Raphael Healthcare Limited (The Farndon Unit)

Quality Report

The Farndon Unit
Farndon Road
Newark
Nottinghamshire
NG24 4SW
Tel:01636 642380
Website:www.raphaelhealthcare.org.uk

Date of inspection visit: 13 - 15 March 2017
Date of publication: 19/06/2017

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 rating for this location	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

Summary of findings

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

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

Overall summary

We rated Farndon Unit as requires improvement because:

- Staff had not checked emergency equipment consistently and some of this was out of date.
- Some parts of the wards were dirty and not well maintained. We required improvements to be made to the cleanliness of wards at our two previous inspections.
- The provider did not share the findings of incident and complaints investigations with all staff so they could learn lessons from these.
- The provider did not deploy staff to safely meet all patients' needs.
- Some medicines were stored at too high a temperature which could affect their safety and effectiveness.
- Staff had not recognised that one patient was in long term segregation so the patient had not been reviewed as often as they must be to ensure their safety.
- Ten of the 12 care plans we looked at were not personalised and did not record how the patient had been involved in their care plan.
- Staff had not always recorded their observations and monitoring of patients' physical health needs.
- Staff had not always followed the Mental Health Act and Mental Capacity Act when treating patients. Audits had not picked up where these Acts had not been followed.
- The provider had not updated their policies in line with the Mental Health Act code of practice 2015.
- The provider did not make sure all staff received regular supervision and an appraisal.
- Five of twenty patients we spoke with told us staff did not knock on their bedroom door before entering which did not respect their privacy and dignity.
- Actions agreed at patients meetings were not always followed up and improvements were not made.
- The visitors' room did not offer a relaxed, comfortable and safe environment. Patients were not able to have regular visits as the room was not always available.
- All patients were not offered regular, meaningful activities.
- Patients told us the food was bland and tasteless. Seasoning and sauces were not provided for all patients. Patients were not offered a range of food that met their cultural and religious needs.
- Audits did not always identify where improvements were needed and patients' views were not always listened to so that improvements could be made.
- The provider did not always make sure that action was taken to reduce the risks to staff and patients.

However:

- The provider trained all staff in safeguarding adults and children from abuse. Staff knew how to make a safeguarding referral and did this when needed.
- The provider had made sure that ligature points were reduced to help keep patients safe.
- Each patient had their risks assessed and plans showed how staff supported the patient to manage these.
- Patients had a physical health check on admission.
- Patients were offered a range of psychological therapies.
- The multidisciplinary team worked well together to meet patients' needs.
- We observed all staff treated patients with kindness and compassion.
- Staff knew the individual needs of patients and how to support them.
- Patients knew how to make a complaint and these were investigated.
- The provider took part in national quality improvement programmes and research to improve the quality of the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Requires improvement 	

Summary of findings

Contents

Requires improvement

Raphael Healthcare Limited (The Farndon Unit)

Services we looked at

Forensic inpatient/secure wards.

Summary of this inspection

Background to Raphael Healthcare Limited (The Farndon Unit)

We previously inspected the Farndon Unit on 22 December 2016. It was rated as good overall and we did not change this rating; however, we found the service to be in breach of Regulations 9, 12, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Prior to that inspection, we inspected the Farndon Unit on 15 February 2016. We rated the unit as good overall; however, we found it to be in breach of Regulations 9, 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

Team leader: Sarah Bennett

The team that inspected the Farndon Unit consisted of one CQC mental health hospital inspection manager, four CQC mental health hospital inspectors, one specialist adviser who had experience as a consultant psychiatrist, one expert by experience (a person who has used mental health services) and one CQC Mental Health Act Reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and checked the clinic and dispensing rooms
- observed how staff were caring for patients
- spoke with 20 patients who were using the service
- interviewed the clinical director and registered manager with responsibility for the service
- spoke with the managers for each of the wards
- spoke with 21 other staff members; including doctors, nurses, occupational therapist, housekeeping manager, psychologist and a social worker
- received feedback about the service from a pharmacist and commissioners
- spoke with an independent advocate
- attended and observed three handover meetings and three multidisciplinary meetings
- looked at 12 care and treatment records of patients
- carried out a specific check of the medication management on five wards and reviewed 32 prescription charts
- observed patients' morning meeting on one ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

Information about Raphael Healthcare Limited (The Farndon Unit)

The Farndon Unit is registered with the Care Quality Commission as an independent low secure mental health hospital. The hospital, run by Raphael Healthcare Limited (now part of Elysium Healthcare Limited), accommodates up to 48 female patients over the age of 18. The Farndon unit is able to offer assessment, care and treatment to meet the needs of individual patients within the following diagnostic groups: mental illness, personality disorder and learning disability.

The Farndon Unit is registered with the Care Quality Commission to provide the regulated activities of:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983.

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

Patients cared for at The Farndon Unit may:

• Be detained under the Mental Health Act (1983), sections 2,3,37, and 41 or informal.

• Be detained under Deprivation of Liberty Safeguards, Mental Capacity Act (2005).

• Have a primary diagnosis of mental illness with complex needs.

• Have a history of substance, drug and alcohol misuse.

• Have a history of sexual abuse or domestic violence.

The Farndon Unit consists of a single building built around an internal garden area. The building contains five ward areas; Ward A, Ward B, Ward C, Ward D and Recovery Ward, a low secure rehabilitation/recovery ward.

At the time of inspection, 48 female patients were accommodated over the four ward areas and recovery ward. The registered manager is Anne Armitage.

What people who use the service say

- Two patients said they felt safe at the hospital. Another two patients said they did not feel safe as they had been hurt by other patients.
- One patient told us they were clear about their treatment for their physical health needs. However, another patient said they were not sure what physical healthcare treatment they had and why they needed the medicines the doctor had prescribed.
- All patients told us there did not seem to be enough staff. One patient said because of this they could not have a bath as staff needed to supervise them. Two patients told us there was nothing to do during the day because there was not enough staff. Another patient told us that sometimes there were unfamiliar nurses on the ward. The patient commented that they did not like new faces.
- One patient told us they could not go to their bedroom from 9am to 9pm because of their risks. This meant if they wanted to sleep or relax they had to hope there was a space on the sofa in the lounge area.
- One patient said they were offered a lot of psychology and told us the occupational therapist was fantastic.
- Patients told us staff explained their rights under the Mental Health Act to them on admission.
- All patients told us staff were caring. They said that the care assistants were fantastic. One patient said that some of the staff were amazing.
- Five patients told us staff did not knock on their bedroom door before entering.
- One patient said staff did not tell them when they were doing well and felt that there were no incentives to get better.
- One patient said the choice of halal meat was limited. She told us the hospitality manager would not add protein to her salads. The patient described the food as horrible and felt the shop run (where staff went to local shops to get toiletries and food items for patients) was used to compensate for the poor food. Other patients described the food as bland and tasteless.
- One patient said that when religious festivals such as Eid took place, there was no recognition of this on Ward D.

Summary of this inspection

- Most patients told us they were involved in their care plan and their relatives were invited to their reviews. However, two patients told us they were not involved and did not have a copy of their care plan.

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?

Inadequate

We rated safe as inadequate because:

- Staff had not checked the emergency bags consistently. Some equipment in the emergency bags was out of date.
- The designated seclusion room (although not used) was not safe at the time of our inspection. Following our inspection, the mirror was replaced so that staff would be able to see the patient in all areas.
- Some parts of the wards were dirty and not well maintained.
- Action had not been taken to make sure that an uneven concrete area in the courtyard was made safe.
- The managers did not deploy staff well at all times to make sure patients' care and treatment needs were safely met.
- Staff did not follow the updated guidance from the Department of Health (2014) when giving medicines through an injection. The hospital policy stated that patients would be given this when restrained in a face down position.
- The hospital had a blanket policy that said that Christmas trees were not allowed due to the risks to some patients.
- One patient was nursed away from other patients due to the risk of them hurting others. Staff had not recognised that this was long term segregation and so doctors had not reviewed the patient as much as needed, in line with the Mental Health Act Code of Practice.
- On three wards, medicines were stored in a room where the temperature was too high. This could have affected the medicines so they did not treat the patient as prescribed.
- We saw that one patient's medicine had not been given as prescribed by their doctor.
- There was not a photograph of each patient on their medicine record. This meant that unfamiliar staff might not know who to give the medicine to.
- Learning from incidents was not shared with all staff.
- The provider did not make sure that all staff and patients were debriefed following an incident.

However:

- The provider had reduced the risk of ligature points throughout the hospital.
- All staff carried alarms and these were responded to quickly in an emergency.

Summary of this inspection

- The provider made sure that staff received mandatory training and were up to date with this.
- Each patient had their risks assessed and plans showed how staff supported the patient to manage these.
- The provider trained staff in safeguarding adults and children from abuse. Staff knew how to make a safeguarding alert when needed and did this.
- Staff knew how to report incidents and did this appropriately.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Ten of 12 care plans we looked at were not personalised and did not show evidence of a discussion with the patient about their plan.
- One patient's care plan did not show staff how to meet the patient's physical health needs.
- Staff had not recorded patients' weight or physical health observations consistently in the records we looked at.
- Staff had not received regular management supervision or an appraisal.
- Care assistants told us they did not always attend handovers but the nurses passed information to them.
- The provider did not offer specialist training to all staff.
- Staff did not show they had knowledge and understanding of the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Policies that related to the Mental Health Act referred to the previous Code of Practice and had not been updated to reflect the changes from 2015.
- Capacity assessments in the records we looked at were brief and did not show staff had assessed the patient's capacity.
- Previous consent to treatment forms were in patients records and staff referred to these at the patient's multidisciplinary meeting notes, which could cause errors.
- Responsible clinicians authorised urgent treatment over the telephone and did not see the patient. This did not follow the hospital policy or the Mental Health Act Code of Practice.
- Audits had not picked up where the Mental Health Act and Mental Capacity Act had not been followed.

However:

- Patients had a physical health examination on admission.
- Staff offered psychological therapies recommended by the national institute for health and care excellence to patients.
- Staff completed an induction and mandatory training when they first started working there.

Summary of this inspection

- The multidisciplinary team included doctors, psychologists, nurses, occupational therapists and social workers. They worked together to provide treatment for the patients.
- The hospital had good working relationships with the local authority safeguarding team.
- Patients were aware of their Section 17 leave and where they could go, who with and for how long.
- Where a patient lacked the capacity to make a decision about their physical healthcare, this decision was made in line with the Mental Capacity Act in their best interests.

Are services caring?

Good

We rated caring as good because:

- We observed that staff were kind and respectful of patients.
- Patients told us that staff were caring and responsive to their needs.
- Staff knew the individual needs of patients and how to support them.
- Patients were involved in meetings about their care and treatment.
- Ten records showed that patients were involved in their care plan and had a copy of these.
- Relatives and carers of patients were involved in their care where patients had agreed to this.
- Patients were asked their views in community meetings and feedback questionnaires.
- Patients' views were recorded in written advance decisions.

However:

- Five of 20 patients we spoke with told us that staff did not knock on their bedroom door before entering, which did not respect their privacy and dignity.
- Two patients' care plans did not show involvement of the patient and the patient was not offered a copy.
- Patients told us and we saw that the visitors' room was cold, sparse and unwelcoming.
- Patients had to book in advance to use the visitors' room and this was often booked which meant they did not have regular visits.
- Actions from previous community meetings were not always followed up and improve the service as a result of listening to patients views.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

Summary of this inspection

- The visitors' room did not offer a relaxed, comfortable and safe environment. Patients were not able to have regular visits and some were unable to have visits as the room was not always available.
- The provider told us that all patients were offered 25 hours per week of recovery focused meaningful activity. However, patients told us that they got bored and did not have access to regular activities.
- Although seasoning and sauces were available on all wards by the provider, patients told us the food was bland.
- Regular meaningful activities were not offered to all patients, particularly in the evenings and at weekends.
- Patients were not always provided with a choice of foods that met their cultural and religious needs.
- Information was not always provided on each ward about how to make a complaint and safeguarding.
- Staff did not always receive feedback about the outcome of complaints investigations so that improvements could be made.

However:

- Patients could make a phone call in private.
- There was not information displayed about how to make a complaint but patients knew how to do this and staff knew how to respond.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Audits did not always identify where improvements were needed.
- The provider did not always make sure that action was taken to reduce the risks to staff and patients.
- Ward managers were not aware that they could add items to the risk register in order to input to the overall organisation and the risks.
- The provider did not always take action to make improvements from listening to patients' views.
- Staff said the staffing levels affected their job satisfaction and morale.

However:

- Ward managers were given the opportunity to develop their leadership skills.
- The provider took part in national quality improvement programmes and research to improve the quality of the service.

Detailed findings from this inspection

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.

- On unit A, one patient was being nursed away from the other patients. She was nursed in a specific lounge area (known as lounge two). The patient was on 3:1 nurse observation. She was not allowed to freely mix with the other patients due to the risks to others. Lounge two had access to a courtyard and an ensuite. We were informed the patient slept in her own bedroom at night. The care plan stated for the patient to be nursed in lounge two from 9am to 9pm and at night to sleep in her own bedroom. The staff did not recognise this as long-term segregation in line with the Mental Health Act Code of Practice. We told the hospital managers of our concerns. Consequently, the hospital has informed us the patient is now being managed in line with the requirements of the Mental Health Act Code of Practice. The hospital did not have a policy regarding the use of long-term segregation.
- Staff told us there was a seclusion room but it had never been used. Due to a patient being nursed in lounge two, we were unable to view the seclusion room comprehensively. However, we noticed there might be a blind spot in the corner of the room. Following our inspection, the registered manager told us that the mirror had been replaced to reduce the blind spot. The seclusion policy was not aligned to the current Mental Health Act Code of Practice 2015. Therefore, the required review processes did not comply with the Code.
- The responsible clinician authorised section 17 leave using a standard system. Patients, staff and carers (where applicable) were aware of what leave was granted, including the risk and what to do if there was a crisis. The hospital policy regarding "Leave of Absence (Section 17 Leave)" referred to the previous Mental Health Act Code of Practice and therefore was out of date.
- We found the responsible clinicians authorised Section 62 treatment (urgent treatment) over the telephone. The responsible clinician did not see the patient in person and relied solely on the description of the patient from the nursing staff. The hospital policy regarding "Urgent Treatment (Section 62 MHA 1983)" stated "a full medical review must be undertaken before the decision to impose a Section 62 is finalised by the responsible clinician. This must be clearly documented in the patient's care plan, nursing notes and medical records. Section 62 forms must be completed prior to any treatment being given". We did not find that staff followed this policy. The Section 62 form did not specify how long the treatment was necessary for.
- We found old statutory treatment forms were not removed from the files. In the multidisciplinary meeting notes, we found reference was made to out of date statutory treatment forms as well as the current forms. This could potentially lead to errors being made.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider told us that all staff had received training in the Mental Capacity Act. This is included in the training about the Mental Health Act. We found that staff did not have a good understanding of the Mental Capacity Act, and its guiding principles. Two staff were not aware that they had received training in the Act.
- We saw in two patients' records that an assessment of the patient's capacity to consent to treatment was recorded. However, staff had not recorded how the decision was reached that the patient lacked the mental capacity to consent to a decision or not.
- We reviewed the statutory treatment forms for the patients. The form entitled "capacity for consent to

Detailed findings from this inspection

treatment record" lacked detail. There was limited information about the discussion between the patient and responsible clinician. The form did not include the diagnostic test as required by the Mental Capacity Act.

- We found two examples of where patients lacked the capacity to make decisions about their physical healthcare. A best interests meeting was held and a decision to give treatment to the patient was made.
- The Mental Health Act administrator completed an audit on the use of the Mental Capacity Act every three months. Staff obtained advice and guidance about the Act from the Mental Health Act administrator, advocate and social work team.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are forensic inpatient/secure wards safe?

Inadequate

Safe and clean environment

- On all wards we saw that the ward layout did not allow staff to observe all parts of the ward. Bedrooms on Wards A, B and the Recovery Ward were out of view from staff. Staff told us that the risks of this were reduced by risk assessments and observation levels. On Ward A this meant that staff were assigned at all times of the day to observe patients using these areas. There were no convex mirrors which would have reduced the need for staff to constantly observe patients in these areas.
- Staff completed an annual ligature risk audit. They reviewed this every three months and when new equipment was provided. A ligature risk audit is a document that identifies places/objects to which patients intent on self-harm might tie something to strangle themselves. Ward managers submitted a compliance document weekly, which confirmed the ward environment had been checked for ligature risks. The provider had reduced the risks of ligature points by using anti ligature fittings, for example, taps, curtain rails and shower fittings. Staff completed individual risk assessments for the risk of ligatures in each patient's bedroom. Staff had access to ligature cutters in the office of each ward and checked these daily.
- The Farndon Unit exclusively provided a service for female patients, therefore was compliant with guidance on same sex accommodation.
- We saw the medication dispensary room on each of the wards. There was one central clinic room, which had an examination couch, where patients had physical examinations where needed.
- An emergency bag was shared between Wards A and B and another between Wards C and D. Each locked bag was located in the corridor between the wards so it was easily accessible by both wards. Staff checked the contents of each bag daily to ensure that all emergency drugs were available. In the bag between Wards C and D, we found that three suction tubes were out of date and staff had not identified this during the checks. Records showed that in February 2017, staff had not checked the bag between Wards A and B on 12 occasions and there were no spare suction tubes available in January and February 2017. We saw that the emergency bag checklist records stated that different quantities of equipment were available in the bag from January to March 2017. When we looked at the bag on 15 March, there were also different quantities of these to what the records stated should be available. The Recovery Ward had its own emergency bag. Records showed that there were four times in February and two in January 2017 when staff did not check this. This meant that it was not clear that staff checked the bags thoroughly so that they were confident the necessary equipment would be available when needed.
- There was a designated seclusion room on Ward A. However, all staff spoken with told us this had not been used since the unit opened 10 years ago. We saw that it was not possible to see all areas of the room from the viewing panel. Following our inspection, the registered manager noticed that a mirror that should have been in place was removed when the area was redecorated. This was replaced at the time. We saw a half door on the

bathroom area of the seclusion room, which would impact on patients' privacy. The registered manager informed us that they ordered a full door to replace this following our inspection.

- We saw that some parts of the wards were dirty and not well maintained. One patient on Ward A showed us their en suite toilet. The sink was blocked as it was full of vomit. The patient said it had been there for three days and was reported to staff. The patient told us they were not able to clean their teeth properly and had used hand gel to wash their hands after using the toilet. The weekly ward cleaning rota stated on 13 March 2017 "sink drain full of sick" but no action had been recorded. The provider told us that the sink was cleaned on 13 March 2017 and the vomit was new. However, this had not been recorded and the patient experience told us the vomit had been there for three days.
- In two patients bedrooms on Ward A, there were spillages of drinks on the window sills that had not been cleaned up and the floors were dirty. Drawers were broken. One patient told us that their wardrobe door broke "a long time ago" so there was no door on the wardrobe and it had never been replaced. The paintwork on the bedroom walls was worn and in need of redecoration. The kitchen was dirty; there were spillages on the work surfaces and dirty crockery.
- On Ward B, we saw the paintwork was worn, there was paint on the chairs in the lounge area and the chair covering was peeling. There were not enough comfortable chairs for all the patients to sit in the lounge. In the kitchen, the hand towel dispenser was broken and the cupboards were dusty and sticky to touch. The bin in the clinic room was broken.
- On Ward C, we saw the work tops in the kitchen used for patient's drinks and snacks were dirty and there were several crumbs. The paintwork was worn and peeling.
- In the Recovery Ward kitchen, there were worn areas of paint, the work top was dirty, the extractor fan was greasy and dirty to touch and the oven was dirty. Staff said they had requested that housekeeping staff do a deep clean of the oven but they could not find evidence of this. We saw staff had requested that the maintenance team replace the kitchen work top and this was planned to be done by 28 February 2017. However, this had not been done. Night staff on the Recovery Ward cleaned the communal areas. We saw that the cleaning rota had not been signed as being done four times in February 2017.
- The registered manager sent us copies of the weekly cleaning rotas following our inspection. These showed that bedrooms on Ward A had not been cleaned the week of our inspection as the cleaner was late getting to the ward so did not have enough time. Records also showed that the bedrooms on Wards C and D were not cleaned that week as the cleaners were short staffed. Cleaning records showed that other areas were cleaned.
- The courtyard was used for patients to access fresh air and was the main walkway from the wards to the reception, resource room and café. In the middle of the courtyard we saw a concreted square area of uneven ground. A member of staff had tripped on the uneven ground about nine months before our inspection and had been injured as a result. The action following this was to paint a yellow line around the area and put a sign on the door to the courtyard from reception to make people aware of the hazard. We saw the sign in place and saw that the yellow paint was faded. Staff said the uneven area was not visible at night. The registered manager showed us evidence that they had tried to get contractors in to repair the uneven ground on 23 February 2017. Contractors who visited were unable to do this work. The registered manager told us that it had now been agreed to install a wooden planter to cover the uneven ground and this was ordered on 9 March 2017. There was no date set for when this was to be installed.
- Records showed that housekeeping completed an environmental audit every two months. On the Recovery ward, we saw that the last audit requested that maintenance replace the work top around the sink by 28 February 2017. This had not been done at the time of our inspection.
- All staff were given alarms at reception at the beginning of their shift. We saw, and staff and patients told us, that alarms were responded to quickly.

Safe staffing

- The provider had estimated the number and grade of nurses required for the whole hospital not for each ward. An allocations officer allocated staff to each ward depending on which staff were available and patient leave, escorts and observation levels needed for each ward. In the hospital, during the day hours from 7.30am to 9pm, there should be six registered nurses and 15 care assistants. At night, from 8.45pm to 7.45am, there should be six registered nurses and 13 care assistants.

Information provided by the registered manager showed that at 27 February 2017 there were 12 whole time equivalent (WTE) registered nurse vacancies and 4 WTE care assistant vacancies in the hospital. This had improved from our previous inspection in December 2016. Offers of employment had also been made to three registered nurses and five care assistants.

- The overall staff sickness rate at 27 February 2017 was 4.7%. The service had a key performance indicator of four per cent for sickness. Managers said ward managers closely monitored sickness to transfer short-term to long-term sickness and completed return to work interviews promptly with staff.
- Locum nurses and bank and agency staff were employed to cover the vacancies and sickness absence. From 9am to 5pm on weekdays, there was a ward manager on each ward who was not included in the numbers, an activity worker on Wards A and B, occupational therapists, psychologists and three patient transport drivers. An additional ward manager had been employed. This meant that there was always a ward manager in the hospital until 9pm to provide leadership to ward staff.
- We found that the agreed staffing levels were provided on 14 and 15 March 2017. However, staff were regularly moved around wards which impacted on continuity and a timely response to patient's needs. Two staff members and two patients said patients' section 17 leave was regularly cancelled due to staffing. However, the registered manager provided data which stated section 17 leave was cancelled three out of 1935 times from October to December 2016. This was due to patients being unsettled not issues with staffing. Other staff said that sometimes section 17 leave was delayed but not cancelled due to staff moving around wards to cover. Locum nurses told us they were moved daily between wards and as the nurse in charge this affected continuity. On 15 March 2017, managers moved staff from the Recovery Ward to cover other wards which left them short of one staff.
- On 13 March 2017, we visited Ward B unannounced at 8.15pm. On arrival, there was two staff (one registered nurse in the office and one care assistant) on the ward with 10 patients. One care assistant had gone to a local shop to get patients shopping. We were escorted to the ward by a ward manager and found one patient slumped on the floor in the ward entrance and non-responsive. The ward manager initiated the emergency response and the patient was supported appropriately. However, staff were not safely deployed on Ward B at that time to meet patients' needs.
- Five of six patients on Ward D told us that the low number of staff on the ward negatively impacted on their leave, activities and access to fresh air. They and staff said the ward started with the planned number of staff, but during the day staff were moved to other wards. The advocacy service told us that they had supported patients to raise the issue of staffing as it impacted on patients access to fresh air. We also found that in February 2017, two patients (Wards A and D) had their church visits cancelled due to insufficient staffing.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.
- The provider had ensured staff had received and were up to date with appropriate mandatory training. The weekly hospital target for mandatory training was 90%.

Assessing and managing risk to patients and staff

- We looked at the care records of 12 patients. Staff undertook a risk assessment of every patient on admission. This was recorded in each patient's "My risks" document. These were detailed and updated regularly and after each incident. Patients also had a 'tool access' form, which was reviewed at their fortnightly ward round with the multidisciplinary team. This included which areas the patient could access, for example, the kitchen, their bedroom, bathroom, café and resource room, dependent on their risks. Registered nurses could review and change the areas that the patient had access to if their risks changed. The multidisciplinary team assessed and changed observation levels.
- Restrictions were mostly based on individual needs and not blanket restrictions. For example, some patients did not have access to their bedrooms during the day as this was a risk to them being unsupervised by staff. Staff had assessed that it was more beneficial to the patient's treatment to be in communal areas and accessing activities during the hours specified in the patients risk plan.
- We found that a blanket restriction (a restriction that is placed on all patients regardless of their individual risks) was placed on not allowing Christmas trees in the hospital. This had not been reviewed for several years. Staff searched all patients on return from leave out of

the hospital. This was a 'pat' down search and was not based on patient's individual risks. Staff also did monthly random searches of patients' bedrooms. This was more often if a specific risk had been identified.

- All staff told us that restraint was only used as a last resort. We saw that de-escalation rooms were provided and patients told us that they used this room to speak with staff if they felt anxious or agitated. We observed an incident which resulted in staff restraining a patient on Ward B. They restrained the patient in the face up position and gave the patient an opportunity to de-escalate. The patient's behaviour had been unpredicted and they were at risk of harming others. The patient was offered oral medicine to help them to calm down. Other patients were not moved away from the incident which impacted on the patient's privacy and dignity.
- The provider had trained 84% of staff in the management of violence and aggression. The hospital target for this was 90%. This included the use of de-escalation and a positive behavioural support approach to using least restrictive practices. There were 387 episodes of restraint recorded from 1 June 2016 to 30 November 2016. The highest number was on Ward B where there were 216 episodes. The episodes of restraint included 48 patients. There were 31 prone restraints during this period, 19 of which were on Ward B.
- The administration of rapid tranquilisation did not follow the latest guidance. The service's recognition, prevention and therapeutic management aggression and violence policy referred to out of date guidance from The National Institute for Health and Care Excellence (NICE). They provide national guidance and advice to improve health and social care. The policy referred to NICE guidance short-term management of disturbed/violent behaviour in adult psychiatric setting (March 2005 draft version). This was updated in May 2015. Their policy stated that they would use prone (face down) restraint to give a person an injection into their muscle. This meant that they were not following updated guidance in relation to the use of rapid tranquilisation. Guidance from the Department of Health Positive and Proactive Care: reducing the need for restrictive interventions 2014 states that there must be no planned face down restraint on any surface, including the floor. The provider told us that there were 11 episodes of restraint that resulted in rapid tranquilisation being given from 1 June to 30 November 2016.
- There was a designated seclusion room in Ward A; however, this had not been used for seclusion since the hospital was opened. The seclusion policy stated that there was not a seclusion room at the hospital. The policy was not aligned to the current Mental Health Act Code of Practice 2015. Therefore, the required review processes did not comply with the Code.
- The hospital did not have a policy regarding the use of long-term segregation. On Ward A, staff nursed one patient away from the other patients in a specific lounge area (known as lounge two). Lounge two had access to a courtyard and an en suite shower and toilet. Staff said the patient slept in their own bedroom at night. The patient's care plan stated to be nursed in lounge two from 9am to 9pm and at night to sleep in own bedroom. The patient was observed by three staff and was not allowed to freely mix with the other patients due to the risks to others. The staff did not recognise this as long-term segregation in line with the Mental Health Act Code of Practice. We told the registered manager and clinical director of our concerns about this. They took action and told us that staff now managed the patient in line with the requirements of the Mental Health Act Code of Practice. The provider had referred the patient to a medium secure placement and the patient was waiting to be transferred.
- The provider had trained 85% of staff in safeguarding adults and children from abuse. This was below the hospital target of 90%. All staff spoken with were aware of how to make a safeguarding alert and did this when appropriate. The provider had good links with the local safeguarding team. The hospital senior social worker met with the team every six weeks.
- Medication was supplied by an external pharmacy. The pharmacist visited the hospital weekly and completed audits.
- We saw that some medicine cards did not include a recent photograph of the patient. This meant that unfamiliar staff giving medication may struggle to identify the patients. At the morning managers meeting on 15 March, an incident was discussed where the previous day a patient had told an agency nurse administering medication their wrong name. The action discussed was to ensure that all staff looked at a

photograph on the medicines card before giving. This would not have reduced the risks for patients without a photograph. The provider told us following our inspection they had added a photograph of the patient on each patient's medicines card.

- Medicines were not stored safely. Staff monitored the temperatures of the rooms where medicines were stored. Some medicines were not to be stored above 25C as this could affect their safety and effectiveness. Records showed that on Wards A, C and D the temperatures had been recorded above 25C on several occasions. For example, on Ward A the room had been over 25C nine times in March 2017. The pharmacy had highlighted this to the ward managers and senior managers in their audits. However, there was no record on any of the wards of what action had been taken to reduce these temperatures.
- Medicines were not always given as prescribed. On Ward D, we saw that a patient was prescribed a different medication for their diabetes following an adverse reaction on 4 January 2017. We saw that the patient was not given this medication for seven days after this. The patient's notes stated on 7 January that the medication had not been collected as the medical centre was closed over the weekend. We found no further reference in the notes as to when the medication was collected and this was not recorded as an incident.

.

Track record on safety

- Within the nine months prior to this inspection, the service reported one reportable injury to the Health and Safety Executive. This was a member of staff injured on the uneven area of concrete in the courtyard. We saw that appropriate action to remove this hazard was not completed at this inspection.
- The registered manager told us there had been seven serious incidents from 1 January to 27 February 2017. Four of these incidents had been reported to the care quality commission as required to meet the regulations.
- The registered manager told us of improvements made to reduce the risk of these incidents happening again. For example, they had employed another ward manager so that there was leadership support to staff in the hospital until 9pm each night as they had found that more incidents happened after 5pm.

Reporting incidents and learning from when things go wrong

- All staff spoken with said they knew what to report and how to report incidents.
- We saw on Ward D in January 2017 that staff had not given a patient their medication for diabetes. Staff had not reported this as an incident.
- Staff told us that they had not received information about learning from incidents that had occurred in Farndon Unit. We saw that incidents were reviewed daily from Monday to Friday at the managers' morning meeting. However, it was not clear how this information was passed on to ward staff. Staff meetings were not held and care assistants did not have work email accounts so would not receive electronic communication about learning lessons. Managers told us that a hard copy of the monthly team brief was available that included information about learning from incidents. None of the care assistants we spoke with were aware of this.
- During the managers' morning meeting on 15 March 2017, we observed discussion about an incident where a patient had given their wrong name to the agency qualified nurse administering their medicines. The clinical director stated the action to be taken to reduce the likelihood of this happening again was to ensure staff looked at patients' photographs on their medicine cards. However, we found that there was not a photograph of the patient on several medicine cards we looked at.
- Three of the ward managers we spoke with about debrief after incidents said that this was given to all staff to support them. However, five staff we spoke with said they did not receive a debrief following an incident on a ward. The provider told us that the term debrief was not widely used within the service and that a debrief process was followed.

.

Requires improvement

Forensic inpatient/secure wards

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 12 patients' care records. Staff had completed an assessment of the patients' needs and developed care plans and risk assessments from this. Two of the care plans were detailed, personalised and holistic. The care plans were detailed in the other ten records; however, they were prescriptive and did not show evidence of the patient's voice or involvement. For example, one care plan for suicide stated "Staff will be ….; your observation levels are…", but did not describe how this had been discussed with the patient to make this personalised.
- Care records showed that staff had completed a physical health examination of each patient on admission and all but one of these was comprehensive. This patient's physical health care plan and physical health passport was only half completed. Following our inspection the provider told us that the healthcare passports were new and in the process of being completed. There was no mention of the patient's dietary needs that were identified elsewhere in their records. Staff had not recorded and monitored the patient's physical health problems. The patient's GP had requested that staff record what the patient had eaten and drank and record their blood glucose levels. However, it was not clear for the doctors to see if any further medical input was needed. Staff had ensured that the patient had the required blood tests and these were recorded as within normal range. The records also stated that the psychiatrist had written to the GP and suggested that the patient would benefit from seeing a dietician. There was no record as to whether or not the GP had agreed with this and made a referral.
- We saw that records were in paper format and accessible to staff within the service. The new provider planned to introduce an electronic care records system which would make it easier to share information as needed with external services.

Best practice in treatment and care

- We looked at 12 care records. We saw that staff followed National Institute for Health and Care Excellence when prescribing medication.
- Staff offered psychological therapies recommended by the National Institute for Health and Care Excellence to patients. Psychologists based at the hospital assessed each patient's psychological needs within three months of their admission. Psychological therapies included compassion focussed therapy, cognitive behavioural therapy and the hospital psychological model that was based on positive behaviour support. They also offered eye movement desensitisation and reprocessing, a therapy used to help patients with the symptoms of post-traumatic stress disorder. Two patients told us this was an effective treatment for them.
- Two patients' records showed variations in how staff had recorded the patient's weight. For example, one record showed variations of weight recorded from 89 to 120.6 kilogrammes in the same month. Their care plan said to encourage the patient to choose healthy options as obesity was a problem. It was not clear how staff were supposed to do this or how they would monitor this. Another patient's records showed that they had gained 15 kilogrammes in weight in one year. There was no plan to clarify whether this was needed or if this would now cause the patient to be overweight. If so, there was no plan for staff to support the patient to lose weight.
- Staff were to record the physical observations every four hours for one patient on Ward B following an incident where they had been found on the floor unresponsive. Staff had only recorded this twice and records did not show that medical staff had reviewed the patient's physical health following this incident.
- The provider had recently trained 10 staff in taking bloods and electrocardiograms so that patients were offered these at Farndon Unit. One member of staff was doing a course that would qualify them to do cervical screening for the patients which meant it would be easier for patients to receive this on site.
- We saw that ward managers (who were registered nurses) audited care plans and medicines management systems every month. Psychologists audited how many psychology sessions were offered each week. On 27 February 2017, records showed that 30 patients were

offered a one to one psychology session and 18 patients accepted this session. There were four group psychology sessions offered that week which 14 patients attended.

Skilled staff to deliver care

- The full range of mental health disciplines provided input to the hospital. These included three consultant psychiatrists, four psychologists, occupational therapists and a social work team.
- There were 12 whole time equivalent vacancies for registered nurses. These vacancies were covered by locum and agency nurses. Agency nurses did not receive training from the provider.
- Staff received an induction that was appropriate to their role. This included the mandatory training which they received annually once employed.
- Not all staff received regular supervision and an appraisal. The provider told us that 64% of staff had received regular management supervision and 85% of staff had received clinical supervision as at 27 February 2017. The hospital target for supervision was 95%. The provider told us that at 30 November 2016 the appraisal rate for non-medical staff was 56.6%. They said on Wards A, B and Recovery this was due to staff being off sick long term, maternity leave and with less than a year's service. An additional ward manager had been appointed from January 2017 whose role involved assisting with appraisals and carrying out supervisions. We were not informed of the current appraisal rate but three out of the four staff we asked said they had not received an appraisal. 100% of doctors had been revalidated at 30 November 2016.
- The provider did not offer specialist training to staff to meet the needs of all the patients there. For example, they did not receive training in learning disability and eating disorders. Managers told us that all staff received training in diabetes and epilepsy. However, two staff told us they had not received this training. Ward managers told us they received leadership training.
- We saw that poor staff performance was addressed promptly and effectively. For example, an incident occurred during our inspection. Managers viewed the closed circuit television camera footage on the ward and suspended the member of staff involved pending investigation. This was referred to the local authority safeguarding team and an investigation was started.

Multi-disciplinary and inter-agency team work

- Each patient had a ward round every fortnight. This included all members of the multidisciplinary team. We attended three patient's meetings with their consent and saw that they were effective.
- We observed three handovers between shifts. These were led by the nurse in charge. Care assistants told us they did not always attend handovers but the nurses passed information to them. This meant that all staff on the shift may not know the information needed about patients to be able to effectively meet their needs.
- There were effective working relationships with other teams in the hospital. Members of the multidisciplinary team passed on relevant information about patients to other members of the multidisciplinary team.
- The hospital had good working relationships with teams outside the organisation, for example, local authority safeguarding team.

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

- Mental Health Act papers were examined by a competent staff member on admission and we saw that they included all the information required.
- Staff knew who the Mental Health Act administrator was. The Mental Health Act administrator had good knowledge of the Act and offered support to make sure the Act was followed.
- The responsible clinician authorised section 17 leave using a standardised system. Patients, staff and carers (where applicable) were aware of what leave was granted, including the risk and what to do if there was a crisis. The hospital policy regarding "Leave of Absence (Section 17 Leave)" referred to the previous Mental Health Act Code of Practice, rather than the updated which meant that this policy was out of date.
- The provider told us that all staff had received training in the Mental Health Act. Staff told us that the training was included in their induction. We found that staff did not have a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were not always adhered to. We found that eight assessments of the patients' capacity were brief or not present. One patient's record said, "Understands risks and benefits". This did not explain how the patient's capacity had been assessed and how staff had come to this conclusion.

Requires improvement

Forensic inpatient/secure wards

- We found old statutory treatment forms were not removed from the files. In the multidisciplinary meeting notes, we found reference was made to out of date statutory treatment forms as well as the current forms. This could potentially lead to errors being made.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely and regularly after, depending on the needs of the individual.
- We found responsible clinicians were authorising treatment under section 62 (urgent treatment) over the telephone. They did not see the patient in person but relied solely on the description of the patient from the nursing staff. The hospital policy regarding "Urgent Treatment (Section 62 MHA 1983)" stated "a full medical review must be undertaken before the decision to impose a Section 62 is finalised by the responsible clinician. This must be clearly documented in the patient's care plan, nursing notes and medical records. Section 62 forms must be completed prior to any treatment being given." We did not find this was taking place. We noted the Section 62 form did not specify how long the treatment was necessary for.
- We looked at the audit dated 10 March 2017 to ensure the Mental Health Act was being applied correctly. The only action identified was that the wards needed to ensure they did not archive the section renewal forms. The audit had not identified the issues we found about Section 62, consent to treatment and capacity assessments and the removal of old statutory treatment forms.

Good practice in applying the Mental Capacity Act

- The provider told us that all staff had received training in the Mental Capacity Act. This is included in the training about the Mental Health Act. We found that staff did not have a good understanding of the Mental Capacity Act and its guiding principles. Two staff were not aware that they had received training in the Act.
- We saw in two patients' records that an assessment of the patient's capacity to consent to treatment was recorded. However, staff had not recorded how the decision was reached that the patient lacked the mental capacity to consent to a decision or not.
- We reviewed the statutory treatment forms for the patients. The form entitled "capacity for consent to treatment record" lacked detail. There was limited information about the discussion between the patient and responsible clinician. The form did not include the diagnostic test as required by the Mental Capacity Act.
- We found two examples of where patients lacked the capacity to make decisions about their physical healthcare. A best interests meeting was held and a decision to give treatment to the patient was made.
- The mental health act administrator completed an audit on the use of the Mental Capacity Act every three months. Staff obtained advice and guidance about the Act from the mental health act administrator, advocate and social work team.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed that staff were respectful and kind to patients throughout our inspection. Staff provided appropriate practical and emotional support. We saw that staff responded to requests from patients to spend time talking with them.
- Patients told us that some staff were fantastic and amazing and helped them to feel safe at the hospital.
- Five of 20 patients we spoke with told us that staff did not respect their privacy as they did not knock on the door before entering their bedroom. We did not observe this during our inspection but this impacted on how some patients felt about how staff treated them.
- Some patients told us that there was not always a registered nurse on duty who they knew and they found this difficult.
- Staff spoken with had an understanding of the individual needs of patients. They also showed this in the way they treated patients.

The involvement of people in the care they receive

- Patients told us that when they were admitted they were shown around the ward and introduced to other patients and staff. They were allocated a named nurse and keyworker. They also said that staff told them of what was expected of them and their rights under the Mental Health Act.

Requires improvement

Forensic inpatient/secure wards

- Patients told us they were aware of their care plans and felt involved in the process. However, two patients said they were not involved and did not have a copy of their care plan. Ten of the 12 care plans we looked at were not written in a way that reflected the involvement of the patient.
- We observed at three multidisciplinary meetings that the patient was involved and offered the opportunity to be involved in a way that was comfortable for them. Patients told us that they met with staff before their multidisciplinary meeting to discuss what they wanted and to ask their views.
- 'Advent' advocacy provided the independent mental health advocacy service to the hospital. We saw posters on the noticeboards in the wards promoting the service. The advocate visited all wards in the hospital once a week. Patients were able to self-refer to the advocate or staff could make the referral on their behalf. Patients were aware of this service and knew what to do should they require advocacy support.
- Patients told us their families and carers could be involved in their care if they agreed with this. We found that there was only one visitors' room and patients had to book this in advance so their families could visit. Patients told us that this room was not always available so they could not have visitors very often. Staff confirmed this. Patients told us and we saw that the visitors' room was cold, sparsely furnished and unwelcoming.
- The social work team communicated with patients' families and carers where appropriate and with the patient's agreement.
- On each ward patients were expected to attend a morning meeting from Monday to Friday. At this meeting they discussed what was happening that day and which staff would be supporting them to any appointments or leave.
- Weekly community meetings were held on each ward. We looked at minutes of community meetings held on the Recovery Ward. These did not show that actions from previous meetings had been followed up or reviewed. This meant it was not clear that staff listened to patient's views and took action to make improvements based on them.
- Staff gave patients feedback questionnaires at least every three months and also at community meetings.
- We saw on Ward B and the Recovery Ward that staff had written on the board what patients had said and what action they had taken as a result.
- Records included advance decisions about how the patient wanted to be restrained or treated when they were anxious or agitated.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- There were no vacant beds at the time of our inspection. The provider told us that from 1 June to 30 November 2016 the bed occupancy on Ward A was 90%; Ward B 95%, Ward C 99%, Ward D 95% and the Recovery Ward 94%.
- There was access to a bed when a patient returned from leave.
- Records showed and patients and staff told us that patients were sometimes moved between wards to avoid conflict between patients, not always because of clinical need. We saw that where there had been an incident between patients, one of them was moved to another ward.
- Staff told us that patients were not admitted or discharged out of hours in the evenings or at weekends.
- The provider told us that the average length of stay for patients discharged in the period 1 December 2015 to 30 November 2016 was 1192 days (over three years).During the reporting period requested by the CQC the average length of stay was over three years. However, this was due to a number of longer stay patients being successfully discharged which increased the average length of stay for that time period.
- The provider told us that there were four patients whose discharge was delayed at 30 November 2016. These patients were from Ward C, Ward D and two from the Recovery Ward. However, one of these patients had since been discharged. The pathway had changed for another patient and they were staying at the Farndon unit. One patient was awaiting a specialist placement and the other patient was to be discharged to a step

down placement and was awaiting housing. The provider had escalated the delayed discharges to the commissioners and had regular communication with them.

The facilities promote recovery, comfort, dignity and confidentiality

- There was not a couch in the clinic rooms where patients could be examined. Staff told us that the doctor, escorted by staff, would examine a patient in their bedroom if needed. De-escalation rooms on the wards were used as quiet rooms for patients to talk with staff if they wanted to. There were no quiet lounges on the wards for patients to do this. There were two lounges on Ward A, however one lounge was used to nurse a patient who was observed by three staff and separate from other patients. The second lounge was away from the main ward area and staff would not be able to observe patients safely if this room was available.
- One patient said that the visitors' room was booked up until August 2017 so their parents were not able to visit them. All staff spoken with confirmed that the visitors' room was booked up for months in advance. This made it difficult for patients who did not have section 17 leave to see their families. We looked at the visitors' room. The temperature was cold and the room was not suitable for children to visit. There were no toys available and the room was sparse. There were no easy chairs that would help visitors to feel comfortable and relaxed.
- The hospital gave each patient a mobile phone without a camera and the internet so they could make phone calls in private. Some patients were observed when making phone calls depending on their risks and this was recorded.
- Patients did not have independent access to outside space. Patients accessed the courtyard with staff. This was coordinated between wards due to the mix of patients in the hospital. The registered manager told us there had been problems when all patients accessed the courtyard together and the space was limited. Patients were not free to access outside space during the night due to security issues and the risk of disturbing other patients' sleep. The registered manager also stated that there was additional courtyard space at the back of Ward A that was secure and accessible if patients needed to use alternative space.The advocate told us they had supported patients to raise issues when staffing levels had meant that they did not have regular access to fresh air and this had been resolved.
- Five patients described the food as "bland, horrible and disgusting". They had met with the hospitality manager but felt nothing had changed. The advocate had also supported patients with this issue. The hospitality manager told the advocate that the food was not seasoned as they catered for a large number of patients. Therefore, patients had to season their food themselves. We saw that on Ward D patients had access to sauces.
- Patients on the Recovery Ward had their own budget and could cook their own meals with staff support as needed. On other wards, access to the kitchens was based on individual risk assessment. Each week a member of staff from each of the other wards did a 'shop run.' This meant that patients who were not granted Section 17 leave could ask for toiletries and items of food and drink to be purchased from a local shop. During our evening visit to Ward B, we saw staff deliver the shop run items. These included fizzy drinks, sweets, chocolates and crisps. Patients said these items made up for the food that was provided. Some patients ate large amounts of sweets and sugary items in the hour we observed. Staff told us they had encouraged patients to have smaller bottles of fizzy drinks to reduce the effects of these on their health and wellbeing. Each patient was given a weekly allowance of 10 points in which they could purchase from the hospital low fat and low sugar snacks. Staff said this was to encourage patients to eat a healthier diet. We did not see that this was based on individual dietary needs.
- Patients told us they could personalise their bedrooms and we saw some personal items. Some patients could not have certain items in their rooms based on their individual risk assessments. These were stored safely in a room on each ward and patients had access to these supervised by staff.
- Patients told us they got bored and did not have regular access to activities, particularly in the evenings and at weekends. Activity workers were employed on Wards A and B during the hours of 9 to 5, Monday to Friday. Three qualified occupational therapists and two assistants worked across the wards. There was one vacancy for a qualified occupational therapist. Each patient was allocated an occupational therapist before admission. We looked at the group activity programme. This

included cooking skills, arts and crafts workshop and sessions on Mindfulness, coping with emotions and interviewing skills. There was a café based in the courtyard. Patients and staff told us that this was not open every day due to issues with staffing levels required to support patients there. The provider told us that in the week ending 27 February 2017, six sessions where patients could access the café were offered. Some patients were trained to work in the café.

- There was a gym and the provider had recently purchased some new equipment. However, a gym instructor visited the hospital once a week. This meant there was a limit to how many patients could use this facility. The provider told us in the week ending 27 February 2017, nine patients accessed the gym.
- The provider told us in the week ending 27 February 2017, there were 23 one to one occupational therapy sessions offered and 22 of these were accepted. The occupational therapists offered four group sessions that week, which 23 patients attended overall. In the weeks from 23 January 2017 to 6 February 2017 the café, gym and resource room (where patients could access the internet) were not open due to issues with staffing.

Meeting the needs of all people who use the service

- Adjustments could be made if a patient required disabled access. Some wards were on the ground floor and there was a lift to access the upstairs wards.
- Some information leaflets were not provided on the wards. For example, on Ward D, there was no information about complaints or safeguarding until we raised this.
- Staff told us that interpreters or signers could be accessed if needed.
- One patient told us halal meat was provided but the choice was limited. The hospitality manager told us that halal meat was provided. However, they told us that it was difficult to source some items needed for African and Caribbean foods so they had offered ready meals. The provider told us in the data they submitted that over 8% of patients were from an African or Caribbean background.
- Patients had access to appropriate spiritual support where requested. A chaplain visited weekly. However, we found in Ward D that two patients were not able to attend church one Sunday due to staffing levels. We saw that the Christian festivals of Christmas and Easter were celebrated. However, one patient told us there was no recognition on Ward D of other religious festivals, such as Eid.

Listening to and learning from concerns and complaints

- The provider told us that there were 58 complaints received in the last 12 months. Fifteen of the complaints were upheld and none were referred to the Ombudsman. The provider had received five compliments in the last 12 months.
- Patients told us they knew how to make a complaint but did not always receive feedback from these. However, the provider said they always sent feedback letters to patients.
- All staff spoken with knew how to handle complaints made and responded appropriately.
- Staff told us the provider did not always share feedback on the findings from complaints so they could act on these.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- The vision of the Farndon unit was “Care without compromise”. Staff were aware of this vision.
- Staff knew who the most senior managers within the organisation were and these managers had visited the wards. Some staff told us that the registered manager was not always visible on the wards. However, other staff told us they could always contact the registered manager if needed and they would respond. The clinical director was a psychologist and provided therapy to patients and was often visible in the hospital.

Good governance

- Systems were effective in ensuring that staff received mandatory training, incidents were reported and safeguarding procedures were followed. However, sufficient staff did not receive regular management supervision or an appraisal. Staff did not receive feedback on learning lessons from incidents or

complaint investigations. Staff did clinical audits. However, actions identified in these audits were not always completed to make improvements. Mental Health Act policies did not comply with the current Code of Practice 2015 and referred to previous guidance. Staff did not always follow the Mental Health Act and Mental Capacity Act policies.

- Action had not been taken to make sure that the wards were clean following our reports which identified this during our inspections on 15 February 2016 and 22 December 2016.
- Action had not been taken following pharmacy audits which identified that medicines were stored at too high a temperature which could affect their safety and effectiveness. The provider said the system for auditing was undertaken by Ashtons pharmacy and was an online system. However, we did not see any record of what action had been taken from pharmacy audits during our inspection.
- Environmental audits had not identified issues with the fire doors and equipment. This was identified in the fire officers' report on 13 March 2017 and action was required. The fire risk assessment was found to contain insufficient detail during the fire officers' visit.
- Action was not taken following patients' community meetings to make improvements. For example, patients raised the issue that sanitary bins needed to be emptied more regularly on 9 January 2017. This was raised again on 2 March 2017 but there was no clear record of what action was taken.
- Ward managers were not sure if they had the ability to submit items to the organisation's risk register.

Leadership, morale and staff engagement

- There were no cases of bullying and harassment reported.
- Staff knew how to use the whistle blowing process. Seven staff asked told us they felt able to raise concerns without fear of victimisation however, three staff told us they did not feel able to do this.
- Eight of 21 staff spoken with told us that morale was good. Thirteen members of staff spoken with said morale was not good. This was a contradiction to a recent Investors in People report that the provider shared with us. Staff told us that the staffing levels affected how they felt about their job satisfaction and they did not always feel their concerns were listened to.
- The provider surveyed all staff in 2016.They received 57 completed questionnaires out of a total of 142 sent out to staff. Staff were encouraged to respond and were given the opportunity to complete the survey during work time. The provider told us that staff felt satisfied with the quality of work and patient care they delivered, they worked well as a team, were satisfied with the benefits they got and believed that the training/ progression opportunities were good.
- There was a joint consultation group in the hospital which included managers and staff. The provider told us that this had been the focus of improving ward staff engagement, particularly as it was difficult to have individual ward staff meetings. Each ward was invited to provide a representative to attend the group.
- Ward managers said they had opportunities to attend leadership courses.
- Staff meetings were not held. Staff told us they did not have regular opportunities to give feedback on the service or have input into the service development.

Commitment to quality improvement and innovation

- The provider told us that the Farndon Unit was part of the following: National Benchmarking for Low Secure; UK post-traumatic stress (UKPTS) network; Responsible officers' network and the National association of psychiatric intensive care and low secure units (NAPICU).
- The provider told us they had won the following awards: Laing and Buisson national award for outstanding contribution to mental health services and Laing and Buisson national award for risk management.
- The clinical director had undertaken the development of best practice evidence based interventions informed by research and service evaluation. The Clinical Director had driven this forward leading to the development of two treatment pathways at the Farndon Unit; complex post-traumatic stress disorder and challenging behaviours.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must make sure the care environment is cleaned and properly maintained.
- The provider must make sure at all times there are sufficient staff to meet the care and treatment needs of all patients.
- The provider must make sure that all staff are safely deployed to meet patients' needs in a timely way.
- The provider must make sure that staff consistently check the contents of the emergency bags.
- The provider must make sure that medicines are safely stored and are given as prescribed.
- The provider must inform staff of all incidents and lessons learned and these must be reflected in practice.
- The provider must make sure all staff and patients are offered debriefing sessions following incidents.
- The provider must make sure that an examination couch is provided so that patients do have to be examined in their bedroom.
- The provider must make sure that all staff consistently record patients' weight and physical health observations.
- The provider must make sure that all staff have specialist training required for their role, regular management supervision and an appraisal.
- The provider must make sure that all staff follow hospital policies, the Mental Health Act and Mental Capacity Act.
- The provider must make sure that patient's capacity is assessed in line with the Mental Health Act and Mental Capacity Act.
- The provider must make sure that patients' nutritional needs are assessed and reviewed regularly. Where a patient is assessed as needing a specific diet, this must be provided.
- The provider must make sure that when patients' views are asked for, they are listened to and action is taken to make improvements where needed.
- The provider must make sure that actions identified in audits are completed, so that improvements are made to reduce the risks to patients and staff.
- The provider must make sure that all risks are identified and action taken to reduce these.

Action the provider SHOULD take to improve

- The provider should make sure that all staff on the shift attend the handover and receive the information they need.
- The provider should make sure that all care plans are recorded in a way that reflects the involvement of the patient.
- The provider should make sure that all staff respect patients' privacy and dignity at all times and knock on their bedroom doors before entering.
- The provider should make sure that facilities provided for visitors are safe, suitable and welcoming.
- The provider should make sure there are sufficient visitors' facilities so that all patients can have regular visits.
- The provider should make sure that all patients are offered the opportunity to be involved in regular meaningful activities.
- The provider should make sure that all patients are offered sauces and seasoning so they can flavour their food to their individual taste.
- The provider should make sure that information about how to make a complaint and about safeguarding is provided in an accessible format on all wards.
- The provider should make sure that information about the outcome of complaints investigations is shared with all relevant staff so that improvements can be made as a result.

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	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse • Consent to treatment and capacity requirements were not always adhered to. We found that eight assessments of the capacity of the patient were brief or not present. • The form entitled "capacity for consent to treatment record" did not include the diagnostic test as required by the Mental Capacity Act. This was a breach of Regulation 11(1) (4) (5)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • There was not consistent recording of the emergency bag checks and some items were out of date or missing. • All patients were searched on return from leave and there were monthly random searches of patients' bedrooms. These searches were not based on individual risk assessments. • Lessons learned from incidents were not shared with all staff. • The rooms where medicines were stored were above the recommended safe temperatures and action was not taken to reduce these. • One patient was not given medicine prescribed for diabetes in January 2017.

This section is primarily information for the provider

Requirement notices

- Staff had not recorded physical health observations consistently.

This was a breach of Regulation 12(2) (a)(b)(d)(g)(h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs • Staff had not recorded patients' weight consistently and taken action to review patients' nutrition and hydration needs. • The provision of healthy snacks was not based on the patient's individual dietary needs. This was a breach of Regulation 14(1) (4)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staff were not deployed to meet patients' needs in a safe or timely way. • Staff had not received regular management supervision and appraisals. • Staff were not offered training to give them an understanding of the needs of some patients, for example, learning disability, eating disorders, diabetes and epilepsy. This was a breach of Regulation 18 (1) (2)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- An examination couch was not provided. Patients were examined when needed in their bedroom which could compromise their privacy and dignity.

This was a breach of Regulation 15 (1) c

This section is primarily information for the provider

Enforcement actions

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • Some areas of the wards were dirty and action had not been taken to repair or clean identified areas in a timely way. • Action to repair an uneven square of concrete in the courtyard was not completed. This was a breach of Regulation 15 (1) (a) (c) (2).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Actions identified in audits had not been completed to make sure that improvements were made. • Audits had not identified all risks to patients and staff. • There was no evidence in community meeting minutes that staff took action to make improvements from listening to patients' views. • Policies were not updated to reflect changes to the Mental Health Act Code of Practice 2015 and the Mental Capacity Act 2005. This was a breach of Regulation 17(1) (2) (b) (e) (f)