Surrey and Borders Partnership NHS Foundation Trust

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

Quality Report

Farnham Rd,
Guildford
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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)
RXX22	Farnham Road Hospital	Juniper ward Mulberry ward Magnolia ward Rowan ward (PICU)	GU2 7LX

This report describes our judgement of the quality of care provided within this core service by Surrey and Borders 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 Surrey and Borders Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Surrey and Borders NHS Foundation Trust.

Summary of findings

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 this inspection

Detailed findings from this inspection

Summary of findings

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

Are services safe?

We found the following areas of good practice:

- There were effective governance processes in place to evaluate and improve practices in response to reported incidents relating to the health, safety and welfare of patients and others who may be at risk.
- The clinic rooms were clean and medicines were stored safely and securely.This included the recommended emergency medicines which were checked on a weekly basis.
- The hospital had identified through their risk register there were significant issues with the recruitment and retention of staff and had taken action to think flexibly about how to attract new starters and keep the staff they employed.

However;

- Across all wards, we found inconsistent recording and reporting of risks identified through the risk assessments which were completed on admission.On Rowan ward we found that none of the patients had risk management plans in response to assessed behavioural risks
- The door entry systems on two wards allowed patients and members of the pubic to walk freely onto the wards and despite being reported and placed on the “minor works tracker” this had not yet been addressed.

Summary of findings

Information about the service

Farnham Road Hospital in Guildford is registered to provide the following activities; assessment or medical treatment for persons detained under the Mental Health Act 1983, treatment of disease, disorder or injury.

Farnham Road has four wards:

• Juniper Ward - 18 bedded mixed gender ward for patients from Waverley and Woking.

• Magnolia Ward - 15 bedded mixed gender ward for patients from Guildford.

• Mulberry Ward - 15 bedded mixed gender ward for patients from Hart and Rushmoor.

• Rowan Ward - 12 bedded mixed gender psychiatric intensive care unit (PICU) with capacity to increase to 14 beds if needed. The trusts only seclusion suite is located on this ward. This ward provides assessment and treatment for people who have acute mental health problems within an intensive care setting and a secure environment and /or planned admissions for intensive therapeutic interventions for patients from across the county.

We last inspected Farnham Road hospital in March 2016 as part of the trust comprehensive inspection. During that inspection, we found the trust had breached three of the regulations. We asked the trust to take steps to address breaches of regulation and the trust responded with an action plan to do this.

Our inspection team

The team responsible for inspecting Farnham Road was led by:

Team Leader: Jayne Norgate, Inspection Manager, Care Quality Commission (CQC).

The team that inspected acute wards for adults of working age and psychiatric intensive care unit comprised of 8 people; one expert by experience, one pharmacist, four CQC inspectors, one CQC inspection manager and one specialist adviser who was a mental health nurse with expertise in the care of adults with mental health problems.

Why we carried out this inspection

This inspection was an unannounced focused inspection triggered by information of concern raised to the Care Quality Commission regarding the safety of Farnham Road Hospital. The information of concern related to low numbers of appropriately trained staff across the hospital, this meant that there was a concern that staff were not able to support the patients safely.

How we carried out this inspection

We asked the following question of the service:

- Is it safe?
- Before the inspection visit, we reviewed information that we held about this service and considered the action plan provided by the trust following our last comprehensive inspection.

During the unannounced inspection visit, the inspection team:

- Visited all 4 of the wards at Farnham Road Hospital and looked at the quality of the ward environment and observed how staff were caring for patients

Summary of findings

- spoke with 14 patients who were using the service and two of their carers and friends
- spoke with the managers or acting managers for each of the wards
- spoke with 12 other staff members; including doctors, nurses, health care assistants and pharmacists
- looked at 27 care and treatment records of patients
- looked at 18 sets of prescription and administration cards and carried out a specific check of the medication management on allwards
- 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 14 patients and two carers during the inspection. Ten of the patients we spoke with told us they felt safe on the ward and staff were caring and compassionate. Four of the patients we spoke with told us they did not feel safe on the wards and told us of occasions where they felt other patients had been aggressive to them. However, they told us staff had dealt with the situation appropriately.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider Should take to improve:

- The provider should ensure consistent use of a risk assessment tool across all wards and that this risk assessment tool identifies where risk assessments and care plans should be updated in response to an incident.
- The provider should ensure the actions from the “minor works tracker” that relate to the door entry systems are undertaken to maintain the safety of the patients and the staff in the hospital.

Surrey and Borders Partnership NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Juniper ward	Farnham Road Hospital
Magnolia ward	Farnham Road Hospital
Mullberry ward	Farnham Road Hospital
Rowan ward	Farnham Road Hospital

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

- Farnham Road hospital was a new hospital and the wards were designed to allow clear lines of sight throughout the communal areas with minimal ligature points.A ligature point is something, which people can use to tie something to in order to strangle themselves. Staff told us that the risk of harm was minimised because they knew where these risks were and staff used an annual ligature audit to identify them. We reviewed all of these audits and found that they had been updated annually, as per trust policy on all four wards.
- All wards were mixed gender and complied with guidance on same sex accommodation. There was a separate female lounge as well as the main shared lounge on all wards. The wards all had single en-suite bedrooms with male and female bedrooms on separate corridors.
- The clinic rooms were clean and medicines were stored safely and securely.This included the recommended emergency medicines which were checked on a weekly basis.
- The seclusion room on Rowan ward was not fit for purpose because it did not meet the requirements of chapter 26 of the Mental Health Act Code of Practice 2015. There was no functioning two-way intercom facility in the seclusion facility within Rowan Ward. There was a blind spot in the seclusion room, meaning it was not possible to maintain safe observations of a patient in seclusion.Patients in the seclusion room were unable to see a clock by which they could tell the time. There was no suitable bedding available for use by people in the seclusion room. The seclusion room had no externally controlled heating and/or air conditioning which enable observing staff to monitor room temperature. It was also possible for other patients to interact with the patient in seclusion using the window into the seclusion room which could be opened from the garden.
- We raised our concerns with a senior staff member on the day of the inspection and were informed that the trust were stopping the use of the seclusion room at that time unless patients displayed extreme aggression until the remedial work on the seclusion could be completed. Subsequently, an environmental risk assessment was completed in the event that the seclusion had to be used to maintain the safety of the secluded patient.
- The trust provided us with an action plan detailing how they were planning to meet the issues as described above and when we re-visited the service on the 30th November 2017 we could see that all the actions had been carried out.
- The wards all had up to date cleaning schedules and dedicated cleaning staff and it was clear to see that the wards were regularly cleaned.
- Maintenance tasks were not regularly resolved in a timely manner and we saw evidence that this had an impact on the safety of the ward.On Mulberry and Magnolia wards the main door to the ward was not secure. This meant that people walking around the hospital were freely able to enter the ward without staff awareness. During the inspection, the inspection team were able to walk onto these two wards without staff on duty being aware. We were told this had been reported to the site maintenance contractor three months previous to the date of the inspection but had still not been resolved. The senior managers of the service were aware of this matter and had been attempting to resolve it. After the inspection, we saw evidence that this issue was addressed on a “minor works tracker” record, which indicated that a review of the operation of all security doors across the hospital had been undertaken and completed by the 21st November 2016.
- There was a system in place for ensuring keys and personal alarms were managed in a structured way using the “Keyguard system”. This is an automated key safe that accounts for keys when staff come on and off duty.Personal alarms were individually assigned to staff and the expectation was that they were responsible for managing their own individual alarm.

Are services safe?

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- Due to previous issues with patients walking around the hospital, staff were able to take their personal alarms home with them so they have them on their person when they come in for duty.On all wards, spare alarms were kept in the keyguard safe. However, on Rowan ward when we checked, two of the spare alarms did not work and this had not been recorded.

Safe staffing

- Staff rosters were checked with the ward manager or deputy manager on each of the four wards for the period 01 November 2016 to 14 November 2016. Across the four wards inspected, the vacancy level for qualified staff ranged from nine vacancies on Rowan ward to two vacancies on Magnolia ward.The vacancy level for health care assistants ranged from five on Rowan ward to one on all of the other wards inspected.It was clear from talking to ward staff and senior management that Rowan ward had been identified as a concern in terms of recruitment and there were targeted plans to improve the recruitment and retention of staff. The ward manager told us that they mitigated the impact of this by using regular bank and agency staff wherever possible.The ward reached their minimum staffing levels on all shifts in the last two weeks. In order to maintain this safe level of staffing on Rowan ward more than 50% of all shifts had one or two agency/NHS Professionals (NHSP) staff.
- Rowan ward had converted three Band 5 nurse positions to Band 6. This was a strategy piloted on the PICU to improve both retention of current nurses and also to make the unit more attractive for nurses applying for the current vacancies.It was clear that the ward managers had the capacity to think flexibly around the support workers shift hours using standard eight hour shifts alongside 12 hour shifts if staff preferred.
- Two staff members and three patients told us that planned escorted leave could be postponed when there were not enough staff on the ward. However, this information was not collated at a ward level.
- MAYBO is a training the trust use to support staff to physically manage patients safely, we found that all wards had 90% or above completion rate. This meant that the majority of the staff on duty across the wards were available to support and de-escalate patients when required.

Assessing and managing risk to patients and staff

- During the course of the inspection, we reviewed 27 sets of care and treatment records including all 10 sets of care records for the 10 patients on Rowan ward.
- Across all wards, we found inconsistent recording and reporting of risks identified through the initial risk assessments of patients completed on admission.There was no risk assessment tool being used consistently across the hospital and inconsistent evidence of risk assessment and care plans being reviewed after ward rounds and with the multidisciplinary team.
- On Mulberry ward from the five sets of care records we reviewed, we identified one patient who had repeated falls on the ward and a high risk of falls identified in the ward review but no falls risk assessment had been completed. We also found that not all risk reviews were done by the date identified on the electronic notes system.
- On Magnolia Ward of the six records we reviewed, during the inspection we found that not all of the risk assessments or care plans were amended in response to incidents or changes in risk whilst on the ward.For example, one patient had presented property damaging behaviour and the risk assessment had not been updated or care plans reviewed as a response to this behaviour.Another example was when a patient had self-injurious behaviour and the risk assessment had not been updated following surgery whilst on the ward. We could find no change to the management plans or risk information on the electronic records system.
- On Juniper ward most of the care plans and risk assessments reviewed had a more structured approach and it was positive to see that the care plans mostly fed through from the initial risk assessments, there were good explanations recorded as to changes in risk. We were told that this ward was piloting the new approach to risk assessment and care planning and this was due to be rolled out across the whole hospital site.
- We reviewed 10 sets of care and treatment records on Rowan ward the PICU. We found that none of the patients had risk management plans in response to assessed behavioural risks.For example, one patient had progress notes detailing violent behaviour, sexually disinhibited behaviour and allegation making, but no risk assessment was found in the electronic record.

Are services safe?

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- Risks were being recorded in the daily notes for patients but there did not seem to be a consistently used risk assessment and management tool. Patients were being RAG rated (red, amber, green) but there was little evidence as to how this decision was being made and on several occasions risk scores were being discussed in the ward round and changed with no description as to how the decision was being made.
- We raised our concerns immediately on the day of the inspection. The trust took immediate action in response to the concerns raised. Rowan ward was closed to admissions and all patients had a 72 hr risk care plan completed by the second day of the inspection.
- When the Inspection team revisited the hospital on the 30 November 2016 to review the trusts immediate actions we could see that the hospital had significantly reduced the amount of patients on Rowan ward and the remaining patients all had care plans and risk assessments completed.

Track record on safety

- There had been 28 serious incidents over the past 12 months across the hospital site.
- Magnolia ward 6 serious incidents, (1 under 18 admissions and 5 AWOLS)
- Mulberry ward 11 serious incidents, (1 under 18 admission, 9 AWOLS and 1 death of a person who uses services)
- Juniper ward Juniper 3 serious incidents, (1 under 18 admissions and 2 AWOLS)
- Rowan ward 8 serious Incidents, (8 AWOL)
- There had been 24 absconsions in the past 12 months, many of which related to the security issues at the hospital. These were a mixture of procedural errors, for example staff allowing patients access to lift to abscond, reception staff allowing patients to exit the building, visitor leaving a pass unattended that patient used to exit building, and security system errors, for example kicking or forcing of doors to exit secure area, doors opening when fire alarms activated).
- The trust risk register had four extreme risks (highest category) two were for Rowan ward including 'security measures are inadequate to prevent absconsions, violence and aggression' (11/03/16) and low levels of staff at Rowan and Juniper ward (09/10/16). There were action plans in place to mitigate some of the risk; however, there were design faults within the building that remained outstanding.
- In addition, there were six high risks registered for this hospital which included; high risk of AWOL, Inadequate seclusion facility, inadequate site security.

Reporting incidents and learning from when things go wrong

- Staff were aware of the incident reporting and management system (Datix), staff recorded patient related incidents in patient daily notes, this information was extracted into the Datix system.
- Non-patient related issues could be input directly on to the Datix system.
- There was a wide range of incident reporting which included, AWOL (absent without leave), assaults, self-harm, security system failures and staff shortages. For example, Mulberry ward had 159 Datix entries that had been reviewed and 17 entries awaiting review for the period December 2015 to November 2016.
- All staff were able to access the system to record incidents.
- There were a few incidents that met the criteria for reporting as a serious incident. Some incidents originally classified as serious incidents by ward staff were reviewed and re-classified by the Clinical Risk and Safety team as per guidance. were very few incidents classified as serious incidents. Some incidents reported appeared to warrant an adult safeguarding alert to be triggered, which had not occurred. We found seven such incidents.
- Staff we spoke with gave personal assurances that they would explain to patients when things might have gone wrong in their care although were not able to cite any particular examples.
- Within the incident management system there were examples of delays in securing patients' medication, the report listed under actions that apologies had been given to the patient concerned and the issue rectified.
- The incident management system did not facilitate feedback of the outcome of the incident investigation to the incident reporter. One ward manager had

established their own practice for copying the text found in the actions taken and the lessons learned components to the reporter via email. This practice was not adopted across all of the wards; therefore, feedback was not routinely given. When we revisited the hospital on the 30th November we could see that the wards had started having "Datix incident huddle" meetings where individual incidents where now routinely being discussed by the staff teams.

- Clinical risk alerts which were often related to a previous incident were cascaded to each ward from the risk management department and posted on noticeboards for staff to see.
- Ward manager's described how debrief was available to staff post-incident.