Elysium Healthcare Limited (The Farndon Unit)

Quality Report

Farndon Road
Newark
Nottinghamshire
NG24 4SW
Tel:01636 642380
Website:www.elysiumhealthcare.co.uk

Date of inspection visit: 12 July 2017
Date of publication: 26/09/2017

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

Overall summary

- The provider had made significant improvements to the safety and cleanliness of the environment.
- The provider had refurbished and refurnished two wards and planned to complete this in all wards.
- The provider had installed air conditioning units and fans in medication dispensary rooms so that medicines were stored safely.
- The provider had redecorated and refurnished the visitors room. This was available for more patients to use and safe for children to visit.
- Staff took action following audits and from listening to patients views to make the hospital safer for patients, staff and visitors.

However:

- Some registered nurses did not know how to dispose of medicines safely.
- Some staff were not aware of how improvements had been made to the care of patients following learning from incidents.
- Some staff and patients did not feel supported following incidents.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards		We found: • The provider had made significant improvements to the safety and cleanliness of the environment. • The provider had refurbished and refurnished two wards and planned to complete this in all wards. • The provider had installed air conditioning units and fans in medication dispensary rooms so that medicines were stored safely. • The provider had redecorated and refurnished the visitors room. This was available for more patients to use and safe for children to visit. • Staff took action following audits and from listening to patients views to make the hospital safer for patients, staff and visitors. However: • Some registered nurses did not know how to dispose of medicines safely. • Some staff were not aware of how improvements had been made to the care of patients following learning from incidents. • Some staff and patients did not feel supported following incidents.

Summary of findings

Contents

Farndon Unit

Forensic inpatient/secure services

Summary of this inspection

Background to Elysium 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, previously 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 with a diagnosis of 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.

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.

The hospital had a manager registered with the CQC in post at the time of the inspection.

We carried out a comprehensive inspection of the Farndon Unit in March 2017 and a responsive inspection in December 2016. The inspection in March 2017 had identified the need for action to make sure the environment was safe and clean. There was also action needed to make sure the systems and processes in place assessed, identified, monitored and reduced risks to the health, safety and welfare of patients and staff. The inspection in March 2017 found the service to be requires improvement overall. This inspection was focused to determine if improvements had been made.

Our inspection team

Team leader: Sarah Bennett.

The team consisted of three CQC mental health hospital inspectors.

Why we carried out this inspection

We carried out an announced comprehensive inspection at the Farndon Unit on 14 and 15 March 2017 and visited unannounced on the evening of 13 March 2017. That inspection found that the hospital managers had failed to maintain appropriate standards of hygiene and adequate maintenance of the premises used to carry on the regulated activity. The hospital managers had also failed to show that they assessed and monitored their systems and processes to improve the quality and safety of the service and reduce the risks to patients' health and safety.

The CQC issued two warning notices to the provider requiring the provider to improve the situation by becoming compliant with Regulation 15, section (1) (a) (c) (e) (2), by 28 April 2017 and Regulation 17 (1) (2) (a) (b) (e) by 16 June 2017, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consequently, the hospital managers provided the CQC with an action plan about how they would achieve compliance.

We carried out an unannounced inspection on the 12 July 2017 to the Farndon Unit for assurance that improvements had been made. This report contains the findings of that inspection.

Summary of this inspection

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?

During the inspection visit, the inspection team:

- visited all five of the wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the registered manager and managers for each of the wards
- spoke with 11 other staff members; including nurses and social workers
- attended one morning meeting for patients on Ward A.
- collected feedback from one patient using comment cards
- carried out a specific check of the medication dispensing room on each ward and the central clinic room
- looked at the visitors room
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Elysium 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, previously 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 a diagnosis of 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.

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, 46 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

During this inspection we spoke with 10 of the 46 patients at the hospital.

One patient on Ward B told us that all the furniture and everything on the ward was new and the ward was a lot better than it was. One patient on Ward A said they were happy with their bedroom as it had recently been refurbished.

Summary of this inspection

Another patient on Ward B said that the staff on the ward worked really hard and the ward had changed since our previous inspection. They said that staff respected patients more, were able to facilitate more activities for patients whereas previously staff said they did not have enough time. The patient said there was more to do and it was easier to talk with staff.

One patient on Ward A said that since our previous inspection, staff cleaned the ward more often and staff encouraged her to tidy her bedroom, which she did.

Another patient said that staff did not treat patients like 'kids' now and the hospital had got a lot better since our previous inspection. They said that the ward had been redecorated; the provider had provided new chairs and tables which had made the ward more homely. They also said that there was always staff to talk to.

Patients on Ward A said there was nowhere to sit down and they spent more time alone in their bedroom because of this.

One patient on Ward A said that the new wardrobes did not have doors on due to ligature risks but a cupboard above the wardrobe could be used to store clothes. We saw and the patient told us that the cupboard could only be accessed by using furniture to climb on as a ladder which was unsafe. This meant that their clothes could not be stored in a tidy way.

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?

- The provider had redecorated and refurbished all areas of Wards A and B and provided new furniture in bedrooms and communal areas.
- The provider had refurbished all ward kitchens and purchased new fridges so that food was safely stored.
- Staff cleaned the wards more often to reduce risks of cross infection.
- The provider had repaired the uneven area of the courtyard so that it was safe for patients and staff to use.
- The provider had purchased air conditioning units for the medication dispensary rooms on four wards and a fan for the Recovery Ward. This meant that medicines were stored safely and would be more effective in treating patients.

However:

- Some registered nurses were unsure of how to dispose of medicines safely. This meant that large quantities of medicines no longer needed were stored around the hospital.
- New furniture provided did not allow patients to store their clothes safely.
- Some staff were unclear of how lessons were learnt from to make improvements at the hospital.
- Some staff did not receive support following incidents.

Are services responsive?

- The provider had redecorated and refurnished the visitors' room and this was now safe for children to use.
- Patients and staff told us that the system for booking the visitors room was better. This meant that patients could have visitors and keep in touch with their family and friends.

Are services well-led?

- Managers had provided supervision for more staff. However, we found that staff did not have an allocated supervisor so supervision was not consistent for all staff.
- Staff took action following audits to make sure that the hospital and equipment used was safe for patients to use.
- Staff listened to comments made by patients and took action to make improvements as a result.

Forensic inpatient/secure wards

Safe	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- The provider had refurbished Wards A and B and provided new bedroom furniture since our previous inspection. The new wardrobes did not have doors on due to ligature risks (a place/object to which patients intent on self-harm might tie something to strangle themselves), however a cupboard above the wardrobes could be used to store clothes. We saw and patients told us that they could only access the cupboard by using furniture to climb on as a ladder which was unsafe. The registered manager told us they had looked at how similar furniture to reduce ligature risks in other hospitals had been used to make sure that patients could store their clothes safely.
- At our previous inspection, we found that the temperatures of the medication dispensing rooms on the wards were too high to safely store medicines. At this inspection, we found that the provider had installed air conditioning units in these rooms on four wards and the central clinic room. The provider had provided a fan for the medication dispensary room on the Recovery Ward. This meant that medicines were stored at a safe temperature so they were effective in treating patients. Staff tested the temperatures daily to make sure they continued to store medicines safely.
- At this inspection on Ward C, we found that staff had removed the box of medicines to be disposed of to a central storage room as the box was overfull and caused a hazard in the medication dispensary room. Staff we spoke with were unsure of how to dispose of medicines that were out of date or no longer required for patients. In Ward D, we saw that the bin in the medication dispensary room did not have a lid on it. This meant that there was a risk of cross infection.
- At our previous inspection in March 2017, we found that the seclusion facilities did not comply with standards set out in the Mental Health Act (1983) or the Code of Practice (2015). The provider confirmed that the seclusion room had not been used since the Farndon Unit opened. The provider had sought quotes to refurbish the seclusion room to meet the standards. They had also sought advice from NHS England as to whether they needed a seclusion room at the hospital as it had not been used. They were waiting for feedback about this.
- Since our previous inspection, the provider had done a lot of work to refurbish the wards so that they were safe and well maintained. The provider had refurbished all the kitchens and fitted new cupboards, worktops and fridges on all wards. Records we looked at showed that staff had monitored the kitchen fridge temperatures. These were within the safe limits for storing food. The provider had redecorated Wards A and B and provided new furniture in all bedrooms and communal areas. We saw that decorators were on site and were continuing to refurbish the hospital. This would include the other three wards which would be redecorated and refurnished in the same way. On Ward A, we observed that there were only six chairs for nine patients so that some patients were not able to sit in a comfortable seat. Patients and staff we spoke with told us that it had been like this since the refurbishment.The ward was crowded as only one lounge was being used. Patients and staff told us that the other lounge was used by one patient for activities. We saw that three patients sat on the floor around the nurses' office and the entrance to the de-escalation room. Staff escorted another patient to the de-escalation room but this was difficult as other patients were congregated in this area. On 19 July 2017, we visited the hospital for a meeting with the providers. Before the meeting, we asked to go to Ward A. The ward manager told us that patients had decided that they wanted to use the second lounge as a dining room. Maintenance staff had moved the dining room tables and chairs from the other lounge area which made it less crowded. One patient was doing an activity with staff at the dining table. The lounge area was relaxed and calm and patients sat with staff who were talking

with them. There were 10 chairs in the lounge area available to sit on. The provider told us that they had ordered more chairs so there would be enough for all patients and staff supporting them to sit comfortably. There were no patients outside the nurses' office.

- From the lounge area now used as a dining room, there was a small garden and another longer garden. Patients did not have access to these as they were not safe. There were several stones around which patients could use to self-harm and the walls were not high enough to keep patients safe. Managers spoke with us about making these areas safe and providing fencing to make them secure. This meant that patients would have more access to safe outside spaces from the ward.
- The provider had repaired the uneven concrete area in the courtyard and installed a planter. This made the area safe and looked attractive in an area where patients could sit outside.
- Staff cleaned all areas regularly and recorded this on the cleaning rotas we looked at. The wards were clean and staff had cleaned equipment where needed.Housekeeping staff cleaned each ward once a week and nursing staff on the wards cleaned daily with patients as much as possible. The registered manager told us that they had recruited more housekeeping staff and were waiting for their checks and references to be returned before they could start working there. This meant that there will be a housekeeper allocated to each ward to clean daily.
- Since our previous inspection, the managers had reviewed and updated the fire risk assessment. The fire officer had visited the hospital again to monitor the risk assessment and make sure that fire equipment was provided and maintained. The registered manager told us most of the required equipment had been fitted with the exception of self- closing devices on doors. This was because they were a ligature risk. However, the registered manager had liaised with other similar hospitals to get advice on how they had managed these risks. The registered manager and the provider had plans to keep patients safe from the risks of ligatures and fire. We saw that a fire safety contractor had serviced the fire extinguishers on each ward in June 2017. In the week before our inspection managers had tested how staff and patients would safely leave the hospital if there was a fire. This had been successful and all patients and staff were able to evacuate the building safely.

Reporting incidents and learning from when things go wrong

- Some staff on the wards were not clear as to how they had learned from incidents that had occurred on the wards. At our previous inspection, 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. At this inspection, we found that the provider had made sure that all staff had email accounts and emails about learning lessons from incidents at the Farndon Unit and in similar hospitals were communicated to all staff. However, four of the 11 staff we spoke with told us that managers did not provide feedback from incidents to staff on the wards. They said that managers only gave them feedback if they had not completed incident forms properly. Managers told us and we saw that since our previous inspection incidents were reported using an online system. They said this allowed managers to go back to staff to ask for more information. Two staff we spoke with told us that there were no staff meetings and we saw no evidence that these occurred. At our meeting with the provider on 19 July 2017, the registered manager told us that staff were given information about lessons learnt through emails, briefings and supervision. However, we found that staff on the wards needed more support to learn how improvements were made on the wards and to the care of patients as a result of learning from previous incidents.
- Some staff did not feel supported following incidents. At our previous inspection, five staff we spoke with said they did not receive debrief following an incident on a ebrief following incidents to reflect on what happened

and discuss any ways that they might handle the situation differently in the future. One staff member told us there were never debriefs following incidents for staff and patients. Another staff member told us that managers had not supported them following an assault by a patient. Managers told us examples of where they had offered staff support but staff had refused this.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

The facilities promote recovery, comfort and dignity and confidentiality

- At our previous inspection, we found 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. The temperature of the visitors' room 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. At this inspection, the temperature of the room was warm and comfortable. The provider had purchased safe toys, books and children's DVDs and easy chairs. Staff and patients told us that the provider had a better system for booking the room which made it fairer and made sure that all patients could see their visitors.

Are forensic inpatient/secure wards well-led?

Good governance

- At our previous inspection, we found that managers did not regularly provide regular supervision to all staff. The provider showed us information at this inspection which showed improvements had been made. In April 2017, 69% of staff across the hospital had received supervision. In June 2017, this had risen to 82% of staff. On Ward A, all staff received supervision in June 2017. However, two staff told us that they had received supervision but this was with a different nurse each time which meant it was not consistent. Supervision records we looked at confirmed that staff did not have an allocated supervisor.
- We found at our previous inspection that actions identified in audits were not always completed to make improvements. At this inspection, staff identifying actions on audits followed these up to make sure improvements occurred. This meant that the environment and equipment were safe for patients, staff and visitors. It also meant that medicines were stored at safe temperatures so they would be effective in treating patients.
- At our previous inspection, we found staff did not take action to make improvements following comments patients made at community meetings. At this inspection, we saw posters displayed on notice boards on the wards and around the hospital. These showed what patients had said and what staff had done as a result of listening to their comments. For example, providing more gym sessions for patients. On Ward A, patients had decided to make the second lounge a dining room which made more room in the lounge. Staff immediately responded to this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- 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 all medicines are disposed of safely.

Action the provider SHOULD take to improve

- The provider should consider how the outside spaces from Ward A can be made safe so that patients can use these.
- The provider should consider ways to make sure that patients can store their clothes safely.
- The provider should make sure that all bins have lids on to reduce the risk of cross infection.
- The provider should consider how supervision for staff could be consistent to support all staff and make sure they have the same opportunities for development and learning.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • Lessons learned from incidents were not shared with all staff. • Some staff and patients did not receive a debrief following incidents. • Staff were not aware of how to dispose of medicines safely. This was a breach of Regulation 12(2)(b)(g)