Good

Cornwall Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ866	Bodmin Hospital	Fletcher Ward	PL31 2QT
RJ866	Bodmin Hospital	Harvest Ward	PL31 2QT
RJ866	Bodmin Hospital	Perran Ward	TR15 3ER
RJ866	Bodmin Hospital	Carbis Ward	TR15 3ER

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	Good
Are services safe?	Good
Are services effective?	Good
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

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Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as **good** because:

- Patients told us that they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us that staff were nice towards them and were interested in their wellbeing. Staff showed patience and gave encouragement when supporting patients. We observed this consistently throughout the inspection. Patients told us that they were the priority for staff and that their safety was always considered. Patients were involved in their care and all patients had either signed a copy of their care plans or said they did not want to sign the plans. The approach of the staff towards patients was person centred, individualised and recovery orientated. The trust encouraged feedback from patients and satisfaction surveys were available for patients to complete on every ward. On each ward a 'you said we did' initiative was advertised on patient information boards and gave examples of staff making changes on the wards in response to patient requests.
- The wards provided safe care. Staff had received training on managing ligature risks and staff were able to tell us where the high-risk ligature anchor points and ligatures were and how these risks were mitigated and managed. Staff on each of the acute wards had created areas of the ward for particularly vulnerable patients to use, for example, older adults who may be quite frail. There were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were always sufficient staff on duty. There were low staff vacancies on the wards. Staff practiced relational security to a high standard and staff actively promoted de-escalation techniques to avoid restraints and seclusion where possible. As a result of this approach, the number of seclusion episodes had decreased by 64% compared to the previous year. The number of restraint incidents had decreased by 6% compared to the previous year.
- Staff shared risks in the daily handover meetings in a written handover to all staff. The handover was recorded on the electronic system. In addition each ward carried out a daily 'safety huddle' which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards. The meetings involve all available staff to discuss specific patients' risks and any potential harm that may affect patients.
- Staff worked together to provide effective care. In all of the 27 care records we reviewed across the four wards, there were detailed and timely assessments for patients. Staff had assessed all patients for their current mental state, previous history and physical healthcare needs. The care plans were recovery focused. Patients told us that they were included in the planning of their care. Staff used National Institute for Health and Care Excellence guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring good standards of physical health care delivery. Patients had discharge plans and told us staff helped them to achieve these plans. Well-staffed multidisciplinary teams worked across the wards. Regular and inclusive team meetings took place.
- The wards were well led. The senior management and clinical teams were visible and staff said that they regularly visited the services. All staff and patients knew who the senior management team were and felt confident in approaching them if they had any concerns. Governance systems were in place with comprehensive clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly, for managers to measure their progress and achievements.

However:

- There was one blind spot, impairing staff observation, in the garden area of Harvest ward. There was a risk of patients gaining access onto the low roofs, accessible to patients, in all of the four ward gardens, across both hospital sites. There had been one incident, on Perran ward when a patient climbed onto the roof. The patient came down from the roof voluntarily and was transferred to Harvest ward.
- The trust should consider, highlighting high dose antipsychotic medicine on medication administration charts, to ensure there is a method to easily alert any nurse administering medicines.

Summary of findings

- The privacy windows in the bedroom doors on Harvest ward did not afford patients privacy and dignity. Patients were not able to close the blinds, when they were in their bedrooms. The doors and blinds had been scheduled for replacement in November 2017, soon after our inspection.
- There was one incident, involving one patient when staff did not carry out physical observations and record these accurately, post rapid tranquilisation, to reduce the risk of adverse effects.
- Staff did not always complete care records to reflect discussions on decision specific 'best interests' assessments when they have taken place.
- The locality model on the acute wards was difficult to organise because at any one time there could be between six and 16 different doctors looking after their patients on the wards. This put nursing staff under pressure, to organise and hold several clinical meetings at the same time.
- Occupancy figures and length of stay figures were high on Carbis and Fletcher wards because a number of patients were on extended leave from the ward under Section 17 of the Mental Health Act.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Staff had received training on managing ligature risks and staff were able to tell us where the high-risk ligature anchor points and ligatures were and how these risks were mitigated and managed.
- Staff on each of the acute wards had created areas of the ward for particularly vulnerable patients to use, for example, older adults who may be frail.
- There were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were always sufficient staff on duty. There were low staff vacancies on the wards.
- Staff practiced relational security and actively promoted the use of de-escalation techniques to avoid restraining and secluding patients where possible. The number of seclusion episodes had decreased by 64% compared to the previous year. The number of restraint incidents had decreased by 6% compared to the previous year.
- Risk assessments were completed for all patients on admission to hospital and staff used nationally recognised risk assessments. The percentage of clinical staff that had received risk assessment and management training was 94%, against a target of 90%. All patients were encouraged to have advanced directives in place in case of incidents that may escalate into violence or aggression. Patients said how they wanted to be treated in these circumstances.
- Staff gave us examples of incidents reported and lessons learnt. There was a debriefing policy and staff reported that debriefing took place for both staff and patients.
- There was a potential risk of patients gaining access onto the low roofs, in all of the four ward gardens, across both hospital sites. We were confident that the trust was managing the risk. Staff were aware of this risk and were taking adequate precautions such as supervising patient use of the garden areas. Trust managers were in discussion with the owners of the hospital sites to plan a longer term solution to this risk.

However:

Summary of findings

- There was one blind spot, impairing staff observation, in the garden area of Harvest ward. This was managed by enhanced staff observation, every 15 minutes.
- The trust should consider, highlighting high dose antipsychotic medicine on medication administration charts, to ensure there is a method to easily alert any nurse administering medicines.
- There was one incident, involving one patient when staff did not carry out physical observations and record these accurately, post rapid tranquilisation, to reduce the risk of adverse effects. Staff had learned from this and the trust policy for rapid tranquilisation was discussed in team meetings across all four wards.

Are services effective?

Good

We rated effective as **good** because**:**

- All patients had detailed and timely assessments of their current mental state, previous history and physical healthcare needs. The care plans were recovery focused. Patients told us that they were included in the planning of their care.
- Staff used National Institute for Health and Care Excellence guidance when prescribing medicines and for planning treatment.
- Well-staffed multidisciplinary teams worked across the wards. Regular team meetings took place.
- Over 83% of staff had received updated training on the Mental Health Act, including the revised Code of Practice. Staff knew their responsibilities regarding the application of the Act and patients' rights under the Act.

However:

- Staff did not always complete care records to reflect discussions on decision specific 'best interests' assessments when they had taken place. There was no detailed record of the discussions we were told had taken place about capacity and consent.
- Nurses said it was difficult to organise so many clinical meetings on the wards at the same time, due to having between six and 16 different doctors looking after their patients on the wards at any one time.

Are services caring?

Good

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

Summary of findings

- Patients told us that they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us that staff were nice and were interested in their wellbeing.
- Staff showed patience and gave encouragement when supporting patients. We observed this consistently throughout the inspection. Patients told us that they were the priority for staff and that their safety was always considered.
- There was evidence of patient involvement in the care records we looked at and all patients had either signed a copy of their care plans or said they did not want to sign the plans. The approach of the staff to patients was person centred, individualised and recovery orientated.
- The trust encouraged feedback from patients and satisfaction surveys were available for patients to complete on every ward. On each ward a 'you said we did' initiative was advertised on patient information boards and gave examples of staff making changes on the wards in response to patient requests.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Patients had discharge plans and they told us staff were helping them to achieve these plans.
- The majority of patients said the quality of food provided was good. The Bodmin hospital site scored 96% for quality of ward food in the 2016 patient-led assessment of the care environment assessment, which is better than the England average of 92% and the overall trust score of 93%.
- Information was available to patients on treatments, therapy, local services, and patients' rights. The information boards in all of the wards were displayed creatively and contained relevant and updated information for staff, patients and relatives.
- Copies of the complaints process were on display on the information boards on the wards and in the ward welcome packs. Patients we spoke with all knew how to make a complaint, should they wish to do so. Staff knew how they would handle a complaint. Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training.

However:

Summary of findings

- Occupancy figures and length of stay figures were higher than expected due to a number of patients who were on extended leave under Section 17 of the Mental Health Act.
- The privacy windows in the bedroom doors on Harvest ward did not afford patients privacy and dignity. Patients were not able to close the blinds, when they were in their bedrooms. The doors and blinds had been scheduled for replacement in November 2017.

Are services well-led?

Good

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

- Staff we spoke to understood the vision and direction of the organisation. Staff felt part of the service and were able to discuss the philosophy of the wards.
- The senior management and clinical teams were visible and staff said that they regularly visited the services. All staff and patients knew who the senior management team were and felt confident in approaching them if they had any concerns.
- Governance systems were in place with comprehensive clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly to managers so they could monitor their progress and achievements.
- Staff received mandatory training, supervision and appraisals. There were sufficient staff available on every shift in each ward to deliver good care to patients.
- Clinical audits were regularly carried out to ensure treatment and therapy was effective. Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.
- Patients told us that they were encouraged by staff to participate in making suggestions towards improving many aspects of the service.
- Staff spoke very highly about their management teams and there was evidence of clear leadership at ward level. The culture on the wards was open and encouraged staff to bring forward ideas for improving care. All of the ward staff we spoke with were enthusiastic and engaged with developments on the wards.

Summary of findings

Information about the service

Two acute admission wards for adults are located at Longreach house within the Camborne and Redruth Community hospital. The third acute admission ward and the psychiatric intensive care ward are at Bodmin hospital. The wards aim to provide a safe environment for assessment and treatment of people over the age of 18 with a mental health condition.

The two wards at Longreach house are Perran ward and Carbis ward. Both these wards are mixed gender and have 15 beds each for adults from age 18 to end of life.

Fletcher ward, Bodmin hosptial is a 24 bedded mixed gender ward.

Harvest ward, Bodmin hospital is an eight bedded mixed gender psychiatric intensive care unit. This ward provides intensive treatment to people aged 18 years or above who, because they are mentally very unwell and need a level of nursing input that cannot be provided on a normal acute psychiatric unit.

The three acute wards and psychiatric intensive care unit were previously inspected in April 2015 as part of the Care Quality Commission comprehensive mental health inspection programme and received an overall rating of requires improvement. We rated the safe and responsive key questions as requires improvement, all the other key questions were rated as good.

We served two requirement notices for breaches of Regulation15, premises and equipment and Regulation 12, safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we told the provider it must:

- Ensure that all staff working in the acute wards and psychiatric intensive care unit are clear about the steps they need to take to reduce the risks of ligature points to patients.
- Take action to reduce the blind spots in the seclusion rooms on the psychiatric intensive care unit, so that staff can observe patients at all times when secluded.
- Repair the intercom in the seclusion room to ensure staff and patients can communicate when patients are in seclusion.
- Clean and maintain the wards at Bodmin hospital, to reduce the risk of infection to patients and staff.

On this inspection we found that the provider had fully achieved the required actions from these requirement notices and was no longer in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

The inspection of Cornwall Partnership NHS Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection, supported by Michelle McLeavy, inspection manager, mental health and Mandy Williams inspection manager, community health.

The team that inspected this core service included one Care Quality Commission (CQC) inspector, Jackie Drury (inspection team lead), another CQC inspector, a CQC pharmacy inspector for one day, three specialist nurse advisors and one expert by experience. An expert by experience is someone with lived experience of using mental health services.

Why we carried out this inspection

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

Summary of findings

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all four of the wards at the two hospital sites, looked at the quality of the ward environments, and observed how staff were caring for patients
- spoke with 18 patients who were using the service, two carers and one advocate
- received 53 comment cards from patients
- spoke with the managers or acting managers for each of the wards
- spoke with 30 other staff members including doctors, nurses, health care assistants, psychologists, occupational therapists and therapy staff
- attended and observed a hand-over meeting and three multi-disciplinary clinical meetings
- carried out a specific check of the medication management on all four wards and looked at 21 medicine charts
- looked at 27 care records and 13 incident forms
- looked at a range of policies, procedures, and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 19 patients and two of their relatives. Patients we spoke with complimented staff providing the service throughout the wards and felt they got the help they needed. Patients told us that they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us that staff were nice and were interested in their wellbeing. We received 53 comment cards from patients, 29 were positive about the service and staff, 11 negative and 13 had mixed feedback. Examples of the positive comments were that staff were genuinely kind and interested in patients. Examples of negative comments were patients wanting more leave from the ward and, at times, feeling bored.

Good practice

- Each of the acute wards had created areas of the ward particularly for vulnerable patients to use, for example, older adults who may be frail. On Carbis ward this area had a separate lounge and the patients had their own entrance door with a keypad lock.
- Each ward carried out a daily 'safety huddle' which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards. The meetings involve all available staff to discuss specific patients' risks and any potential harm that may affect patients.
- Patients were encouraged to have advanced directives in place in case there was an incident that might escalate into violence or aggression. For example patients had identified their preferred methods for

calming down and where appropriate their preferred medication to be prescribed. Staff had received training on advanced directives and positive behaviour support plans.

- The 'Safe ward' initiative was well embedded on all wards. This nationally recognised good practice initiative proposes 10 interventions are used on a ward to reduce conflict and distress for patients and make wards safer places for patients and staff. For example using methods to calm down other than medication such as listening to music, soft lighting and distraction techniques.
- The leadership of the service enabled the warsd to develop in response to feedback. Staff encouraged patients to make suggestions to improve the service. The wards carried out 'you said we did' meetings, gaining the views of patients on service improvement. In addition monthly carer and family days were held so that families could meet the staff providing the care and ask questions about care and treatment.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff complete care records to reflect discussions on decision specific 'best interests' assessments when they have taken place. There was no detailed account of the discussions we were told had taken place about capacity and consent, recorded in the documentation.
- The trust should ensure there is no blind spot impairing staff observation, in the garden area of Harvest ward.
- The trust should investigate and implement a solution, to reduce the risk of patients gaining access onto the low roofs, accessible to patients in all of the four ward gardens, across both hospital sites.
- The trust should ensure, in all cases, that staff carry out physical observations, post rapid tranquilisation or following intramuscular injections, administered for agitation, to reduce the risk of adverse effects and record these accurately .
- The trust should ensure it's mandatory training target of 85% is reached across the acute and PICU wards.
- The trust should consider, highlighting high dose antipsychotic medicine on medication administration charts, to ensure there is a method to easily alert any nurse administering medicines.
- The trust should ensure the privacy windows in the bedroom doors on Harvest ward afford patients privacy and dignity. Patients were not able to close the blinds, when they were in their bedrooms.
- The trust should review the arrangements for which psychiatrist looks after which patient on the acute wards. Ward managers and staff told us ward rounds were difficult to organise because at any one time there could be between six and 16 different doctors looking after patients on each ward.
- The trust should review arrangements for the length of time patients are on arranged leave, as the occupancy figures and length of stay figures were significantly inflated due to a number of patients who were on extended leave arrangements under Section 17 of the Mental Health Act.

Cornwall Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fletcher ward	Bodmin Hospital
Perran ward	Longreach Hospital
Carbis ward	Longreach Hospital
Harvest PICU	Bodmin Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff were trained in the use of the Mental Health Act as part of their mandatory training.

There were systems to record that patients had consented to their treatment and when they did not the correct process was followed to gain a second opinion. Consent documentation was completed and correctly stored with medication charts.

Staff routinely informed patients of their rights under the Mental Health Act. These were repeated to patients to ensure they understood them. Information was provided to patients about their rights in leaflets which were produced in other languages where needed.

Patients were referred to the Independent Mental Health Advocate service where appropriate. Posters were displayed for patients to refer themselves to the advocate who also visited the wards each week.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the quality of documentation in the care records in regards to capacity to consent to treatment was of a variable standard. Staff could not tell us, where in the documentation, discussions on decision specific 'best interests' assessments had taken place.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- All three acute wards and the psychiatric intensive care unit had areas not clearly visible to staff and this presented some challenges for clear observation of the patients. Staff managed these challenges through individual risk assessments and regular checks of patients. There were sufficient staff available to increase the observation of patients at a high risk of self-harming, for example. Harvest ward had one blind spot in the garden area, which could mean that a patient may harm themselves, without staff knowledge. Staff managed this risk by checking the garden area every 15 minutes. The ward manager said this risk could be better managed by installing a closed circuit television camera.
- We had concerns in our previous inspection in 2015 that staff were not always clear about the steps they needed to take to reduce the risks of ligature points to keep patients safe. At this inspection we found that improvements had been made. Staff had received training on managing ligature risks and staff knew where the high-risk ligature anchor points and ligatures were and how these risks were mitigated and managed. Staff had carried out ligature risk assessments using the provider's ligature audit tool at least once each year. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounges and dining rooms and ensured they regularly monitored these areas. Bedrooms, bathrooms and toilets had been fitted with anti-ligature fixtures and fittings. Rooms such as the laundry room and kitchen areas were locked and only used with staff supervision. Ligature cutters were easily accessible in the wards' clinic rooms, the managers' offices and nursing offices. Any new risks staff identified were reported through the provider's incident reporting system and were escalated onto the service line risk register.
- We had concerns at our previous inspection in 2015 about the low level fences in the garden areas of the acute wards. There had been several incidents of patients climbing over the fences and potentially putting themselves at risk of absconding. During this inspection considerable improvements had been made. The garden areas on all the wards now had colourful and secure perimeter fences which reduced the risk of patients attempting to climb over the fences. All of the wards on both sites had low roofs and there had been two occasions when a patient had gained access to the roof on Perran ward. We discussed this concern with the associate director of services. The trust was investigating the best solution to reduce the risk of patients gaining access onto the roof areas and was planning to implement a long term solution over coming months.
- All three acute wards and the psychiatric intensive care wards were mixed gender and complied with the guidance on same-sex accommodation. The guidance states that all sleeping and bathroom areas should be segregated and patients should not have to walk through an area occupied by another gender to reach toilets or bathrooms. All the wards had female only lounges.
- Each ward had a clean and tidy clinic room. Staff kept appropriate records which showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the clinic rooms. An automated external defibrillator and anaphylaxis pack was in place on each ward to use in an emergency and staff knew how to use the equipment. The wards had access to an electrocardiogram machine. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally. We had concerns during our previous inspection in 2015 that emergency equipment had not been checked regularly however on this inspection improvements had been made and the equipment was regularly checked to ensure it was in order. Equipment such as weighing scales and blood pressure machines were regularly calibrated and the equipment was checked on a regular basis. All of the clinic rooms had an examination couch, if required, for doctors and nurses to examine patients.

Good

Are services safe?

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- Each of the acute wards had created areas of the ward for particularly vulnerable patients to use, for example, older adults who may be frail. On Carbis ward this area had a separate lounge and the patients had their own entrance door with a keypad lock.
- During our previous inspection in 2015 we had concerns about the seclusion rooms on Harvest ward which had separate bathing facilities and no working intercom system. The trust had refurbished one seclusion suite and this was due to be opened the week after our inspection. The suite had integrated bathroom facilities, no blind spots, closed circuit television, a two way intercom and a staff observation room. The two remaining seclusion rooms were due to close and undergo refurbishment into a wet room and a meeting room.
- Staff carried out regular environmental risk assessments and these formed part of the wider service line risk register. These were up to date and reviewed regularly. We had concerns at our last inspection in 2015 that the wards, in particular Harvest ward, were not clean. During this inspection all of the wards were clean. Cleaning schedules were available to guide staff. In addition there were audits of infection control and prevention and staff hand hygiene to ensure that patients and staff were protected against the risk of infection.
- During our last inspection in 2015 we had concerns that the furniture on Fletcher ward needed replacing or repairing. During this inspection the furniture and soft furnishings were of a good standard. The physical environments on all of the wards were maintained to a good standard although staff on Fletcher and Harvest wards, at the Bodmin hospital site, told us they still had to wait some time to have maintenance requests responded to in a timely manner. The trust was discussing the responsiveness of maintenance with the landlord of the Bodmin site.
- Alarms were available throughout the wards in bedrooms, bathrooms and toilets. Staff carried Individual alarms. Staff and patients said that alarms were responded to quickly.

Safe staffing

- The number of nurses identified in the staffing levels set by the trust matched the number on all shifts across all wards. All staff told us there were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were always sufficient staff on duty.
- The total number of substantive staff across the four wards was 117, 44 whole time equivalent (wte) nurses and 73 wte health care assistants and there were low staff vacancies across the wards. There were two qualified nursing vacancies and three health care assistant vacancies, equating to 4% vacancies across the wards and managers were actively recruiting to fill these posts. The staff turnover was 14%. The average staff sickness rate across the four wards was 6%, slightly higher than the trust average of 5%.
- When required bank and agency staff were used and in the majority of cases managers chose temporary staff who were familiar with the wards. During the preceding year 6.8% of qualified nursing shifts were filled by bank nurses and 2.5% by agency nurses. During the same period 16.8% of health care assistant shifts were filled by bank staff and no shifts were filled by agency staff. 2% of available shifts were not filled by either bank or agency staff.
- There was administrative support available across all of the wards which included reception staff during the day. This meant clinical staff could spend more time in direct contact with patients.
- Staff told us senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required. We saw examples during our visit of extra staffing being made available. For example, to provide one-to-one observation of patients.
- Qualified nurses were present in communal areas of the wards at all times. There were sufficient qualified and trained staff to safely carry out physical interventions. All nurses were trained to deliver intermediate life support and all staff were trained in basic life support.
- Staff were available to offer regular and frequent one-to-one support to their patients. There were enough staff on each shift to facilitate patients' leave and for activities to be delivered. Staff and patients told us that activities were rarely cancelled due to staffing issues.

Good

Are services safe?

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Patients told us they were offered and received a one-to-one session with a member of staff most days. Information from the patients' daily records showed that this was the case.

- The wards had adequate medical cover over a 24 hour period, seven days a week. Out of office hours and at weekends, on-call doctors were available to respond to and attend the hospitals in an emergency. Consultant psychiatrists provided cover during the regular consultant's leave or absence.
- The trust classed 50 training courses as mandatory for all clinical staff. Eighty percent of all staff, across the four wards, had completed mandatory training throughout the year. The trust set a compliance target for mandatory training at 85%. The trust had implemented a new information system to capture training compliance in June 2017 and was still completing data quality checks on the system at the time of our inspection.

Assessing and managing risk to patients and staff

- In the preceding year there had been 164 episodes of restraint, 15 in the prone position which accounted for nine percent of the restraint incidents. Four percent of all restraints resulted in rapid tranquilisation. The highest number of restraint episodes, equated to 40% of all restraints and took place on Harvest ward. Use of seclusion was low with 33 episodes taking place in the preceding year, all on Harvest ward. The number of seclusion episodes had decreased by 64% compared to the previous year. The number of restraint incidents had decreased by 6% compared to the previous year. There were no episodes of long term segregation on any ward.
- Staff on Harvest ward had developed an information leaflet for patients to explain what restraint was and other associated information, such as about rapid tranquilisation.
- All staff received training which included the management of actual and potential aggression. Staff practiced relational security and promoted de-escalation techniques to avoid restraints and seclusion where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict.
- Risk assessments were completed for all patients on admission to hospital and followed the format in the electronic care record system. Staff used nationally recognised risk assessments and tools such as the 'historical, clinical and risk management scales'. This is a set of comprehensive guidelines for assessing risk of violence. In addition staff were trained to carry out the 'STORM' self-harm assessment tool. Risk assessments were updated following any incidents. The percentage of clinical staff that had received risk assessment and management training was 94%, which is over the trust target of 85%.
- The crisis and contingency section of the risk summary contained information that patients had contributed to and participated with the risk assessment and care planning process. All patients were encouraged to have advance directives in place in regards to dealing with incidents which may escalate into violence or aggression. For example patients had identified their preferred methods for calming down and where appropriate their preferred medication to be prescribed. Staff had received training on advance directives and positive behaviour support plans.
- Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased in response to increased risks. The 'Safe ward' initiative was well embedded on all wards. This nationally recognised good practice initiative proposes 10 interventions are used on a ward to reduce conflict and distress for patients and make wards safer places for patients and staff. For example using methods to calm down other than medication such as listening to music, soft lighting and distraction techniques.
- There were blanket restrictions across the four wards. Restrictions had been thought through with staff and patients before implementation or had a clear rationale. Patients admitted to the wards underwent searches to ensure no contraband was brought into the ward. This was to ensure a safe environment for patients and staff and this had been put in place following incidents of contraband being brought onto the wards. Contraband is an item which is banned from the ward such as weapons, drugs or alcohol. A list was displayed showing these banned items. Staff told us that patient searches

Good

Are services safe?

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

were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender of staff. Staff told us blanket restrictions were under ongoing review.

- Staff followed the trust rapid tranquillisation policy for prescribed medicines to be given in an emergency and followed the National Institute for Health and Care Excellence guidance. Staff on Harvest ward had developed an information leaflet for patients which explained what rapid tranquilisation was and other associated information. However, on one occasion, one patient had been given two intramuscular injections to reduce agitation following a refusal to take their oral medicines. It was not possible to tell if staff were adequately observing the patient to reduce the risk of adverse effects as the observation form was not completed fully.
- All staff we spoke to said that if patients were informal they were able to leave the wards. All informal patients we spoke with said they knew they could leave the ward should they wish to do so. There were notices by the ward entrance doors reiterating this point.
- All of the staff we spoke to knew how to raise a safeguarding issue or concern. Staff said they completed an electronic incident form and informed the nurse in charge or the ward manager. All staff were aware of who the trust's safeguarding lead was and how to contact them. The safeguarding team contact details and flow charts of the safeguarding procedure were placed in all of the wards both in the nurses' office and also on the patients' notice boards. Over 90% of staff had up to date safeguarding children and adults training. Sixty seven safeguarding alerts had been raised by staff across the four wards in the preceding year.
- There were appropriate arrangements for the management of medicines. Staff gave patients information about their medicines. There were no errors or omissions in the recording of medicines dispensed. If patients had allergies, these were listed on the front of the prescription chart. All medicines patients needed were available. We looked at the ordering process and saw the process for giving patients their regular medicines. All medications checked were in date. There were good processes and procedures in place on the ward in relation to medication reconciliation. This is where the ward staff would contact general practitioners on admission, to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward. This meant patients were provided with their prescribed medicines promptly. Staff discussed medicines in multidisciplinary care reviews. A pharmacist visited each of the wards daily and carried out routine audits to ensure that staff were managing medicines safely. Patients at risk of side effects from taking high dose antipsychotic medicines were monitored. Medicine to be given when required, were prescribed for patients appropriately and staff regularly reviewed and discontinued them if no longer needed. Medicines to be given to patients detained under the Mental Health Act were documented accurately. Forms were always signed by the consultant overseeing the patient's treatment, by the patient, if they had capacity to do so or by a second opinion appointed doctor.
- However, if any high dose antipsychotic medicine was prescribed, this was not noted on the front of the medicine administration record, to easily alert any nurse administering medicines.
- Staff used clear protocols for patients to see their family and children. Each request was risk assessed. Age appropriate toys were available in well-furnished visitors' rooms, near but off all of the ward areas. Harvest ward had access to its own visitors room that was nicely furnished and equipped.

Track record on safety

- In the preceding year to our inspection, there had been seven serious untoward incidents involving the acute and psychiatric intensive care wards.
- Staff shared risks in the daily handover meetings in a written handover to all staff. The handover was recorded on the electronic system. In addition each ward carried out a daily 'safety huddle' which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards. The meetings involve all available staff to discuss specific patients' risks and any potential harm that may affect patients.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the providers' electronic recording system. Incidents and

Good

Are services safe?

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

lessons learnt from incidents were shared at the wards' daily 'safety huddle' meetings. Incidents were presented in a monthly summary report which detailed when incidents took place and what had occurred. Staff gave us examples of incidents reported and lessons learnt relating to restraints, patient absconsions, the use of rapid tranquilisation, self-harm, assault, verbal abuse, and inappropriate behaviour. The trust implemented a debriefing policy following incidents and staff confirmed these took place. Staff also debriefed patients following incidents. The trust sent a learning bulletin to staff each month.

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.

Our findings

Assessment of needs and planning of care

- All patients had detailed and timely assessments of their current mental state, previous history and physical healthcare needs. The care plans were recovery focused. Patients told us that they were included in the planning of their care. All patients had a 72 hour care plan completed, following admission. A physical examination was carried out for all patients on admission and included a routine blood test and electrocardiogram.
- Patients told us that they were included in the planning of their care. All of the wards had implemented the, 'about me' workbook. This initiative encouraged patient engagement and a recovery focussed model of care. The aim of the 'about me' workbook was to help patients develop their own understanding of their problems and to plan their journey towards recovery. The understanding happened when staff met with patients, to think about their difficulties, strengths and the important events in their life and to share ideas about the patients' journey towards recovery.
- All care plans were stored securely on the electronic recording system and were accessible to all staff as required.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE in the delivery of the therapeutic programme, that included nationally recognised treatments for patients. Patients had access to a range of psychological therapies such as cognitive behaviour therapy, occupational therapy, drama and movement therapy, music therapy, art therapy, dialectical behavioural therapy and these were delivered via one to one sessions and in groups. Patients told us therapies had helped to decrease their anxiety and had equipped them to address their issues and journey to recovery.
- Staff described how they developed complex physical health care plans. Over 80% of staff had received training in assessing and effectively managing physical health care needs. Staff supported the integration of mental and physical health and staff developed comprehensive care plans that covered a range of physical health conditions such as diabetes, cardiac conditions, cancer, incontinence, addictions and breathing problems. On harvest ward, staff carried out physical health observations for all patients every day using the national early warning score.
- There was an occupational therapy team across the wards. The team consisted of occupational therapists, sports therapists, and occupational therapy support staff. On Fletcher ward we attended a group facilitated by the occupational therapist to manage the discharge of patients. The group was attended by a housing officer, benefits advisors, community psychiatric nurses, and representatives from the rehabilitation services.
- A number of nurses on the wards were trained in Dialectic Behaviour Therapy which is a therapy designed to help people change patterns of behaviour that are not helpful, such as self-harm. Some staff had basic counselling and cognitive behavioural therapy skills and staff were keen to give patients talking time. A mindfulness practitioner also visited the wards weekly and provided therapy sessions.
- Staff assessed patient's nutrition and hydration needs and developed care plans if needed. Health care assistants had received specific training to enable them to effectively monitor nutritional and hydration needs.
- Staff used the recognised rating scales known as the 'health of the nation outcome scale' to assess and record outcomes. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- Staff engaged in clinical and management audits. These included ensuring good physical healthcare for patients, risk assessing ligature risks on the wards, reviewing enhanced observations, ensuring patients had positive behaviour support plans and reducing the use of seclusion. Staff audited risk assessments and care plans to ensure quality and completion.
- Staff representatives from each ward, senior clinicians and managers attended the monthly ward assurance meeting to review clinical effectiveness and looked at, for example, models of care, quality of care records, physical health promotion, consent, audit and research.

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Skilled staff to deliver care

- The staff across the wards came from various professional backgrounds, including medical, nursing, occupational therapy and psychology. Staff were experienced and qualified to undertake their roles to a high standard.
- All staff, including bank and agency staff received a thorough induction into the service. The care certificate standards were used as a benchmark for health care assistants. These standards set out the skills and knowledge required by staff.
- Staff received appropriate training, supervision and professional development. Staff were encouraged to attend additional training courses. For example, ward managers were encouraged to undertake leadership courses and staff had received training on working with patients with a personality disorder. In addition staff had undertaken courses, for example, in counselling, psychological therapies, physical healthcare conditions and family therapy. We met two staff who had been health care assistants and had subsequently been supported to undertake and successfully complete their professional qualification in nursing.
- In our previous inspection in 2015 we had concerns that not all staff had received regular supervision. During this inspection staff said they received individual and group supervision on a regular basis as well as an annual appraisal. Over 90% of staff had received regular supervision. All staff participated in regular reflective practice sessions to reflect on their practice and incidents that had occurred on the wards. The number of staff that had had an appraisal was 98% against the trust target of 85%. The appraisals included objectives that incorporated the trust key values. The revalidation of the medical staff was up to date.
- Ward managers told us they were performance managing a small number of staff for capability issues at the time of our inspection, and were well supported by their human resources staff.
- Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed to complete their role and they were well supported.

Multi-disciplinary and inter-agency team work

- Well-staffed multidisciplinary teams worked across the wards. Regular team meetings took place. We observed care reviews and staff handover sessions and found all of them to be effective.
- Staff worked with other agencies. There were links with primary care (doctors, pharmacists, physiotherapists, podiatrists, and dieticians), mental health crisis and home treatment teams and housing organisations being particularly positive examples.
- Nurses said it was difficult to organise so many clinical meetings on the wards at the same time, due to having between six and 16 different doctors looking after their patients on the wards at any one time.

Adherence to the MHA and the MHA Code of Practice

- Over 83% of staff had received updated training on the Mental Health Act, including the revised Code of Practice. Staff knew the Mental Health Act, their responsibilities with the application of the Act and patients' rights under the Act.
- We looked at 15 care record files of patients who were detained under the Mental Health Act. The Mental Health Act documentation was present and available in the files. Each ward maintained an updated patient board that detailed when rights should be repeated for each patient. This information was audited every week.
- There was active involvement of the independent mental health advocacy (IMHA) service, and information about the service was displayed on information boards in communal areas.
- Patients were encouraged to contact the Care Quality Commission if they chose to about issues relating to the Mental Health Act. This was contained in the information folders given to all new patients.
- The Mental Health Act administrators on each site monitored requirements and compliance with the Act and Code of Practice, daily. Bi annual audits were carried out on accuracy of consent certificates (known as T2 and T3 forms), medication charts and section 17 leave documentation.
- Copies of up-to-date section 17 leave forms were kept electronically and in files accessible in the nurses'

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offices. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. These were regularly reviewed and updated. Staff recorded who had been given copies of the section 17 leave forms.

- Assessments of patients' capacity to consent to treatment were available. We found that both T2 and T3 certificates were reviewed in line with the trust's policy. These certificates show that patients detained under the Mental Health Act had the proper consent to treatment forms in place.

Good practice in applying the MCA

- Ninety eight per cent of staff had received training in the Mental Capacity Act as part of their mandatory training in the preceding year to our inspection.
- The quality of documentation in the care records in regards to capacity to consent to treatment was of a variable standard. Staff could not tell us, where in the documentation, discussions on decision specific 'best interests' assessments had taken place.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Patients we spoke with in all of the wards were complimentery about the staff providing their care. Patients told us they got the help they needed to assist their recovery. Patients told us they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us staff were nice and were interested in their wellbeing.
- Patients said staff; whilst very busy, were available for them most of the time. We saw staff treating patients with compassion and care. Patients told us staff were consistently respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we saw positive interactions between staff and patients. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.
- Staff showed patience and gave encouragement when supporting patients. Patients told us they were the priority for staff and that their safety was always considered. One patient became distressed and agitated and staff intervened gently and in a kind and pleasant way. The intervention calmed the patient considerably and they were able to continue with the task they had been carrying out.
- The staff from the acute wards and psychiatric intensive care unit received 97 compliments in the previous year.
- The atmosphere throughout the wards was calm and relaxed. Staff were particularly patient focused and not rushed in their work so their time with patients was meaningful. Staff were able to spend time individually with patients, talking and listening to them. All patients said they had regular one to one time with staff during the day and night and we saw staff were responsive when approached by patients.
- All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences.
- Patients had access to multi-faith rooms and a variety of spiritual support.
- The privacy windows in the bedroom doors on Harvest ward did not afford patients privacy and dignity. Patients were not able to close the blinds, when they were in their bedrooms. The doors and blinds had been scheduled for replacement soon after our inspection.

The involvement of people in the care they receive

- Staff told us about their approach to patients and the model of care practiced across all of the wards. They spoke about enabling patients to be as well as possible in order to resume their lives back in the community. Staff were non-judgemental towards their patients and empowered them to encourage their involvement in their care.
- Patients received a comprehensive welcome pack on admission to the wards. The welcome pack gave detailed information to patients. This included information about health needs, the multidisciplinary team, care and treatment options, medication and physical health needs and care plans. We found the folder helped to orientate patients to the service and patients commented on it positively. On all of the wards a reception area had been created, called 'welcome areas' where information about the ward was available and there was art work displayed which had been produced by patients which created a calm and cordial environment.
- There was evidence of patient involvement in the care records we looked at and all patients had either signed a copy of their care plans or said they did not want to sign the plans. Staffs' approach was person centred, individualised and recovery orientated. Patients reviewed their care plan at least once every week with the multidisciplinary team. Patients told us they were involved with their treatment and care planning. We attended two care reviews and patients were fully involved in discussions about their care and treatment.
- Local advocacy services were advertised on notice boards and in patient welcome packs.
- Patients told us that their families were included in their care planning. Each ward had an information board for carers that included, for example, information on how to raise a concern. Information leaflets were made available to relatives and friends and regular information sessions were available at all of the hospital

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sites. The wards had embedded the 'triangle of care' initiative that attempts to improve carer engagement in acute inpatient units by ensuring staff worked closely and in partnership with families and friends.

- Patients could become involved in their care. Each ward held a daily planning meeting where patients discussed the routines for the day and allocated staff and patients to carry out tasks and achieve goals throughout the day. Each week the wards held a business meeting where suggestions could be made of how to improve the services or where patients could raise any concerns they had. The trust encouraged feedback from patients and satisfaction surveys were available for patients to complete on every ward. On each ward a 'you said we did' initiative was advertised on patient information boards and gave examples of staff making changes on the wards in response to patient requests. For example, the Fletcher ward garden area had been completely re-designed in response to patient feedback. Patients on the acute wards could use their mobile phones and activities had been increased over weekends to avoid patients becoming bored or unstimulated.

Are services responsive to people's needs?

Good

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

Our findings

Access, discharge and bed management

- Bed occupancy for the three acute wards and psychiatric intensive care unit ranged from an average of 45% to 132% for the previous 12 months. Harvest ward had the lowest average bed occupancy, usually below 90% which meant there was always bed availability on the psychiatric intensive care unit. The three acute wards always had bed occupancy above 100% which meant there would not be beds available if a patient returned from leave unexpectedly. The occupancy figures were inflated due to a number of patients who were on extended leave under Section 17 of the Mental Health Act. Whilst on long term leave, patients were supported by the community mental health teams and/or the home treatment teams. Referral of patients to the wards was always via the crisis and home treatment teams. The average length of stay on the three acute wards ranged from zero to 229 days however, these figures were inflated due to those patients on extended leave arrangements. The Harvest ward average length of stay was 12 weeks.
- There had been 98 patients placed on acute wards and 10 patients placed on a psychiatric intensive care unit out of area in the preceding year. At the time of our inspection there were no patients placed out of area.
- There had been four delayed discharges from the wards in the previous year.
- Patients told us how staff were helping them to achieve the goals set in their discharge plans.

The ward optimises recovery, comfort and dignity

- The wards had a variety of well furnished rooms for patients to use including quiet lounges. A selection of interview and group rooms were available. The wards at Longreach house were bright and airy and the quality of the environments were superior to the wards at Bodmin hospital. For example, maintenance requests were dealt with quicker at the Longreach house site. Both sites were managed by a Private Finance Initiative (PFI) company and the trust was in discussion with the Bodmin site PFI company to try to improve the maintenance and overall management of the building.
- All of the units had kitchen areas, however on Fletcher and Harvest wards the kitchens were locked and only used under staff supervision, as they were assessed as too high risk to be kept open. Patients had access to hot drinks which were brought out regularly on a trolley. Snacks and fruit were readily available on all of the wards. The majority of patients said the quality of food provided was good. The Bodmin hospital site scored 96% for quality of ward food in the 2016 patient-led assessment of the care environment, which is better than the England average of 92% and the overall trust score of 93%.
- All of the units had attractive and large garden areas.
- Patients could make private phone calls and had access to their own mobile phones on the three acute wards. There was a policy available on mobile phone use and patients signed a contract, for example, agreeing not to use cameras. A communal phone was available for patients on harvest ward to use privately.
- Patients' bedrooms were personalised if this is what they wanted to do, with for example their photos and personal items on show. Patients could access their bedrooms at any time. Patients were able to securely store all of their possessions in their bedrooms in a locked cupboard.
- There was an activity and therapy programme running all week from Monday to Sunday on every ward. Patients told us that the activities available were offered flexibly and according to the interests and wishes of the patients. There were dedicated therapy staff providing this programme and staff engaged in these activities. We joined a number of these activities, such as breakfast cooking, art, music and craft sessions, during our inspection visit. Alongside the therapy and treatment programmes, additional activities were available throughout the week such as pampering and going for local walks.
- The privacy windows in the bedroom doors on Harvest ward did not afford patients privacy and dignity. Patients were not able to close the blinds, when they were in their bedrooms. The doors and blinds had been scheduled for replacement in November 2017, soon after our inspection.

Meeting the needs of all people who use the service

- Accessible bath, toilet, and shower facilities were provided on all wards and they were all in keeping with single sex accommodation guidance.

Are services responsive to people's needs?

Good

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

- Staff told us that information could be made available in different languages as required by patients using the services. Information was available on interpreters.
- There was information available on treatments, therapy, local services, patients' rights and how to complain. The information boards in all of the wards were displayed creatively and contained relevant and updated information for staff, patients and relatives. All units had photographs of the staff to show patients who they were and what their roles were.
- Welcome packs of all of this information were available for patients. Some of the wards personalised information packs, others made a pack available in each bedroom. The welcome packs contained information about the various care pathways and treatment options available.
- Patient information leaflets on equality and diversity were available on all wards. Examples were given showing patients how their individual and unique needs could be raised and met. There were leaflets about how patients' needs could be supported with their religion, ethnicity, race, traditions, sexuality, disabilities and food preferences.
- A choice of food was provided to meet patients' religious and ethnic requirements. Some patients told us that the choice of vegetarian diets was sometimes limited.
- Patients had access to spiritual support. Staff would contact the spiritual support team if a patient wanted to see a priest or spiritual leader from another faith.

Listening to and learning from concerns and complaints

- There were nine complaints in the year prior to our inspection and the provider partially upheld three of them. This showed us that the provider was fair and transparent when dealing with complaints. The acute wards and psychiatric intensive care unit accounted for 8% of the total amount of complaints received by the trust. Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example, improving communication between staff and carers in relation to care planning. This prevented misunderstandings so that all parties could work together towards therapeutic aims and improved communication between organisations to ensure a timely and effective discharge.
- Copies of the complaints process were on display on the information boards on the wards and in the ward welcome packs. Patients we spoke with all knew how to make a complaint, should they wish to do so. Information was also available on how patients could contact the Care Quality Commission should the patients wish to do so.
- Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.
- A community meeting was held every week on each ward and patients set the agenda. Staff were responsive to suggestions made by patients. For example weekend breakfast cooking groups were started on Harvest ward , African drum music sessions were arranged on Fletcher ward on a regular basis and pamper sessions were organised every week on Carbis and Perran wards.

Are services well-led?

Good

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

Our findings

Vision and values

- The trust's vision, values and strategies for the service were evident and on display on information boards throughout the wards. Staff we spoke to understood the vision and strategic objectives of the organisation. Staff felt very much a part of the service and were able to discuss the philosophy of the wards. Staff told us that the purpose of the wards was to offer and deliver high quality treatment and therapy programmes to patients to aid their recovery.
- The wards' senior management team had regular contact with all staff and patients. The senior management and clinical teams were visible to staff and staff said senior management regularly visited the services. All staff and patients knew who the senior management team were and that they felt confident to approach them if they had any concerns.

Good governance

- Ward staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly in a key performance indicator dashboard, called the performance and information monitoring report. The operational assurance group scrutinised this document and sub-groups looked at various issues of quality and quality developments. These groups were structured around the Care Quality Commission key questions and focused on different aspects of the services. Ward managers, senior managers and senior clinicians attended this monthly meeting where they looked at patient safety, patient experience and staff management. This meant that the management team were able to receive assurance and apply clear controls to ensure the effective running of the service.
- Staff received their mandatory training, supervision and appraisals. There were sufficient suitably trained staff available on every shift in each ward to deliver good care to patients.
- Clinical audits were regularly carried out to ensure treatment and therapy was effective. Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.
- The leadership of the service enabled the ward to develop in response to feedback. Staff encouraged patients to make suggestions to improve the service. The wards carried out 'you said we did' meetings, gaining the views of patients on service improvement. In addition monthly carer and family days were held so that families could meet the staff providing the care and ask questions about care and treatment. Patients told us about improvements made as a response to their suggestions, for example an improvement in food and menu choices, improved staff attitude and a more extensive activity programme made available over the weekend periods.
- Ward managers and senior clinical staff told us they felt they had the autonomy and authority to make decisions about changes to the service. They commented that they felt very well supported.
- Staff showed us the ward operational risk registers. Staff told us they could submit items of risk for inclusion on the risk register. The risk register had inclusions from all the wards and support services, which showed risks were escalated appropriately from all areas of the service. High risk entries on the risk register included recruitment and retention, ligature risks, patient absconsions and cleanliness.

Leadership, morale and staff engagement

- Staff spoke highly about their management teams and there was evidence of clear leadership at ward level. The ward managers and service manager were visible on the wards during the day-to-day provision of care and treatment. They were accessible to staff and they were proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improving care.
- Ward staff were enthusiastic and engaged with developments on the wards. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of patients and said this had been received positively as a constructive challenge to ward practice.

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.

- The trust had set up a 'care awards' and 'excellence report' schemes when staff were nominated for going above and beyond what was expected of them at work, this further increased staff morale and well-being.
- Staff told us that staff morale was high on the wards. They also told us how they were being supported in their professional development.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- Staff participated in clinical audits to monitor the effectiveness of services provided. They evaluated the effectiveness of their interventions. The initiatives were summarised in the service line quality accounts and included, for example, reducing the need for restrictive practices, therapeutic engagement and observation, positive behaviour support planning, non-contact physical observations, implementing a sexual safety assessment tool, suicide prevention, and reducing chemical interventions.