were accessing education and specialist employment support. Pharmacy support was excellent.
- There was an assistant psychologist and an art therapist on the ward. We were told that the assistant psychologist does group work and 1:1 sessions. Psychological interventions such as cognitive behavioural therapy (CBT) formulation were being used and one patient was receiving cognitive analytic therapy (CAT). There was no time limit for psychology interventions and these were needs led and patient focussed. Patients could be referred for psychotherapy and the personality disorder team provided in-reach services. However, the ward had been unsuccessful in recruiting to the vacant psychologist post and there was limited availability of psychotherapy for psychosis
- Patients could access physical healthcare and staff made appropriate, timely referrals but we were told that it can be a long time before referrals are acted upon. Patients could access a dietician if needed. We saw that physical healthcare was included in care planning. Patients told us that their physical healthcare needs were being met.
- We saw a variety of assessment and rating tools being used including Health of the Nation Outcome Scales (HoNOS). The ward manager was an Occupational Therapist and we saw effective use of a range of OT assessment tools. Information about discharge and readmission rates was used to assist understanding of successful outcomes.
- The manager was able to tell us about re-admission rates because of audits that were done. Audits took place on the ward to monitor care plans, case notes and medication. We saw that the record keeping audit had actions identified but there was no date for completion of those actions.

Skilled staff to deliver care

- There was a multi-disciplinary team on the ward. In addition to medical and nursing staff there were occupational therapists, an assistant psychologist, art therapist, social inclusion workers, a pharmacist and pharmacy technician and a learning disability liaison nurse. There was a vacancy for a full-time psychologist which the ward had been trying to recruit to without success.
- Staff told us that they had supervision every 4 to 6 weeks, and we saw records that showed all staff had received an annual appraisal. All staff spoke positively about the use of team meetings and said all staff were involved and were able to speak freely in them.
- We saw evidence of continuing professional development (CPD) sessions that had taken place over

Are services effective?

Good

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

the last year. This included sessions on advocacy, service evaluation, cultural awareness and a session with the local police. These trainng opportunities had been attended by a variety of staff.

- There were policies in place for managing poor performance and the manager told us about a situation where disciplinary proceedures had been used with a staff member.

Multi-disciplinary and inter-agency team work

- There were a range of multi-disciplinary meetings including ward rounds and CPA reviews. We attended the daily business meeting. This acted as a detailed handover and a planning session for that day. Incidents and concerns were discussed, along with an update of each patients current presentation. Activities and appointments were planned and allocated.
- Staff on the ward worked 12 hour shifts and brief handovers took place twice a day so that essential information could be passed on. The daily business meeting took place at 9am and was used for more detailed handover and planning. Staff told us this system worked well.
- The social inclusion workers had built very effective networks with a wide variety of organisations and teams with the aim of enabling patients at Fettle House to make use of a range of community facilities. They were invoved in quarterly inter-agency network meetings which were attended by a range of community services including 6 district councils, housing providers, colleges, community centres, voluntary sector organisations, the job centre and citizens advice bureau. Staff told us that there was no GP input to the ward but the care records we saw showed that most patients were registered with a GP.

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

- A Mental Health Act Review visit took place as part of the inspection of Fettle House which has been reported separately. Patients were assessed and treated in line with the Mental Health Act 1983. Mental Health Act documentation was clearly recorded and up to date and records showed that patients' rights and status under the Act were explained to them. 82% of staff had completed Mental Health Act legislation and policy training. We found that s.17 leave forms did not have end dates on them. We were told that s.17 leave was reviewed monthly and at the three-monthly CPA meetings, however it would be best practice to have end dates clearly defined.

Good practice in applying the Mental Capacity Act

- Staff had completed the trust's e-learnng module for MCA, and we saw evidence of CPD training about independent mental capacity advocates (IMCAs). There were no patients on the ward that were subject ot Deprivation of Liberty Safeguards (DoLS) at the time of this inspection. We saw patient care records which showed recent capacity assessment regarding consent to treatment. There were notices around the ward that provided patients with information about the ward's independent mental health advocates (IMHAs), including photo and contact details.

Outstanding ☆

Are services caring?

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

Summary of findings

Please see summary at beginning of report.

Our findings

Kindness, dignity, respect and support

- Throughout our inspection we observed warm and kind interactions by staff towards patients. Staff demonstrated respect when telling us about the care of people on the ward. We observed lunchtime and saw lots of friendly chatter and laughter with staff being proactive in talking to quieter patients so that they felt involved. We observed staff being flexible and adapting scheduled activities when a patient requested this.
- We spoke to 6 patients on the ward and got consistently positive feedback about how staff treated people. One patient rated staff as 10/10, and another said that they go above and beyond. Everyone we spoke to said that they felt they could trust staff and one person said "they made me feel like I count". Another patient told us "I think the staff are outstanding and they give far more than they are paid for"
- All the staff we spoke with told us they had been able to build up relationships and understanding of the patients in their care. They told us that due to the longer term contact they had with patients, this resulted in them developing good insight into the behaviours of patients. We saw evidence of individualised needs planning when we looked at care plans. In a business meeting we heard staff considering events in a patient's family life that might affect their mental wellbeing, and taking this into account when planning care and support.

The involvement of people in the care that they receive

- We were told potential patients come to visit the ward before admission and get shown around and patients we spoke to told us that they had been shown around when they first came to the ward. We saw an information leaflet which informed new patients about the aims of the service and included information about a range of subjects such as available activities, meal times, visiting times, storing valuables and discharge planning.
- Patients told us that they were involved in writing their care plans and most told us that they had a copy of their care plan. Staff told us that one patient writes her own care plan independently and then it is discussed with the team. We looked at care plans and saw that patients were being actively encouraged to develop their independence through planned activities. We observed interactions between staff and patients that demonstrated this was embedded in the running of the ward. MDT meetings happened weekly and CPA reviews every 3 months.
- The patients we talked with knew about the independent mental health advocacy service and some patients told us that they have an advocate. Information about advocacy and the PALS service were clearly visible around the ward.
- There was a carer's information pack. We spoke to a carer who told us she had been involved when her relative's care plan was being written and had opportunities to feedback about the service. She told us that the staff were proactive in contacting her each week to keep her informed, and she found this reassuring. Staff told us they had been trying to arrange care planning meetings in the evening for a newly admitted patient so that family could attend. It was difficult for some carers to visit as often as they wanted because of the distance to travel to the ward. We were told that staff collected people from the station to help with this, but there was not any funding available to help families with the cost of travel.
- Community meetings occurred weekly and all the patients we spoke to told us they could give feedback about the service. Some patients told us that they had wanted changes to the menus and quality of food and they had felt listened to, because the chef came to talk to them and the menus and food quality improved after that. One patient told us that he had been able to use an iPad to complete a patient satisfaction survey.
- Patients were not part of the official recruitment panel for new staff, but told us that they met candidates and felt that their views were taken account of when choosing staff.
- The social inclusion team facilitated a wide range of activities and were able to support patients 1:1. Two

Are services caring?

Outstanding ☆

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

twilight workers were on the daily rota so that patients could be supported to attend activities in the evenings and patients told us that there was plenty to do at weekends. Many of the activities assisted patients to develop and maintain their physical health. Examples of activities included going to the beach, bike rides, video nights, gardening, horse-riding, swimming, badminton, gym sessions, and a take away evening. We saw lots of examples of patients' art and craft work on the walls around the ward. There were 3 computers that patients had access to and a well equipped kitchen. We saw the computers and kitchen being used by patients during our visit

Are services responsive to people's needs?

Outstanding ☆

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

Summary of findings

Please see summary at beginning of report.

Our findings

Access and discharge

- Fettle House was the only rehabilitation unit for the trust. It was an 18 bedded unit on the Bodmin Hospital site. One bedroom had previously been used as a s136 place of safety suite. This was no longer the case, but the room was due for refurbishment and not available for rehabilitation patients. Therefore the ward could accommodate a maximum of 17 patients at the time of this inspection. Bed occupancy was 84.8% over a 6 month period from August 2014 to January 2015, with 85% being the recognised optimum. Staff told us they now accommodated a wide range of needs including learning disability, acquired brain injury and Asperger's Syndrome alongside psychosis and severe and enduring mental illness. This could sometime result in a challenging patient mix.
- We were told that there is always a bed available on return from leave.
- Staff told us that they attempted to manage acute episodes of illness where possible but patients could be transferred to an acute setting if there was a clinical need.
- Plans for accommodation were identified in discharge care plans with clear actions identified. Patients were assisted with bidding for council properties when appropriate but staff felt there was a shortage of suitable housing in the area.
- We were told that the ward could refuse admissions but that the ward manager's decision had been overridden by twice in the last year. On one occasion a person had been admitted when they were too unwell and had to be transferred back to the acute ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had a range of rooms and facilities, including a conservatory which was used for activities, two kitchens, communal areas and a clinic room.
- There were no dedicated quiet rooms that we saw on the ward, but patients had their own rooms where they could go for somewhere quiet. Patients could have their own room key although some chose not to
- There was a small room with a phone that could be used to make private calls
- There was access to well kept outdoor space. An enclosed courtyard had seating and planting that made it a relaxing space and we saw patients using the garden during our visit. Grassy areas around the building could be accessed easily. The outside spaces were clean and attractive
- We observed lunchtime. The food was of good quality and we saw menus that showed there was choice available Most patients told us the food was good but some said they did not like it. Staff and patients told us that they could give feedback about the food and that the chef had visited to talk to them about how to improve the meals. People were able to cook their own food and take-away nights were arranged sometimes.
- Patients and staff told us that they could make snacks and hot drinks until midnight but were discouraged from doing so later than this to help with healthy sleeping habits
- Some patients showed us their rooms and these were personalised. We were told patients could bring in items of their own furniture and their own TV if they wished to.
- All bedrooms had a safe for patients to store their valuables in.
- Social inclusion workers supported patients to use a wide range of community facilities. Patients chose what activities they wanted to do. Two twilight workers were on shift each day so that activities could be facilitated in the evenings. Patients told us that there were activities at weekends and that there were always enough staff to support them.

Are services responsive to people's needs?

Outstanding ☆

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

Meeting the needs of all people who use the service

- The ward was on the ground floor with level access into the building. Corridors were wide and some bedrooms had been adapted for use by people with additional mobility needs, including wheelchair users.
- Staff told us that they were able to access information in a range of languages if needed but it was not kept on the ward as the majority of patients had English as their first language.
- We saw a range of information leaflets and posters around the ward, including information about local services and activities, how to make a complaint, PALS, and advocacy services
- Menus that we saw on an information board showed that different dietary requirements were catered for. Patients were able to cook their own food if they wanted
- A chaplain was based on the Bodmin Hospital site and available to patients on the ward. We were told that the chaplain had assisted in contacting the local Imam for a patient so they could access appropriate support for cultural and spiritual needs

Listening to and learning from concerns and complaints

- All the patients we spoke to told us that they knew how to make a complaint. Patients told us that they felt able to raise concerns with the manager of the ward and that things changed as a result of this, for example, the quality of the food had been improved. One patient told us that they had made a complaint and that it had been dealt with well.
- Staff were able to tell us how complaints were dealt with. Most complaints were managed at ward level by the manager. No complaints had progressed beyond this stage in the previous 12 months.
- Staff told us that complaints and investigation outcomes were discussed at team meetings.

Are services well-led?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Vision and values

- Staff we spoke to knew the trust's values. We saw badges being worn by staff that had the values printed on them.
- Staff could tell us who the senior mangers were and that Board members occaisionally came to the ward but that planned vists were sometimes cancelled.

Good governance

- Staff and patients spoke highly of the ward manager. We saw records that showed all staff had regular supervision and appraisal. Shifts were covered with sufficient numbers of staff of various grades and disciplines and who were experienced. Feedback and learning from complaints were discussed in team meetings. Appropriate audits were undertaken and staff knew what types of incidents to report and how to report them. Safeguarding, Mental Health Act and Mental Capacity Act proceedures were followed. However, some staff were not up to date with mandatory training.
- We were told by the manager that they do not use ward specific key performance indicators (KPI's). Information about sickness, training and supervision was readily accessible to the manager and was used for performance management.
- The ward manager told us that he felt he had sufficient authority to fullfill his role. A full-time ward clerk is based on the ward which meantt that admin support was available five days a week.
- The manager confirmed that staff can place items on the risk register. We saw that ligature risks from Fettle ward had been entered on the trustwide ligature risk register.

Leadership, morale and staff engagement

- There had been some long-term sickness for two months earlier this year, but generally sickness rates were low (3.8%).
- Staff told us that they feel confident in raising any concerns with the ward manager and that they would be listened to and treated fairly.
- Morale amongst the staff we spoke to was high and staff were motivated. They spoke extremely positively about the ward manager and said how much they enjoyed working on the ward and that the team was supportive and friendly. They told us that they were able to give feedback via the staff survey.

Commitment to quality improvement and innovation

- The ward has achieved AIMS REHAB inpatient mental health service accreditation.
- There was a team of social inclusion workers whose role was to help patients bridge the gap between hospital and community by using a wide range of services and facilities in the local community. This team was integrated into the ward staff group and provided a graded reintroduction to community involvement for patients. They were involved in quarterly inter-agency network meetings which were attended by a range of community services. The team had built very effective networks with a wide variety of organisations and teams with the aim of enabling patients at Fettle House to make use of a range of community facilities.