Good

Cornwall Partnership NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Cornwall Partnership Foundation NHS Trust
Tel:01208 251300
Website: www.cornwallpartnership.co.uk

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 Community Hospital	Garner Ward	PL31 2QT

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
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

Contents

Summary of findings

Overall summary

We rated wards for older people with mental health problems as **good** overall because:

- The ward was clean, fit for purpose and well maintained.
- There was a good sense of being enough staff on duty to support and observe patients.
- There was a high rate of incident reporting on the ward, with an open culture to report and learn from incidents.
- Staff were compliant with management of aggression and violence training and had received additional bespoke training relating to older people.
- There were high levels of compliance for all staff essential and mandatory training on the ward and staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA).
- There was regular liaison with physical care service and records showed that physical health problems were monitored.
- We saw care records and detailed risk assessments that were up to date and contained family involvement.
- During our observations we saw that there was consistent warmth and good interactions between patients and their relatives or carers.
- There were daily activities and a range of equipment to support care with well-equipped outdoor and indoor areas including a 'pop up' bar.
- There was effective leadership and staff felt well supported by their line managers and service managers through supervision, annual appraisal and regular team meetings.

However;

- The ward was at risk of not fully complying with guidance on same-sex accommodation . There was only one bath which was located at the centre of the ward and one shower was out of use. If several patients required the facilities at the same time then female patients might need to walk through a male only area.
- Aggression towards staff had increased recently and the behaviour of some patients was severely challenging.
- The ward had been unsuccessful in recruiting to the vacant psychology post and there were gaps in consultant cover and independent mental health advocacy services.
- Capacity assessments for Do Not Attempt Resuscitation (DNAR) status records were not always individual and some records of people with DNAR status did not have a capacity assessment.
- Care plans did not consistently include patients' views and patients were not given care plans.
- Patients had frequently stayed longer than needed due to the lack of placements for complex physical needs and challenging behaviour.
- Some staff thought that the senior management team was not visible enough.

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 was large and spacious, clean, well maintained and all at ground floor level. There were enough staff to carry out physical interventions and ward staff had been trained in physical observations with the support of an off-site clinical nurse and medical team.
- Staff we spoke with were aware of the incident reporting process and were clear about incidents that needed to be reported. There was a high rate of reporting on the ward, with an open culture to report and learn from incidents.
- Staff were compliant with management of aggression and violence training and had received additional bespoke training relating to older people. Staff also had access to trainers visiting the ward weekly, which had been introduced in response to the higher incidence of aggression from patients using the service.

However:

- The ward was at risk of not fully complying with guidance on same-sex accommodation . There was only one bath which was located at the centre of the ward and one shower was out of use. If several patients required the facilities at the same time then female patients might need to walk through a male only area.
- Staff on the unit had been assaulted by patients who had become agitated or distressed. Aggression towards staff had increased recently and the behaviour of some patients was severely challenging. Two staff were currently off sick from work with injuries caused by patient assaults at work.

Are services effective?

Requires improvement

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

- There was limited access to psychological therapies on Garner ward as there was difficulty in recruiting to the psychology post.
- On Garner ward the patients had only recently had access to an Independent Mental Health Advocacy (IMHA) services. We were told that this service had only recently been Commissioned by Education Health and Social Care.
- Do Not Attempt Resuscitation (DNAR) status records were not always individual and five records of patients with DNAR status did not have a DNAR capacity assessment.

However:

Summary of findings

- Staff used recognised rating scales to aid with risk assessment and treatment planning.
- Staff were starting to use the Newcastle assessment model and were using the neuro-psychiatric assessment on admission and discharge. Staff used multi-factoral falls risk assessment tool to identify patients at risk of falls.
- There was good access to physical healthcare, including nurse specialists and dedicated access to a ward dietician to support the ward staff with caring for people's physical needs.
- Admission of patients appeared well managed and all required documentation was present on the files scrutinised.

Are services caring?

Good

We rated caring as **good** because:

- Staff were positive, kind and compassionate in their interactions with patients and relatives.
- Staff we spoke with showed a good understanding and knowledge of the individual needs of patients and were enthusiastic about their roles.
- Preferences were accommodated for example in relation to peoples preferred snacks.
- The patient passports and life story books were person-centred, and families and carers had been involved in compiling this information.

However:

- Care plans contained a statement in the clients view column which explained that staff were unable to discuss with the patient due to their cognitive impairment and lack of capacity, which meant that care plans did not consistently include patient's views.
- Patients did not have copies of their care plans.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Staff worked on an individual basis with patients and responded to a range of needs including supporting people with very challenging behaviour. We saw that staff were responsive to people's needs.
- We saw a variety of activities and engagement with patient during our visits to the ward including crafts; guitar playing and singing take place.
- We saw that complaints were investigated and that learning had taken place to improve.

Summary of findings

- There was a discharge coordinator in place to facilitate timely discharges and placements for patients.

However:

- There were delays in discharging some patients due to a lack of availability of suitable placements.

Are services well-led?

Good

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

- Staff knew of the organisation's values, felt well supported by line managers and service managers through good supervision, annual appraisal and regular team meetings.
- Sickness and absence rates were below the trust average. We observed staff rotas to review the levels of sickness and absence and saw that shifts were well planned and staffed.
- There were a number of areas where the ward has shown commitment to quality improvement and innovation, such as introducing reminiscence pods to improve patient experience and becoming 'Dementia friends' following a dementia awareness session.

However:

- Some staff felt that senior managers were not visible enough.

Summary of findings

Information about the service

Garner ward was a complex care and dementia mixed sex ward. Primarily for the assessment and treatment of people living with dementia and complex care needs, some with a high risk of aggression. The ward provides assessment and treatment for all adults living with dementia when required. On the day of our visit there were two patients in their late 50s'.

During the year the trust moved to a single inpatient unit for the care of people with complex needs or dementia. Garner ward was on the site of Bodmin Community Hospital, where there were other adjacent mental health wards.

The ward was a mixed unit with 24 single bedrooms. The ward admitted informal patients and patients that were detained under the Mental Health Act (MHA). Due to the complex needs of the patient group, they did not normally admit more than 18 patients.

On our first visit to the ward there were 18 patients on the ward, all of whom were detained under the Mental Health Act.

Garner ward was staffed by registered mental health nurses and health care assistants (HCAs). The acting ward manager was supernumerary. In addition to the nurses and HCAs, there was a discharge coordinator, two part-time dedicated consultants and junior medical staff. There were three activity coordinators covering seven days a week and two full-time occupational therapy staff. There were also regular sessions from a dietician and input from a volunteer and a music therapist. The ward was fully staffed on our visits.

The ward was clean, large and spacious, and all at ground floor level. There were two long parallel corridors, and a range of sitting and activity areas. There were two lounges, which could provide separate male and female areas. The single bedrooms had ensuite toilets and washbasins. There were communal and individual areas and spaces for therapeutic activities to take place.

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 this core service included a CQC inspector, a Mental Health Act reviewer and a variety of specialist advisors including a psychologist and a consultant psychiatrist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups across Cornwall.

During the inspection visit, the inspection team:

- Visited Garner Ward over three days between 14 and 16 April 2015.
- Spoke with the acting manager.
- Spoke with a consultant psychiatrist for the ward.
- Spoke with seven other staff including nurses, health care assistants and occupational therapists.
- Spoke with two carers of patients who were using the service.
- Looked at the quality of the ward environment and observed how staff were caring for patients.
- Looked at four care records including risk assessments and care plans and mental capacity act assessments of patients using the service.
- Looked at 11 care records of patients who had Do Not Resuscitate (DNAR) status.
- Carried out a check of the medication management on the ward, including a review of 11 prescription records.
- 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.
- Completed two observations using the Short Observational Framework for Inspection tool (SOFI).

What people who use the provider's services say

During our visit we spoke with two patients and two relatives. We observed care using the short observational framework for inspection tool developed with the University of Bradford Dementia Group to capture the experiences of people who use services who may not be able to express this for themselves. Staff spoke to people respectfully and we saw reciprocal warmth in staff interactions with people.

Relatives spoke positively about the staff. One relative thought there could be more activities. Patients who were able to speak with us told us that staff helped them. Relatives described staff as caring and told us they felt supported by the multidisciplinary team on Garner ward.

Good practice

- The service had a specialist risk assessment tool called STORM, which they used to assess and determine the risk of self-harm and suicide. They had specific training on the use of STORM within the service and there was a trainer available within the service if necessary to provide additional support in the use of the tool.
- There were three activity staff rostered in order to cover activities each day over a period of 12 hours for all people using the service.
- Some innovative training had taken place for dementia and some staff had become 'dementia friends' following a dementia awareness session.
- Reciprocal training had taken place with hospice staff were sharing their specialist skills with each other.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all individual mental capacity assessments for DNAR status are completed.
- To work with the commissioners of the IMHA service to ensure lasting arrangements are in place for IMHA input to Garner ward.

Action the provider SHOULD take to improve

- The provider should ensure that care plans clearly reflect patient's views.
- The provider should ensure that patients have access to psychological therapies on the ward.

Summary of findings

- The provider should record the rationale for granting S17 leave and clearly reflect patient and nearest relative discussions.

Cornwall Partnership NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Garner ward	Bodmin Community Hospital

Mental Health Act responsibilities

We conducted a Mental Health Act Review as part of the inspection of Garner ward. We found that four areas of concern found during our last review visit on 27 November 2013 had been addressed or partly addressed. This will be reported separately in more detail.

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. Recording decisions about repeating, or not repeating, rights for a patient who had not understood had been addressed via the multidisciplinary meeting template. Steps had also been taken to prevent delayed visits by doctors approved to give a second opinion, which had previously resulted in treatment being imposed on patients under section 62 of the Mental Health Act.

We reviewed the s17 leave records for 16 patients. These records were in order with out of date leave forms crossed through. However of the s17 leave forms reviewed, most did not record that the leave had been discussed with patient or distributed to anyone.

Leave appeared to being used for therapeutic purposes. Risk assessments were undertaken on admission to the ward and periodically thereafter. However the rationale for granting s17 leave was not clearly recorded in MDT minutes or progress notes.

Care plans only partly reflected patients and families views and patients did not have copies of their care plans.

The actions from the last provider action statement to ensure equal access to the independent mental health advocacy (IMHA) service did not appear to have been resolved until a few days before our visit. This was an issue raised in the last MHA monitoring visit in November 2013.

Detailed findings

We were advised by staff that no advocate had visited the ward until two days before this announced visit so patients and families on Garner ward had not had the opportunity for IMHA support and representation.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in and had a good understanding of the Mental Capacity Act 2005 (MCA). Staff had received training related to the mental capacity act and deprivation of liberty safeguards (DoLS). This was part of the essential training package. Staff demonstrated an understanding of the process for making decisions in the best interests of patients and we saw records to support this. We saw that best interest's decisions were detailed and individual and had considered the person's wishes appropriately.

There was a policy on the MCA, including DoLS, which staff were aware of and were able to refer to.

Staff knew where to seek advice regarding MCA and DoLS within the trust and there were well established links with the Mental Health Act Office and administrator.

We looked at individual do not attempt resuscitation (DNAR) status records and saw that 14 out of the 16 patients had DNAR status. We found the approach was not always individual and this did not clearly set out how the decision-making process regarding the person's capacity was made. The trust had a form for recording this but it did not allow demonstration of assessment of capacity in relation to this.

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 ward was large and spacious, and all at ground floor level. There were two long parallel corridors, and a range of sitting and activity areas. There were two lounges, which could provide separate male and female areas. There were five patients on line of sight observations (where they needed to be where staff could see them) and enhanced observations. This was well managed within the staffing levels on the ward.

The ward areas were clean and maintained. The single bedrooms had ensuite toilets and wash basins. There were three shower rooms and one patient bathroom with one bath which was a 'Parker' assisted bath. The ward layout was designed in such a way as to prevent a breach of same sex accommodation guidance and the ward staff had plans in place to reduce the risk of any such breach. However, with only one bathroom available and one shower out of use at the time of inspection there was a risk that the facilities in the five bedded male wing would need to be used by female patients. This presented a potential risk in relation to not fully complying with same sex accommodation guidance.

There were a high number of ligature points (fixtures and fittings that were a potential strangulation risk for patients). Each patient had a ligature assessment and during our visits to the ward we saw that risks were appropriately managed through a combination of effective observation, risk assessments and safe staffing levels.

The clinic room was clean but cluttered in places. The controlled drugs cupboard was locked and the fridge temperature was checked daily and was within normal limits. There was no treatment couch but we were told that patients were always examined in their single bedrooms.

The ward did not have a seclusion room.

The ward looked clean in all areas. Garner ward had failed to deliver nationally-expected cleaning scores under the Patient-Led Assessments of the Care Environment (PLACE) scheme in August 2014. However, recent Patient Environment Action Team (PEAT) audits demonstrated that cleanliness and infection control was of a high level and rated green.

All staff had alarms and there was a fast track system to the switchboard to summon staff assistance from the psychiatric intensive care unit ward.

Safe staffing

During our visit there were five patients on line of sight observations. This was well-managed. There were enough staff to carry out physical interventions with patients safely.

We were told that staffing numbers were good on the ward and we saw records to support this. Staffing levels had been assessed using a recognised tool. In response to the high number of incidents, a demand and acuity tool had been developed to support safe staffing, particularly if the case mix of patients was more challenging. We saw that the ward was staffed as per the agreed establishment. The number of estimated nurses matched the actual numbers working. There were 18 patients on the unit. Planned discharge of two patients took place on the first day and when we returned on the second morning a new patient had been admitted, with a second admission planned for later that week.

There was an acting manager who was a well-regarded and experienced staff member and was supernumerary to the staffing roster. We were told that the ward manager post was being advertised and that succession planning was in place for staff due to retire later in the year. However, there were also long-term vacancies for a part-time physiotherapist, psychologist and there were gaps in consultant provision. This was partly covered by a job share that was not equivalent to full time between one part-time consultant and a part-time locum consultant.

There was medical cover day and night and a junior doctor could attend the ward quickly in an emergency.

Good

Are services safe?

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

There was appropriate use of bank staff to cover staff sickness and absence. In the three months prior to our visit we saw that 42 out of the 48 shifts where there had been a gap in establishment for nursing or HCA staff had been covered by bank or agency staff.

Most staff were familiar with the ward and the trust was looking to mitigate the risks of staff absence further by recruiting bank staff specifically with skills in working with older people.

There were three activity staff rostered in order to cover activities each day over a period of 12 hours for all people using the service. This was a new initiative and one relative still thought that there was not enough activity on the ward.

There were qualified nurses in communal areas and enough staff so that patients could be managed safely.

There were enough staff to carry out physical interventions and ward staff had been trained in physical observations with the support of an off-site clinical nurse and medical team.

All ward staff had received up-to-date mandatory training, with high levels of compliance for all essential and mandatory training, which were the mandatory training records for the trust. Older people's services had exceeded the trust target of 98% in 2014.

The ward was preparing to move to an e-rostering system where mandatory training time would be factored into the duty roster.

Assessing and managing risk to patients and staff

service had a specialist risk assessment tool called STORM, which they used to assess and determine the risk of self-harm and suicide. They had specific training on the use of STORM within the service and there was a trainer available within the service if necessary to provide additional support in the use of the tool.

There were high levels of restraint recorded, with 157 reported incidents. Staff explained that restraint was only used after de-escalation had failed and that there were high levels of restraint due to the challenging case mix and the need to protect patients and staff. The ward manager explained that they classify any physical interventions such as an arm support hold as restraint. We were also advised that the trust lead for safeguarding was looking at reported incidents, and the service was reflecting on the management of violence and aggression.

In response to the high number of incidents, a demand and acuity tool had been developed to support safe staffing, particularly if the case mix of patients was more challenging.

There was one incidence of seclusion in the last six months.

We did not see use of any blanket restrictions during our visits to the unit.

The ward was locked and all patients on the unit were detained under the Mental Health Act 1983.

Staff were compliant with management of aggression and violence training and had received additional bespoke training relating to older people. Staff also had access to trainers visiting the ward weekly, which had been introduced in response to the higher incidence of aggression from patients using the service.

Staff were aware of safeguarding procedures and how to raise safeguarding concerns.

Track record on safety

In response to the high number of incidents, a demand and acuity tool had been developed to support safe staffing, particularly if the case mix of patients was more challenging.

There had been two serious incidents requiring investigation (SIRI) in the last 12 months in this service. These incidents had led to actions being taken to improve practice and learning in relation to falls assessments and was shared within the service.

The service promoted an open culture of reporting and learning from events, which all staff we spoke with were aware of.

There was one incidence of seclusion in the last six months.

The service had a newsletter that specifically addressed learning from incidents from the service and through the trust.

Good

Are services safe?

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

Staff on the unit had been assaulted by patients who had become agitated or distressed. Aggression towards staff had increased recently and the behaviour of some patients was severely challenging. Two staff were currently off sick from work with injuries caused by patient assaults at work.

Reporting incidents and learning from when things go wrong

We saw records to show that information about adverse events specific to Garner ward were entered onto an electronic database and were subject to investigation.

Staff we spoke with were aware of the incident reporting process and were clear about incidents that needed to be reported. There was a high rate of reporting on the ward, with an open culture to report and learn from incidents.

Multidisciplinary staff met regularly in team meetings to share learning. Learning from incidents was discussed as a part of the meetings. Staff members were able to give examples of how learning from incidents was disseminated.

We reviewed four patient records and we could see that staff undertook a risk assessment when patients were admitted and updated it regularly and after any incident.

There was a trust-wide working group looking at reasons for the challenging behaviour on Garner ward. The group was identifying ways of reducing the incidents through greater understanding of the events leading up to them and seeking improvements that could be made to the environment, such as changing décor colours or use of a sensory room.

The trust was converting a communal room into a sensory room. However, it was not available to patients during our visit. We were advised that the progress had been slow due to delays in access to maintenance staff to assist with wiring. This meant that patients did not have the opportunity to use a space that could potentially help manage challenging behaviour.

Are services effective?

Requires improvement

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

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

We reviewed four care records held on the ward and saw evidence of comprehensive and timely assessment completed after admission and thereafter. However, not all records demonstrated that they were following the 12-week assessment model. We were told that staff were half way through updating the patient records to follow the Newcastle model in full. The Newcastle model is an approach which places the person with dementia at the centre of the assessment and intervention process. It provides a framework for understanding the cause of a person's challenging behaviour and a process by which interventions can be delivered. This is in line with NICE guidelines which state that non-pharmacological interventions are to be used prior to medication in cases involving challenging behaviour.

Care records showed that patients had a physical examination when they were admitted and that any physical health problems were monitored.

We saw care records were up to date and contained some involvement of patients and, particularly, families.

We reviewed eight records that were held within an electronic system (RIO) and were therefore secure and accessible to staff. However, most of the RIO care plans we looked at contained a statement in the client's view column that explained that staff were unable discuss with the patient due to their cognitive impairment and lack of insight so care plans did not consistently include patients' views.

Best practice in treatment and care

We reviewed 11 medication charts and saw evidence that staff had followed NICE guidance, for example, when prescribing medication.

There was good access to physical healthcare, including nurse specialists to support the ward staff with caring for people's physical needs.

We did not see access to psychological therapies on the ward and there was a vacant psychology post in the older people's service line.

We reviewed four care records and saw that staff used recognised rating scales to aid with risk assessment and treatment planning. Staff were starting to use the Newcastle assessment model and were using the neuro-psychiatric assessment on admission and discharge. Staff used a multi-factoral fall risk assessment tool to identify patients at risk of falls. We saw examples that were up to date and subject to review on a regular basis.

Skilled staff to deliver care

A range of mental health disciplines and workers were providing input to the ward. This included input from occupational therapists and social workers, plus dedicated time with a dietician. Most of these professionals were based on the ward, providing direct access to these services. However, there was no psychologist input and no dedicated physiotherapy support.

Most of the permanent staff were experienced in complex care and dementia, and the trust was in the process of improving continuity when temporary staff were needed by developing a bank staff team that were experienced in complex care and dementia.

Staff were qualified, trained, supervised and appraised on a regular and routine basis and had regular team meetings.

Staff were supported to develop their skills and we saw evidence to support this. There was weekly peer support and training sessions, with staff identifying the need each week. Some innovative training has taken place for healthcare assistants, including dementia training. However, staff reported that it was difficult to access training away from the ward. Training included staff attending a play – Inside Out of Mind – at the Northcott Theatre in Exeter and then taking part in workshops raising awareness of dementia care. Staff also learned about end of life support working with hospices offering reciprocal training.

All staff had been recently trained in the Newcastle model and there was more training planned for using the Newcastle model in relation to management and assessment of aggression in dementia.

Are services effective?

Requires improvement

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

Staff performance issues were addressed promptly and effectively and the acting ward manager was able to inform us of disciplinary processes that had been followed in such cases.

Multi-disciplinary and inter-agency team work

Staff took part in weekly multidisciplinary meetings that were routinely attended by the consultant, junior medical staff, nursing staff, the discharge coordinator, pharmacist and occupational therapists. community psychiatric nurses and other staff attended at times – for example, when there was a planned discharge or admission. We saw a template that captured the discussions and included recording of Mental Health Act decisions.

One relative we spoke with confirmed that they were informed about and involved in care meetings and knew when they were due to take place.

There was good liaison with general nursing wards and departments to help staff support physical care needs. This included weekly input from the physical health nurse and access to tissue viability specialists.

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

Staff were trained in adherence to the Mental Health Act 1983 (MHA) and the MHA Code of Practice through mandatory e-learning. There was additional support from a clinical lead for the Mental Health Act.

Patients were assessed and treated in line with the Act. A multidisciplinary meeting template was in use for recording decisions about repeating, or not repeating, rights for a patient who had not understood. However, our review of forms relating to patients going on leave from hospital care under section 17 of the Mental Health Act found that information was clearly recorded but most forms did not record that the leave had been discussed with the patient or that the form had been distributed to anyone.

A Mental Health Act review visit took place as part of the inspection of Garner ward, which will be reported in more detail separately.

Good practice in applying the Mental Capacity Act

All staff were trained in and had a good understanding of the Mental Capacity Act 2005. This training formed part of the mandatory e-learning package.

Staff knew where to seek advice regarding the MCA, including deprivation of liberty safeguards within the Trust and there were MHA officers who reviewed coordination of DoLS applications and supported training.

The majority of the trust-wide DoLS applications were made by older people's inpatient services, with 17 out of the 23 DoLS applications made in the year commencing April 2014 being from Garner ward.

We reviewed how best interests decisions were made and saw that the records were detailed and that decisions had taken account of the person's wishes, feelings and history. We saw that less restrictive options were considered before decisions on more restrictive care were made in the patients' best interests. The multidisciplinary team ward template was used as a tool to support the assessment and recording process.

However, do not attempt resuscitation (DNAR) status records were not always individual and did not clearly set out how the decision-making process regarding the person's capacity was made. Five patients who had DNAR status did not have a capacity assessment recorded.

Patients on Garner ward had not had direct access to independent mental health advocacy (IMHA) services until two days prior to our visit. This service had only recently been Commissioned by Education Health and Social Care. This was an action from our MHA monitoring visit in on 27 November 2013 where we identified concerns about the provision of IMHA service to Garner ward patients.

Good

Are services caring?

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

Summary of findings

Please see summary at beginning of report.

Our findings

Kindness, dignity, respect and support

Interactions between staff, patients and their relatives were respectful and we saw genuine reciprocal warmth.

We used the short observational framework for inspection twice and saw positive interactions between staff and patients. Staff were skilled in de-escalating an issue between two patients. We saw that staff were kind, compassionate and professional in their interactions with patients. It was also observed that staff held hands with patients in a reassuring way when appropriate.

Relatives confirmed this and told us that staff were helpful and attentive.

Staff we spoke with showed a good understanding and knowledge of the individual needs of patients and were enthusiastic about their roles.

The involvement of people in the care that they receive

We saw detail within care records that showed that patients had been provided with information about their inpatient stay on admission to the ward. There was easy-read information about patients' rights under the Mental Health Act.

We observed patient and family involvement in the four care records that we reviewed. The patient passports and life story books were person-centred, and families and carers had been involved in compiling this information.

We saw that preferences were discussed with the patient and their families. We were told that there was a weekly shop where staff purchased biscuits and snacks based on patients' favourite treats and their preferences.

People were able to get involved in decisions about the service they received. For example, carers were involved in recent staff interviews. In addition, the older people's service held a drop-in session, 'our say' and 'tea and talk sessions' for patients and their relatives to encourage involvement in the service. However, the trust reported that this was not well attended.

Are services responsive to people's needs?

Good

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

Average bed occupancy over a six-month period for the trust was 83.5%. For Garner ward this was 57% not including leave, based on 24 beds. However, when we visited Garner ward the beds were limited to 18 due to the complex needs of the patient group. A demand and acuity tool had been developed to support safe staffing matched with bed numbers to ensure that safe care could be provided.

The complex care and dementia unit admitted people from within the area and from outside Cornwall.

There was a supernumerary discharge coordinator who liaised closely with community teams and nursing homes to support patients' early discharge.

There were coordinated discharge plans in place for two patients who were leaving on the first day of our visit to the ward to go to nursing home care. There were two more admissions planned. We saw that planned admissions and discharges had taken place at an appropriate time of the day.

The discharge coordinator and ward manager were aware of patients that were at high risk of requiring admission from the community. We saw that patients at high risk were placed on a 'top 10' spreadsheet and this was shared with the ward team daily and at multidisciplinary team (MDT) meetings.

Discharge was sometimes delayed for non-clinical reasons on Garner ward. The trust had reported one delayed discharge in the past six months. However, we were informed that the ward was unable to discharge five patients because there were not enough suitable safe places for them to go. We saw that one patient had been on the ward for almost three years.

Staff confirmed that patients frequently stayed longer than needed due to the very complex physical needs and challenging behaviour. This placed an extra demand on the ward where they were at full capacity and a demand on the community teams when beds were not available.

The facilities promote recovery, comfort, dignity and confidentiality

We saw a full range of rooms and equipment to support treatment and care. There were well-equipped activity areas. The ward had a 'pop-up bar', which simulated a public bar counter to create a familiar environment for some.

Patients would normally receive visitors out on the seating areas on the ward, in their bedroom or in the Bodmin Hospital café close by. We were advised that if families brought children they could meet with their relative in the meeting room or the café, which were located off of the ward.

Each bedroom could be locked from the outside so that other patients could not wander in but patients could leave their room freely. We were advised that patients were given a key to open their rooms if it was judged that they could manage this, and staff had keys for the rooms and could open patients' doors for them at any time. We saw that rooms were personalised with photographs and belongings.

Patients had somewhere secure to store their possessions and their property was recorded as part of the admission procedure. The manager explained that the process to record and safeguard people's property had recently been strengthened.

Patient-Led Assessments of the Care Environment (PLACE) site scores for the trust published in August 2014 showed that Garner ward had failed to meet nationally-expected catering standards. The trust had taken steps to improve this and there was now dedicated access to a dietician. The ward supplemented meals with high-calorie snacks and biscuits, which were purchased weekly. These were selected by patients and their relatives.

People had access to outside space and fresh air in the garden and a separate courtyard. The garden was well tended and had a domestic garden shed and a padded matting floor to encourage activity.

Are services responsive to people's needs?

Good

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

One relative told us that they did not think there was enough activity. The trust had recently improved this and staff organised activities each day, including weekends.

Meeting the needs of all people who use the service

The trust was in the process of being made into a sensory room. However, it was not available to patients during our visit. We were advised that the progress had been slow due to delays in access to maintenance staff from the PFI company to assist with wiring. This meant that patients did not have the opportunity to use a space that could potentially help manage challenging behaviour.

Leaflets were available for people and their relatives about how to complain and leaflets explaining people's rights under the Mental Health Act in an easy-to-read format.

There was access to appropriate spiritual support. A chaplain was based on the Bodmin Hospital site and available to patients on the ward. There was a spirituality team located within the trust and patients could make requests for visits from representatives of a variety of religious faiths.

Listening to and learning from concerns and complaints

There had been two complaints in the last 12 months that had been investigated and had not been upheld. There were no current complaints being investigated.

Relatives told us that they knew how to complain and would raise their concerns through the ward manager or any staff. However, the lack of advocacy had meant that there was less opportunity for people to be represented in raising concerns if they wished to.

Staff knew how to handle complaints appropriately and were able to tell us how they would support patients raising concerns. Staff received feedback on the outcome of investigations of complaints and described how a previous complaint had resulted in improvements in practice in respect of looking after patients' property.

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 knew of the organisation's values and were familiar with the patient-centred approach, which they applied to their own setting.

Staff felt well supported by line managers and service managers through good supervision, annual appraisal and regular team meetings. Most staff we spoke to knew who the most senior managers in the organisation were. Some staff thought that the senior management team was not visible enough.

Good governance

Staff were receiving mandatory training and some staff had further development opportunities to support their practice.

We saw that shifts were covered by sufficient staff and the majority of shifts had been safely covered by staff at the right grades. The trust was working to achieve a bank of qualified and experienced staff that were skilled at working with complex care and dementia.

We saw that staff could maximise their shift time on direct care activities as opposed to administration tasks. There were supernumerary posts to support this, such as the discharge coordinator and the ward manager, and there were activity staff to support individualised activities with people.

Leadership, morale and staff engagement

Sickness and absence rates were below the trust average of 5.36% during 2014. We observed staff rotas to review the levels of sickness and absence and saw that sickness was low and that shifts were well planned and staffed.

Morale and job satisfaction was good and relationships between the multidisciplinary team were supportive. The team felt that there had been some senior management recognition of the stress due to high numbers of incidents of patients' aggression towards staff on the ward. Funding from the 'Improving working lives' fund had been obtained and the staff had been able to choose how to spend it. Staff reported that they had used this funding to enjoy a social activity as a team.

Staff knew how to use the whistle-blowing policy and told us that they would do so if necessary in order to safeguard patients against bad practice and service delivery.

Staff told us that they felt able to raise concerns without fear of victimisation and were confident that they would be supported by the ward manager in doing so.

Staff told us that they enjoyed their work and we saw that they demonstrated commitment and care towards people using the service and each other.

Commitment to quality improvement and innovation

The ward staff were able to describe their commitment to quality improvement and innovation. Some staff had become 'dementia friends' following a dementia awareness session on the ward.

There were a number of areas where the ward has shown commitment to quality improvement and innovation, such as reminiscence pods to improve patient experience. The ward had also introduced daily activities included at weekends and in the evenings.

Staff were working on an innovative approach to care by developing a communication tool for patients with cognitive impairment to feedback regarding patient nutritional likes and dislikes, which was recently presented at the Peninsula Health Conference.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11(1) Ensure that all individual mental capacity assessments for patients with Do Not Resuscitate status records are completed in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9(3)(e) Provide opportunity for persons to manage their care and treatment by ensuring that robust and lasting arrangements are in place for Independent Mental Health Act Advocacy (IMHA).