Garrow House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall summary

We did not review the rating of this service as we had conducted a focused inspection in response to risk. Garrow House de-registered with the CQC on 27 August 2020.

- The service did not provide consistently safe care. The ward environment was not safely maintained, and they had not responded in a timely manner to environmental risks. The service was unable to demonstrate that all staff were trained to an appropriate level to safely carry out their role, including in safeguarding, immediate life support and the use of restraint. Staff did not always assess and manage risk well, there were a high number of incidents within the service and they did not always conduct appropriate checks following head injuries.
- The governance oversight had not been effective in identifying and responding to documentation errors. The service made multiple errors and omissions in patient documentation; including observation records, restraint documentation, post-rapid tranquilisation forms and patient allergy information. They had not reported statutory notifications to the appropriate professional bodies within the appropriate timeframes. Staff did not feel supported by Turning Point as a provider.
- The provider had not fully addressed all the concerns identified in the warning notices issued following our inspection on 28 and 29 January 2020. As the provider closed the service and de-registered the location on 27 August 2020, we did not take further enforcement action for this concern.

However,

- The wards had enough nurses and doctors on shift who were familiar with patients despite the staffing difficulties they had faced. There had been recent improvements to incident documentation and safeguarding following increased oversight from the

Summary of findings

risk and assurance team. Staff felt supported by the service-level management team and they continued to strive to improve the service up to the date of their closure.

Summary of findings

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Summary of this inspection

Background to Garrow House

Garrow House was a specialist tier four personality disorder inpatient hospital that admitted female patients from the Yorkshire and Humber region. The hospital had 12 beds. At the time of inspection, the hospital was providing care and treatment for four patients.

Garrow House had been registered with the Care Quality Commission since 13 December 2010, as a shared enterprise between Turning Point and an independent Mental Health hospital. Garrow House changed their registration on 1 April 2019 to have Turning Point as the sole provider. They were registered to carry out two regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983, and
- treatment of disease, disorder, or injury.

The hospital de-registered with the CQC on 27 August 2020.

Garrow House was part of the Turning Point Group. The hospital did not have a registered manager or controlled drug accountable officer in place at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager has a legal responsibility for meeting the requirements and associated regulation in the Health and Social Care Act 2008. An accountable officer is a senior person, required by law, with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse.

The hospital had been inspected on one previous occasion under their current registration. A comprehensive inspection of the service was conducted 28 and 29 January 2020. The service was rated inadequate overall; receiving an inadequate rating in the safe and well led domains; requires improvement in the effective and responsive domains and a good rating in the caring domain. The service was placed in special measures and a section 29 warning notice was served under Regulations 12 and 18 of the Health and Social Care Act (Regulated Activities) 2014. This stated that care and treatment was not provided in a safe way for service users; the provider did not do all that was reasonably practicable to mitigate any such risks; or ensure that there were enough suitably qualified, competent, skilled, or experienced persons with appropriate training to enable them to meet patients' care and treatment needs in a safe way.

The provider also received requirement notices under Regulations 13 and 17 of the Health and Social Care Act (Regulated Activities) 2014 following the 28 and 29 January 2020 inspection. This was because systems and processes were not established or operated effectively to prevent abuse of service users and were not necessary to prevent, or proportionate to the risk of harm posed by patients. They did not ensure that they assessed, monitored and improved the quality and safety of the service, or the health, safety and welfare of patients and others who may be at risk within an appropriate timescale.

We did not review all of the concerns raised within the previous inspection report as this was a focused inspection conducted in response to risk information, not a comprehensive review of the service. While there had been areas of improvement, there continued to be concerns regarding the provider's response to patient risk, the training of staff and the provider's governance processes. We also had concerns regarding the suitability of the premises and the provider's delay in sending statutory notifications to the CQC and local authority.

Our inspection team

The team that inspected Garrow House comprised of two CQC inspectors.

Summary of this inspection

Why we carried out this inspection

We inspected this service in response to concerns received regarding the hospital premises, provider response to patient risk, delayed notification of serious injuries and inconsistencies in governance information provided regarding staffing numbers and training figures. At this focused inspection we reviewed these specific concerns, which related to the safe and well led key questions.

How we carried out this inspection

In response to information of concern, we conducted a focused inspection of the service. We asked the following questions of the service:

- Is it safe?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information. During the inspection visit, the inspection team:

- looked at the quality of the hospital environment and observed how staff were caring for patients;
- spoke with two patients who were using the service;
- spoke with six staff members; including the operational manager, senior staff nurse, senior support worker, bank staff, involvement lead and social worker; we were also contacted by one further staff member within the inspection period;
- received feedback about the service from care commissioners and external stakeholders;
- looked at four patients' care and treatment records, risk assessments and management plans;
- carried out a specific review of the service's incident data and corresponding patient records for six patients and reviewed five post rapid tranquilisation monitoring forms;
- carried out a review of the medicine cards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During inspection we spoke with two patients. They were positive about the regular staff who had remained at the service and reported to be sad about the hospital's closure. They stated that the increased reliance on bank and agency staff had reduced the quality of interactions.

Both patients reported that they had been hurt in incidents of restraint due to inappropriate holds being used; that there was a high application of medicines following incidents and that they did not receive debriefs. We were informed that staff occasionally missed observation intervals due to incidents. Patients also informed us of ward maintenance issues that had gone unresolved and errors in Section 17 leave forms had impacted on access to leave.

Both patients reported anxiety about the hospital's imminent closure and felt that there had not been adequate information given by the provider or from stakeholders. They spoke fondly of their earlier experiences of the hospital and the former management team and reported that they had not had adequate support, visibility, or response to their complaint from the current manager.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not review the rating of this service as we had conducted a focused inspection in response to risk.

We found the following areas that required improvement:

- The ward environment was not safe, well maintained or fit for purpose. They had not acted promptly in response to environmental risks or maintenance concerns; including risk of absconsion from the garden, issues with the water temperature in the service, or maintenance of patient bedrooms.
- There was not always enough suitably trained staff on shift. Not all senior nurses were trained to the appropriate level in safeguarding, and multiple agency and bank nurses had not completed essential training such as immediate life support.
- Staff did not assess and manage risks to patients well. The service had a high number of serious incidents. There was a concern that staff had not responded robustly in response to repeated patient incidents and there was limited evidence of physical observations being taken following head injuries. There were also gaps in patient observation records and allergies had been omitted on two patients' second medicine cards.
- Restraint was not consistently carried out or documented appropriately. Three patients had been hurt during the use of restraint in the month of inspection due to unapproved techniques being used or the patient's care plan not being followed. The service was unable to evidence that appropriately trained staff were involved in restraint incidents.

However,

- The service was clean and welcoming and appropriate infection control measures had been introduced in response to Covid-19.
- Staff demonstrated a good understanding of the patients and staff received a comprehensive handover between shifts. Managers investigated incidents and shared lessons learned with the team. There had been improvements to the service's safeguarding processes following the introduction of a new social worker.

Are services well-led?

We did not review the rating of this service as we had conducted a focused inspection in response to risk.

Summary of this inspection

We found the following areas that required improvement:

- Our findings from the safe domain demonstrated that governance processes did not consistently operate effectively. There were errors or omissions in patient documentation, including: restraint information, post-rapid tranquilisation monitoring forms, patient observation records, two patients' MHA status within care records, and allergy information. There was a lack of appropriate action following environmental audits and the service had failed to submit statutory notifications within the appropriate timeframes.
- Documentation regarding mandatory training compliance and staffing levels was inconsistent and unclear. There was a discrepancy between the provider's records and the service's records for the number of staff trained in physical restraint, different training requirements were listed for staff of the same role and staff were listed as holding different roles on different documents.
- Staff expressed a lack of support and respect from Turning Point as a provider. Staff and patients also spoke of feeling a lack of transparency from the provider as well as external stakeholders regarding the closure of the service, which had led to distrust. Patients felt that their complaints were not responded to appropriately by the service manager.

However,

- The new service leaders had the knowledge and experience to perform their roles; they had entered their roles at a difficult time for both the patients and staff team. Staff felt able to raise concerns without fear of retribution and had a good understanding of duty of candour. Staff felt able to approach managers with concerns.
- Staff felt respected, supported and valued by their peers and the service-level management. They were proud of the work they had achieved and their recent progression with patients and were disappointed that they had not been given further opportunity to improve the service.
- There had been improvement to some governance processes, including incident information, since new processes had been introduced and there had been increased oversight from Turning Point's risk and assurance team.

Personality disorder services

Safe	
Well-led	

Are personality disorder services safe?

Safe and clean environment

Staff completed and regularly updated risk assessments of the ward area. Staff described higher risk areas, such as blind spots and the patient kitchen, and explained how they used observation to mitigate risk, including risks specific to individual patients. However, wider environmental issues were not identified.

Environmental risks in the garden had not been responded to in a timely manner. An environmental risk audit carried out by the provider on 25 June 2020 stated that "it was clear that service users attempt to abscond the service by escaping over the fence; however although this was a common knowledge no further risk assessments were completed to manage this risk and no remedial actions were identified, effectively resulting in a service user breaking their ankle while attempting to clear the fence." This had been a concern raised at the previous inspection. At the time of this inspection, the previous risk management strategies had remained in place and the garden bench had been secured to the ground. No further action had been taken in response to the concerns raised regarding the fence.

Patients did not have continual access to hot water. An incident report was completed on 3 January 2020 that stated that patients did not have access to hot water in their bedrooms. Work to try to rectify this concern was carried out on 16 June 2020 but records after this date show that water temperature was still "erratic" due to air blockages in the system. The health and safety executive states that hot water should reach "a temperature of 50°C (55°C in healthcare premises) within one minute at the outlets". A temperature of above 50°C was only recorded seven times during water and maintenance audits conducted between 25 February and 14 July 2020, six of these occasions were in the sluice rooms. During the same period, there were 17 checks conducted in the two bathrooms patients accessed while their showers were out of order; all 17 checks ranged between 29°C and 42°C and on six occasions the hot water was below body temperature. The service had conducted legionella tests which had concluded that the service did not have legionella within the system.

Ward areas were not well maintained or fit for purpose. For example, between 31 March and 14 July 2020, the maintenance audit for bedroom 12 stated "sink blocked and door doesn't shut" on every weekly check and bedroom 11 reported that the "bedroom door [was] broken" on seven consecutive checks. Both rooms were occupied by patients. Patients spoken with raised multiple concerns about the maintenance of the premises and stated "things don't get fixed".

We were informed by the service that there could be difficulties resolving maintenance concerns as the property was rented from a separate organisation. There was evidence, for example, that the service had raised the concern regarding hot water repeatedly to the landlord. While it was evident that this arrangement had caused Garrow House difficulties in responding to maintenance concerns; as the care provider, Garrow House had a responsibility to ensure that an appropriate care setting was provided. This could not be evidenced as having been met while patients did not have reliable access to hot water and were unable to close their bedroom doors properly.

Staff were observed to adhere to infection control principles, including handwashing. Cleaning records were up-to-date, and the premises appeared clean. The decoration and furnishings were homely and comfortable. However, the sofas in communal areas did not adhere to infection control guidance as they were not easy-clean material.

The service had introduced appropriate processes to manage infection control in response to Covid-19. They had a "donning and doffing" station had been established in the hospital entrance and staff were observed to wear face masks in patient areas, in line with Public Health England guidance.

Staff had easy access to alarms and patients had easy access to nurse call systems in their bedrooms. There was evidence within patient records of patients using this to request assistance.

Safe staffing

The service had a high number of nurse vacancies. They had seven vacancies of an establishment level of 10 senior nurses; one of the remaining three senior nurse was still employed but had taken a period of absence. The provider was in the process of closing Garrow House at the time of inspection which had had a large impact on staffing figures and, with decreasing patient numbers, there was no opportunity to replace the nurses who had left. The service had maintained a full establishment of support workers. They had 15 support workers or senior support workers still employed within the service, a number of whom had recently started their employment.

The manager had maintained staffing levels in line with their safe staffing model. We reviewed the rotas between 1 and 25 July 2020, managers had calculated the number and grade of nurses and healthcare assistants required and the rotas demonstrated that the service was routinely staffed in line with their staffing matrix. They mitigated the high number of nurse absences with a high use of bank and agency. Staff rotas demonstrated that Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.and bank staff spoken with during inspection said they had had a period of shadowing prior to working on their own.

There was always members of staff available in communal areas during our visit. At the time of inspection, the nursing team were attending multiple meetings to discuss patient discharges in anticipation of the service closing. However, there was always a qualified nurse available for patients should they require support or assistance. One patient was detained under the Mental Health Act during our visit, they reported that Section 17 leave was facilitated but had recently been impacted by an administrative error on their Section 17 leave form. This had been rectified at the time of inspection.

The patients stated that support had decreased with the increased reliance of agency staff. When asked what happened following incidents, both reported that there was a high use of medicines given, one patient spoken with said that they would fall asleep “because they always give you med[icine]s” and reported that staff had never provided a debrief following a serious incident.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The consultant was on site 3 days and worked from home for two. There was evidence within incidents that staff were able to seek support from a consultant during evenings and weekends and that they had visited the service when required.

The manager aimed to have three staff trained in the use of physical restraint on each shift. Two night-shifts only had two restraint-trained staff on shift, one of these shifts was due to staff sickness. We were informed by the operational manager that it could be difficult to find enough staff trained in physical restraint due to the reduced staffing numbers, sickness, and the training difficulties produced by Covid-19 restrictions; but that they had always ensured there were adequate trained staff on shift and staff would only work within their competency. This was supported by two new staff members who stated that they had been involved in incidents, but that the designated response team had been involved in any physical restraint techniques. There was evidence within weekly staffing meetings that the rota was regularly reviewed to ensure there were suitable numbers of trained staff appointed.

However, the service could not evidence that they had enough staff on each shift to carry out any physical interventions safely. This was because the restraint response team had been allocated according to the training compliance listed within the staff rota. This did not correspond with the mandatory training compliance supplied by the provider, which reported that 13 fewer staff had completed training in the use of physical restraint than the rota recorded. In the 13 restraint incidents in which restraint is recorded, 11 listed a member of staff being involved who was not documented as having had restraint training according to the provider’s mandatory training figures.

Staff appeared to have completed and kept up-to-date with their mandatory training, but the training listed was not always consistently applied or appropriate to role. According to the mandatory training figures sent by the provider on 3 July 2020, senior staff nurses had attained

compliance of 80%, senior support workers had completed 70% and support workers had completed 52%. The low figures for support workers was partly due to a number of new starters, who had been given six-months to complete training. However, the data provided listed different mandatory training requirements for staff of the same role in some instances. For example, different safeguarding training levels were listed as mandatory for senior staff nurses. Equally, one agency nurse who was regularly the nurse in charge on a night shift, was not documented as having completed training in immediate life support.

Assessing and managing risk to patients and staff

Staff used a recognised risk assessment tool but was not updated regularly to remain reflective of current risks. We reviewed four patient care plans and risk management plans. The patient risk summaries documented all incidents that had occurred for that patient, in chronological order. However, these were only updated when the risk documented was reviewed, which was scheduled to be quarterly, meaning the information in the file would not always be contemporaneous.

Patients' risk management plans reflected the risks identified within their risk assessments and there was evidence that they were written collaboratively with the patients. They identified things that could lead to an increase in risk, ways for staff to identify that risk had increased, and preferred methods of support and de-escalation. There were errors in two of the patient files, as they made reference to the patient being detained under the Mental Health Act when they had been made both recently been made informal.

Staff had a good understanding about risks to each patient, but the frequency and severity of self-harm incidents led to concerns around actions taken to reduce these risks. Between 1 and 25 July 2020, the service recorded 49 incidents involving seven patients. Not all forms listed single incidents, some listed separate incidents within one incident record. For example, over the course of six incident records for one patient, 14 separate incidents of self-harm were mentioned.

We had particular concerns regarding staff response to patients who had banged their head. Between 1 and 25 July 2020 there were 13 incidents in which a patient banged their head. Physical observations were only recorded as having been taken following three of these. The consultant confirmed that this was expected of staff and staff spoken with said that they would seek to check the patient's physical observations. However, this was not recorded as having taken place within patient records. This was raised to the operational manager during inspection and assurance was sought following inspection that this had been addressed.

Staff did not always follow the provider's observation policies and procedures to keep patients safe from harm. Observation records had multiple timeframes in which entries had not been made. For example, on the 25th July 2020, four patients had no observations recorded between the hours of 16:00 and 17:00, one patient should have been observed at 10-minute intervals during this timeframe. Patients informed us that staff sometimes missed observation checks when there was an incident happening on the ward. This was supported by omissions on some observation records. For example, there were omissions in patient observation records on 15 July 2020 between 18:00 and 20:00, and 25 July 2020 between 13:00 and 14:00; both periods in which incidents were recorded as happening. This concern was also raised to the operational manager during inspection and assurance was sought following inspection that this had been addressed.

Of the 49 incidents recorded between 1 and 25 July 2020, 13 recorded the use of one or more episodes of restraint and two recorded the use of rapid tranquilisation. Of the 13 incidents involving the use of restraint, there were no incidents of prone restraint. There were no incidents of seclusion or long-term segregation within the period. Most incident records demonstrated that staff had attempted verbal de-escalation prior to the use of physical restraint.

There were errors and omissions in multiple restraint records. Of the 13 reviewed; two restraint records did not list all staff involved in the incident form; three did not list all episodes of restraint listed in the incident form; three did not list the duration of the incidents and four did not specify which holds had been used.

Three patients reported that they had been injured during restraint during the month of July 2020. Two patients reported that members of staff had used unapproved restraint techniques during incidents. One patient described the experience as "undignified". In all three restraint incidents in which a patient reported to have been

hurt or that incorrect techniques had been used, at least one member of staff involved in the restraint was not recorded as having completed restraint in the provider's mandatory training figures.

We reviewed the documentation for these three incidents. One patient's care plan specified that the patient had a preferred restraint hold that should be used due to an existing injury; however, the restraint documentation recorded that staff did not use the hold specified within the care plan during the incident, which had exacerbated the patient's existing injury. The incident and restraint documents for the other two incidents were not appropriately completed by staff. One restraint document recorded the duration as "on and off as required", did not specify the holds used or duration of each hold, and had fewer staff listed as involved in restraint than in the incident form. The second restraint form recorded both the start and end time for the restraint as "20:00", recorded that fewer staff had been involved in restraint than the incident document, that one member of staff had utilised a restraint technique on their own, and it did not mention the further use of restrain that had been described in the incident form. We discussed this incident with staff during inspection and were informed that a staff member had been involved in restraint who was not listed in either the incident or restraint documentation.

Incident records demonstrated that patients were offered oral medication prior to rapid tranquilisation being administered. However, there were errors or omissions in all five post rapid tranquilisation monitoring forms. For example, one form only had one physical observation recorded as being attempted, the form made note of arousal level but not the timeframe for this observation.

Safeguarding

Prior to inspection significant concerns were raised regarding staff understanding of safeguarding principles and reporting of safeguarding alerts. Turning Point had recruited a new part-time social worker to Garrow House in May 2020. At the time of inspection, they were reviewing all incidents that had occurred since 1 January 2020 and we were informed that 24 incidents had been identified that had not been raised as a safeguarding at the time that they had occurred. We were informed that these alerts had been retrospectively raised to the local authority but had still not been received by the CQC when the hospital de-registered (27 August 2020). The social worker had also introduced a tracker to enable staff to monitor the progress of safeguarding alerts.

We were informed by multiple staff during inspection that there had previously been a hesitance in reporting safeguardings and a sense of "fear" surrounding the process. Staff had been given support and guidance in order to manage this and the social worker had provided additional oversight to staff, we observed staff seeking advice on a safeguarding matter during inspection. Senior staff reported that there had been an improvement in staff confidence in safeguarding since these new measures had been introduced.

Despite the progress that had been made, there were still concerns regarding safeguarding processes in place. At the time of inspection, no alerts had been raised regarding any forms of service level safeguarding concerns; such as the lack of hot water in patient shower rooms, the delay in responding to absconsion risk, or delay in reporting the 24 safeguarding concerns.

At the last inspection, concerns were raised regarding staff training in safeguarding, the provider had not fully addressed this concern. Only one of the four senior staff nurses was compliant with level three training as expected for the role. However, training had improved for support workers and senior support workers, two had training in progress, but all others had completed the required training. The social worker had been in post for three months, and had completed safeguarding level three training, but had not yet completed level four as is required for safeguarding leads, we were informed that this was due to training being cancelled as a result of Covid-19.

Staff access to essential information

The service used both paper and electronic patient notes, this did not cause them any difficulty in recording or accessing information. All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. Handovers were effective and reflective of risk.

Medicines management

The medicine records did not demonstrate a routine use of as required medicine to manage patients' mental health, though two patients had used it with higher frequency. We

had been informed by two patients that they felt that there was a high use of as required medicines used following incidents. The incident data from 1 to 25 July 2020 recorded 13 occasions when as required medicine was given and six further instances when it was offered but declined by the patient. We reviewed five patients' medicines cards. While two patients did use as required medicine for "agitation" or a "calming effect" very frequently (one patient used at least one form of as required medicine every day for eight consecutive days and another used at least one form of as required medicine at least once a day for 19 days over a 21-day period), the others did not demonstrate a high use.

There was an error on two patients' medicines cards as their allergy information had only been recorded on one, not both of their medicine cards.

Reporting incidents and learning from when things go wrong

There was not sufficient evidence that staff knew what incidents to report and how to report them. In the week prior to inspection, Garrow House submitted 49 retrospective statutory notifications to the CQC (as part of the terms of their registration, providers have a legal obligation to notify the CQC about certain changes, events and incidents that affect their service or the people who use it; these are referred to as "statutory notifications"). Following a review of incidents, they had identified 49 incidents between 1 January and 5 July 2020 that had met the threshold of a notifiable incident but had not been submitted. All 49 were serious injury incidents; 46 of which required further treatment, such as steristrips, wound dressing, or sutures. We were notified during inspection that a further 24 unsubmitted safeguarding notifications had been identified for the same time period.

Turning Point had moved members of the risk assurance team to work closely with Garrow House. At the time of inspection members of the team were on site and assisted in reviewing some incident data. New processes had been introduced. All incidents that had occurred were reviewed by a member of the risk and assurance team, who asked follow-up questions and discussed all incidents during bi-weekly clinical team meetings; the operational manager, senior nurse and a member of the risk and assurance team then met to discuss this feedback within weekly incident meetings. Staff received feedback from investigation of incidents. There was evidence within the incident data that information recorded within incident forms had improved since this process was introduced. To provide consistency, staff were requested to include set information in each incident form; including a record of physical observations if taken, restraint information and whether as required medicine was provided.

Staff understood the duty of candour. They were open and transparent, and gave patients an explanation if and when things went wrong. Staff reported that they did not routinely receive a de-brief following all incidents but reported that debriefs did take place following serious incidents and stated that they were able to have a debrief should they request one. Patients reported that they did not receive a debrief following incidents.

Are personality disorder services well-led?

Leadership

The service had had a significant change to its leadership team since the previous inspection. Both the operational manager and clinical lead had left the service. The new clinical lead had been a senior nurse within the service for an extended period prior to coming into the role; the new operational manager had joined Garrow House in June 2020. Both had the knowledge and experience to perform their roles and had entered their positions during a difficult period within the service. The operational manager was in post just three weeks at the time the provider decided that the service would be closing on a proposed date of November 2020.

The service was under increased monitoring from external stakeholders at the time of inspection and on the day of inspection there were several patient assessments for new placements. Both staff and patients expressed anxiety that the provider and external stakeholders were not being transparent and honest about the expected timescales for the service closure, which had led to distrust. Staff voiced concern that Garrow House closing earlier than previously anticipated could negatively impact upon patients achieving a safe and effective discharge.

Staff spoke positively about the leadership within the service and reported that supervision and support had improved. Patients, however, reported that the operational manager was not always visible and did not respond to

their complaints or concerns. Staff also expressed a "disconnect" between Garrow House and Turning Point as a provider and some felt that while they were supported and respected at a local level, they were not supported by Turning Point.

Culture

The staff team was a mixture of staff that had worked for Garrow House for a very long period and new starters who had joined the organisation within six months of inspection. All staff reported that they enjoyed working with one another. Staff described a sense of loss that the service would be closing and disappointment that they had not been provided with the opportunity to make improvements and continue the service. Staff reported a sense of pride for the work they had achieved with the patients, the number of patients that were now informal, and some of their achievements under the previous provider. There was acknowledgement that governance had not met the required standards at the previous inspection, but a feeling that this could have been rectified and attempts made to return to their previously good standard.

Staff reported that they felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and gave examples of times they had raised concerns.

Governance

The governance oversight had not been effective in identifying and responding to documentation errors. The provider had failed to notify us of 49 serious incidents of self-harm between 1 January and 5 July 2020, and had identified a further 24 safeguarding alerts that they still had not submitted them at the time of their closure. Maintenance checks had not occurred at their required frequency and maintenance concerns and environmental risks had not been resolved within an appropriate timeframe.

The provider gave us inconsistent information regarding staffing and mandatory training figures. Following the last inspection, the service attended weekly meetings with the CQC and another external stakeholder to monitor actions taken in response to the warning notices. Over the course of the meetings there was a lack of clarity regarding which training modules were mandatory, which staff each module was applicable to, and the number of staff that had completed each training module. Different training documents provided also listed the same staff member as holding different roles. For example, one staff member was listed as a bank nurse on one document and a senior staff nurse on another; and another staff member was listed as a housekeeper on one list but another list stated that they held support worker responsibilities.

There were inconsistencies in the mandatory training information provided. For example, within the provider's mandatory training data, only one of the four senior staff nurses was listed as requiring safeguarding training to level three, the others were listed as requiring level two. This contradicted information held at location level. The team meeting minutes from 20 June 2020 recorded that staff nurses had been reminded that they were required to complete the training to level three. There was also inconsistent training expectations of agency nurses listed. One agency nurse, who was regularly listed as only nurse within the service on a night shift, did not have intermediate life support, physical restraint, Mental Health Act, or safeguarding level two or three listed; however, another regular agency nurse did not have Mental Health Act or safeguarding level two or three training, but was trained in immediate life support and the use of physical restraint.

There was an apparent disconnect between the documentation of restraint training compliance held by Garrow House and Turning Point. The mandatory training figures sent by the provider reported low compliance with regards to management of violence and aggression and the use of restraint. This contradicted the training figures within the rota, which documented that 15 of 19 regular staff members were trained in the use of restraint. In total, 13 members of staff were listed as trained in the use of restraint within the staff rota,who were listed to have not completed it within the mandatory training figures.

There were errors or omissions in multiple forms of patient documentation. There were missing entries in patient observation records; staff included multiple incidents within patient incident forms; some incident forms were unclear and incomplete in their information; restraint documentation did not consistently list the duration, type of hold, or staff member involved; patients were not consistently recorded as having had their physical observations checked following a head injury; patient risk information was not updated promtply; there were errors in

all five post rapid tranquilisation monitoring forms reviewed; two patients' care record incorrectly listed their Mental Health Act status; and two patients' medicines records did not list their allergies on both medicines cards.

Staff undertook or participated in local clinical audits and there had been recent progress in these processes. The hospital had had a recent change in management and Turning Point had hired a new social worker and based risk and assurance staff on site. They had introduced new incident review processes and there was a noted improvement in the quality of incident records and reporting following the introduction of these processes. There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. It was evident within staff interviews, and minutes from team meetings and clinical governance meetings that the service continued to try to improve the service, despite their impending closure.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. There was evidence within patient records of regular involvement with external agencies, such as the practice nurse and their care coordinators. The service had also attended weekly meetings with external stakeholders to review their progress with respect to the warning notices, and had an external stakeholder visiting the service weekly. Staff were understanding of this involvement, though the operational manager felt that the enhanced engagement with external stakeholders had at times been detrimental to the progression of the service, partly due to time commitment involved in this engagement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
If the service had not de-registered we would have required the provider to take the following actions:

- The provider must ensure that patient observations are carried out at the specified intervals for each patient, and in line with the provider's policy.
- The provider must ensure that physical observations are carried out following head injuries.
- The provider must ensure that staff have training appropriate to their role, particularly regarding safeguarding and immediate life support.
- The provider must ensure that physical restraint is only carried out by staff who are appropriately trained, that patient restraint care plans are followed and that staff only use approved techniques.
- The provider must ensure that they respond promptly to maintenance concerns and environmental risks.
- The provider must ensure that they keep accurate patient records, particularly with regards to allergy information on medicines cards, restraint and post rapid tranquilisation monitoring forms.
- The provider must work to improve their governance structures between the service and the provider, to ensure that staffing and training information corresponds.
- The provider must ensure that they notify the CQC of all notifiable incidents in a timely manner.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for patients. They did not effectively asses the risks to the health and safety of service user; do all that was reasonably practicable to mitigate any such risks; or ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. This was a breach of regulation 12 (1) (b) (c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Not all premises and equipment were clean, secure, suitable for the purpose for which they were being used, or properly maintained. This was a breach of regulation 15 (1) (a) (b) (c) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not maintain securely an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission without delay of the incidents of injuries to patients which had resulted in changes to the structure of a service user's body or the patient experiencing prolonged pain or prolonged psychological harm. This was a breach of regulation 18 (1) (2) (a) (b)
	treatment provided to the service user; or maintain other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. This was a breach of regulation 17 (1) (c) (d)