Requires improvement

Elysium Healthcare (Farndon) Limited

The Farndon Unit

Quality Report

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Date of inspection visit: 5-6 December 2018
Date of publication: 19/02/2019

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-113084566	The Farndon Unit	Forensic inpatient/secure wards	NG24 4SW

This report describes our judgement of the quality of care provided within this core service by The Farndon Unit. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by The Farndon Unit and these are brought together to inform our overall judgement of The Farndon Unit.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Requires improvement** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

Our rating of this service went down. We rated The Farndon Unit as Requires Improvement because:

- The hospital continued to have challenges in recruiting enough permanent staff and so had a high reliance on agency staff. These staff were not always familiar with the patients and their needs and this presented a clinical risk.
- The provider did not consistently follow best practice in the safe storage, control and administration of medicines and clinical equipment or infection control principles.
- Staff did not adhere to the provider's policy around the use of safe and supportive observation practice. Staff did not consistently record or escalate a deterioration in patients' physical health and staff had not received training in sepsis identification or management.
- Staff did not consistently know how and when to report a safeguarding concern or referral to external agencies and we saw variation in how and when staff reported safeguarding concerns.
- Patients told us not all staff treated them with compassion and kindness and did not consistently respect their privacy and dignity or understand the individual needs of patients. The hospital did not actively involve families and carers in care decisions.
- The hospital did not consistently provide patients with access to information about their care and treatment, how to complain, access to advocacy and appropriate spiritual support.
- The hospital did not have robust governance processes in place to support the safe care and treatment of patients within the hospital.

However:

- Staff minimised the use of restrictive practice wherever possible and patients were engaged in decisions about their care and treatment.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

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

Are services safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- The provider did not consistently follow best practice in the safe storage, control and administration of medicines and clinical equipment. Staff did not always adhere to infection control principles and we found gaps in cleaning records of the clinic rooms.
- The service continued to have challenges around recruiting permanent staff which resulted in high levels of agency staff use. Patients reported agency staff were not always aware of their needs. At times, the service struggled to have enough female staff members to meet the care and treatment requirements of the patients.
- Staff did not complete patient observations in line with the provider's policy. We saw staff backdated observations, did not complete them at irregular intervals and did not consistently record for signs of life when patients were sleeping, as outlined in the provider's policy.
- Staff did not use tools to monitor a deterioration in patients' physical health accurately. Staff used different systems for recording patients' physical observations, did not score these observations in line with national guidance and did not consistently escalate a deterioration in patients' physical health appropriately.
- We observed visitors attended the ward without removing items from their person that were recorded on the hospital's restricted items list. This presented a serious clinical risk to patients who were at risk of engaging in self-harming behaviour with these items.
- Staff were not clear on when and how to raise safeguarding concerns with the appropriate agencies external to the organisation.

However:

- All communal wards areas were clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Summary of findings

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information.
- There was adequate medical cover day and night and a doctor could attend in an emergency.
- Staff were up to date with mandatory training.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which staff reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The care plans included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. They engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Summary of findings

- Staff supported patients to make decisions about their care for themselves. They understood the provider's policy about the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who had impaired mental capacity.

However:

- We spoke to 14 out of the 16 patients who said there were not enough activities on the ward and reported feeling bored.
- The provider had not reviewed patients' advance decisions or crisis plans for over a year.

Are services caring?

Requires improvement

Our rating of Caring went down. We rated it as requires improvement because:

- Staff did not inform or involve families and carers appropriately. Although the provider had made efforts to engage with families and carers, this had not yet been successful. Patients and their families reported feeling unsupported to maintain these relationships.
- Patients reported that staff did not always treat them with compassion and kindness. Patients told us staff did not always respect their privacy and dignity and some staff who were unfamiliar with the patients did not understand the individual care and treatment needs of patients.

However:

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Patients had access to regular community meetings on the wards. Patients were encouraged to give feedback through the patient survey questionnaires, community meetings, one to one meetings with staff and weekly ward manager drop ins.
- Patients were involved in the recruitment of staff as part of the interview panel.
- During patient review meetings, staff projected the information that was being discussed on a screen so that the patient could see this and the patient was included in the discussion and decision-making about their care.
- Staff arranged for patients to receive first aid training.

Are services responsive to people's needs?

Good

Our rating of Responsive stayed the same. We rated it as good because:

Summary of findings

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service treated concerns and complaints seriously. They investigated them, learned lessons from the results, and shared these with the whole team and the wider service.
- The provider enabled patients to work alongside a theatre company to take part in interactive theatre and drama-based groupwork and patients created a film about moving on from hospital.
- Staff supported patients to work alongside a learning disability charity so that patients within the hospital co-facilitated groups for the charity's clients. The charity attended the hospital as a guest presenter to deliver cooking and computer skills sessions for patients at The Farndon Unit.

However:

- Staff were unable to easily locate patients' personal emergency evacuation plans. One of these plans was out of date and did not reflect the patient's current needs regarding emergency evacuation.
- Staff used one of the assisted bathrooms inappropriately for storage and it was not accessible for patients to use. Staff rectified this during our inspection.
- Staff had not developed care plans to address the specific needs of patients who identified as transgender or gender fluid.
- Some patients reported not having access to information about their care and treatment options, how to complain and advocacy. When this information was given to them, it was not always in an accessible format.
- Patients did not have access to appropriate spiritual support.

Are services well-led?

Our rating of Well led went down. We rated it as requires improvement because:

Requires improvement

Summary of findings

- The hospital did not have robust governance systems in place to ensure the ward environment was kept safe.
- The hospital did not consistently act on findings from audits to make improvements to the service.
- Staff did not know the provider's vision and values or how they applied them in the work of their team.
- Staff did now know the role of the Speak Up Guardian.

However:

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and provided opportunities for career progression. Overall, staff felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Summary of findings

Information about the service

The Farndon Unit is registered with the Care Quality Commission as an independent low secure mental health hospital. The hospital, run by Elysium Healthcare Limited, accommodates up to 48 female patients over the age of 18 years. The Farndon Unit offers 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 following regulated activities:

- 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; Adanac, Bolero, Cortland, Darcy and a low secure rehabilitation/recovery ward called Ruby Frost.

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

Our last inspection of this service was in November 2017. We rated this service as Good in all domains.

Our inspection team

Team leader: Katie Lawson-King

The team that inspected the service comprised one CQC inspection manager, a CQC inspector, two CQC assistant inspectors and two specialists, including a mental health nurse and a social worker and an expert by experience. An expert by experience is a person who has experience of using mental health services.

Why we carried out this inspection

We inspected this service earlier than anticipated in line with our ongoing comprehensive mental health inspection programme because we received intelligence from whistle-blowers, external stakeholders and an increase in safeguarding notifications received from the hospital. As a result, we decided to carry out a comprehensive 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?

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 across the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- Spoke with 16 patients who were using the service;
- Spoke with three family members of people using the service;
- Spoke with the hospital director and clinical director;
- Spoke with 33 other staff members; including doctors, nurses, healthcare assistants, members of the occupational therapy and psychology teams;
- Looked at 18 care and treatment records of patients;

Summary of findings

- Carried out a specific check of the medication management on two wards;
- Reviewed the medication charts of four patients across Bolero and Darcy wards;
- Attended and observed a patient-led community meeting and a multi-disciplinary meeting, and;
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 16 patients. Patients told us staff did not take their physical health needs seriously and there were often delays in accessing treatment. Patients were complimentary about the regular staff who worked on the wards, however almost all patients told us there was often unfamiliar staff working on the wards and this did not make them feel safe. Patients gave mixed feedback about the activities available at the hospital. Fourteen out of the sixteen patients we spoke with told us there were not enough activities available on the ward, particularly at weekends and reported often feeling bored. All the patients we spoke with said they did not feel that the hospital kept their families and carers up to date about their care and felt that it was up to them to do this.

Good practice

Patients worked alongside a theatre company who presented interactive theatre and facilitated drama-based groupwork. Patients at the hospital completed a film about moving on from hospital. This was for other patients to view this in preparation for moving on. The premier was held at the hospital and was a great success. Patients who were involved in this project attended the Elysium service user conference to present their work on the film. One of the patients who was involved in this project had been discharged and had returned to the unit to deliver a paid session on the programme to the current patient group.

Staff supported patients to work alongside a learning disability charity that supported people with learning disabilities in Nottinghamshire. They charity ran courses, social activities and projects to help people get the life they want in their own community. Supported by the occupational therapy assistant, patients within the hospital co-facilitated groups for the charity's clients. As a result of this engagement, the charity attended the hospital as a guest presenter to deliver cooking and computer skills sessions for patients at The Farndon Unit.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff follow best practice in the safe storage, control and administration of medicines and clinical equipment.
- The provider must ensure clinic rooms are cleaned regularly and provide evidence of this.
- The provider must ensure staff complete patient observations in line with the provider's policy.
- The provider must ensure staff receive training in how to identify and manage symptoms of sepsis.
- The provider must ensure staff use nationally recognised tools effectively to monitor deterioration in patients' physical health accurately.
- The provider must ensure that where a patient gives consent for staff to do so, families and carers are involved in the patient's care and treatment and able to maintain regular contact with their family members.
- The provider must ensure robust governance structures are put in place to monitor the safety and culture of the ward environment and to act following audits.

Summary of findings

Action the provider SHOULD take to improve

- The provider should ensure infection control principles are adhered to, including access to and use of anti-bacterial hand soap dispensers in all clinical areas.
- The provider should ensure staff receive training in how to identify and manage symptoms of sepsis.
- The provider should ensure they continue to make efforts to recruit permanent staff, taking into account the gender balance between staff and the patients at the hospital.
- The provider should ensure all staff are aware of when and how to raise safeguarding concerns and make referrals to external agencies as and when required.
- The provider should ensure staff treat patients with dignity and respect and that staff are aware of the individual needs of the patients they work with.
- The provider should ensure all visitors are made aware of the restricted items list before entering the ward environment.
- The provider should ensure advance statements or crisis plans are up to date.
- The provider should ensure all staff have easy access to up to date personal emergency evacuation plans that are tailored to the needs of individual patients.
- The provider should ensure all clinical areas are not used for storage and are used appropriately.
- The provider should ensure patients who identify as transgender or gender fluid have their needs identified within their care plans to enable staff to support them appropriately.
- The provider should ensure all patients are given access to information on treatments available at the hospital, advocacy and how to complain.
- The provider should ensure patients have access to spiritual support within the hospital and in the community.
- The provider should ensure staff are aware of the role of the Speak Up Guardian.
- The provider should ensure staff are aware of and engaged with the provider's vision and values.
- The provider should ensure there are enough personal alarms for all staff and visitors at all times, including when the service has a high number of visitors.

Elysium Healthcare (Farndon) Limited

The Farndon Unit

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Forensic inpatient/secure wards	The Farndon Unit

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.

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

- At the time of our inspection, 88% of staff had received training in the Mental Health Act. Overall, staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. However, staff we spoke with on Cortland ward were unsure about some of the key principles.
- Staff had easy access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrator was.
- Staff had access to local Mental Health Act policies and procedures and to the Code of Practice which reflected the most recent guidance.
- Patients had access to independent advocacy and information leaflets about advocacy and their rights were displayed on the wards.
- Staff explained to patients their rights at the correct frequency. They did this in a way that patients could understand and recorded this.
- Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted. Patients were given a copy of this leave form before leaving the hospital.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records for example, section 17 leave forms correctly so that they were available to all staff that needed access to them.
- Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of our inspection, 83% of staff had had training in the Mental Capacity Act. Overall, staff showed

a good understanding of the Mental Capacity Act, in particular the five statutory principles. However, staff we spoke with Cortland ward were unsure about some of the key principles.

- The provider had not made any deprivation of liberty safeguards applications between 31 March 2018 and 30 September 2018.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. We reviewed the quality of capacity assessments recorded in patient's notes and saw they were detailed and demonstrated clear recognition of patient's fluctuating capacity. Staff discussed patients' mental capacity as part of the multi-disciplinary team meeting.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff supported patients to develop advanced statements and crisis plans. These were plans to outline how the patient would like to be treated in the event of them losing capacity or becoming unwell. However, staff had not reviewed four plans we looked at for over a year.
- The provider completed regular Mental Capacity Act audits and acted upon any findings.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Safety of the ward layout

- Staff completed weekly environmental risk assessments of the care environment and reviewed these monthly at governance meetings. Staff completed ligature risk assessments annually or more frequently when new equipment was added to areas accessed by patients or changes were made to fixtures or fittings. Ligature points are fixtures to which people intent on self-harm might tie something to strangle them self. All fixtures and fittings within the patient areas were anti-ligature and any new furniture, fixtures and/or fittings had to be signed off by the health and safety group to make sure they did not present a risk to patient safety. The ligature risk assessment identified some low risk ligatures and staff had acted to mitigate against these risks, including increased observations and regularly assessing patients' access to risk items.
- The ward layout did not allow staff to observe all areas of the ward but this risk was mitigated by using convex, curved mirrors and staff observation.
- There were nurse call systems in patient bedrooms and all staff carried personal alarms that staff tested regularly. During our inspection visit, staff had experienced problems with their personal alarms. As a result, staff were given screech alarms. These were in addition to their usual alarms as a contingency plan whilst the primary personal alarm system was assessed by maintenance. We noted that during our visit, the primary alarm system that was faulty was activated several times in error and this was disruptive for patients and staff. During our inspection, staff reported the hospital had run out of alarms due to a high volume of visitors. Staff were unable to provide information about a contingency plan to mitigate against this in the future.

Maintenance, cleanliness and infection control

- All ward areas were visibly clean, had good furnishings and were well-maintained. Cleaning records showed the wards were cleaned regularly. Where there were missing signatures within cleaning records, this was highlighted and reported to ward managers to follow up with domestic staff.
- Although there were signs displayed promoting good hand washing, there were several antibacterial hand gel dispensers throughout the hospital that remained empty during our inspection and we did not observe staff using these dispensers. In the clinic room on Cortland ward, there was no soap available and staff used only water to wash their hands.

Clinic room and equipment

- There was one large clinic room situated between wards Adanac and Bolero wards and medication dispensaries were located on all wards. We noted several issues relating to the clinic room and medication dispensaries and equipment stored within them.
- On Cortland ward, cleaning equipment was stored in the medication dispensary and we saw a used wet mop in the room. This presented a serious infection control risk. Medication cards were stored on top of the bin and equipment was inappropriately stored under the sink, including bandages and a first aid kit. This presented a clinical risk as if the sink leaked it would damage this equipment.
- We found gaps in clinic room cleaning records and a lack of evidence to suggest that staff regularly checked stock for expiry dates or that they regularly checked the medical equipment. There were missing signatures for medication for two patients on three separate occasions during the month of November 2018. Staff reported that the medication dispensaries on the main wards were too small to safely store and prepare medication.
- On Darcy ward, we noted expired equipment and nutrition drinks, medication cards not signed correctly and four missing signatures for three separate patients' medication for the month of November 2018. The fridge on Darcy ward was overfilled and frozen. This had resulted in a patient's EpiPen being frozen, as well as the infection box and an Ensure nutritional drink.
- In the other medication dispensaries and the larger clinic rooms between the wards, none of the sharps bins were labelled correctly. This suggested staff did not follow best practice in the safe disposal of medication.

Requires improvement

Are services safe?

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- The larger clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Safe staffing

Nursing staff

- At the time of the inspection, the establishment for the service was 29 whole time equivalent registered nurses and 70 whole time equivalent healthcare assistants.
- There were 10.22 whole time equivalent nursing vacancies and 20.09 healthcare assistant vacancies. Seven of these 10.22 nursing vacancies were currently under offer. This is a significant reduction in nursing vacancy levels since our last inspection in November 2017, where the service had 16.8 nurse vacancies. Staffing concerns remained listed on the hospital's risk register and the provider continued to promote their ongoing active recruitment campaign to reduce vacancies.
- Managers calculated the number of nurses and healthcare assistants required for each shift and used bank and agency staff on a regular basis to fill shifts and support patient observation levels. Managers could adjust staffing levels daily to take into account the requirements of the patients to maintain patient observations on the wards. The nurse in charge of each ward completed the safe staffing database for the areas they were responsible for. This showed the planned staffing against the actual staffing and how the ward staffing requirements were being met.
- The provider ensured there was always a minimum of 10 female staff members across the wards to try to make sure the patients had the appropriate gender mix of staff caring for them. Staff and patients reported that this remained a challenge for the service and we observed this to be the case. Staff prioritised female staff members to be allocated to patients who required one to one observation with a female staff member. This meant that at times there were no other female staff in the communal areas of the ward. There were still occasions on Adanac and Bolero wards where patients who were care planned to have at least one female member of staff on their observations did not have a female member of staff present. This was not addressed in the hospital's risk register.
- The service had introduced a nursing activity oversight document which outlined the nursing needs across the service for each shift and how these were being covered. They had also introduced a break planning document to improve how resources were coordinated and outline contingency plans to support unforeseen or emergency events. Staff reported this and we saw it had greatly improved the coordination of each shift. On the whole, this allowed staff to take their breaks. However, we noted on Adanac ward there were still occasions where this did not happen and qualified nursing staff were unable to take their breaks due to clinical activity on the ward. Staff reported they were often assigned to carrying out patient observations for hours at a time, contrary to the provider's policy which states that observations of the same patient should be handed over at up to a maximum of two hourly intervals.
- The provider tried to fill shifts with bank and agency staff who were familiar with the ward and ensured they had an induction to the ward and the required training.
- The number of shifts covered by bank or agency staff between 1 July 2018 and 30 September 2018 was 1949. Of this bank and agency cover, 41% was provided to Adanac ward.
- The number of shifts not filled by bank or agency staff between 1 July 2018 and 30 September 2018 was 33. The provider reported their safe staffing level daily to head office and if it was not received or the levels were below the safe level then an alert was issued. In this instance, the ward manager instigated the contingency plan, which usually involved the ward managers assisting on the ward or rearranging activities where required.
- As of 30 September 2018, the staff sickness rate was 3.7% and the staff turnover rate was 48.2%. Whilst the sickness rate had declined since our last inspection, the staff turnover rate had increased significantly from 5% to 48.2%. The provider offered all leavers an exit interview. Key themes from these interviews included leaving the service due to a change in personal circumstances, following other careers and dismissal by the management team. Where staff raised issues in their exit interviews about practice or care and treatment, the provider had taken action to address these concerns and embed changes.
- We saw and records showed a qualified nurse was present at all times in communal areas or available in the nursing office. Healthcare assistants were always present on the ward in communal areas.

Requires improvement

Are services safe?

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

- Most of the time, patients could have regular one to one time with their named nurse, access section 17 leave and engage in ward-based activities. Patients and staff told us there were occasions when this did not happen due to increased clinical activity on the ward or when staff were supporting patients on emergency medical leave. Staff tried to rearrange rather than cancel activities at times when this happened. The hospital had recently begun auditing the number of times that staff cancelled activities and patient uptake of activities. We reviewed this information on Adanac ward and saw that staff rarely cancelled activities.
- There were enough staff on the wards to carry out physical interventions safely when required and all staff had been trained to do so. We observed staff responding to alarms during our inspection and saw this response was immediate and well-co-ordinated.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training. This had improved since our last inspection. All training courses had above 75% completion rates. However, not all staff received training in sepsis. Only two nurses across the hospital had attended training about sepsis. This presented a serious clinical risk for patients who may become unwell as staff were not trained in how to identify or manage sepsis. We raised this with the hospital director who told us this was due to be rolled out to staff through induction and as part of staff mandatory training from January 2019.

Assessing and managing risk to patients and staff

Assessment and management of patient risk

- We looked at 18 sets of patient care records across the wards. All of them demonstrated that staff assessed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Patient electronic care plans had alerts on them to indicate if a patient was at high risk, for example, for self-harming behaviour.
- Staff used a recognised risk assessment tool and updated this regularly, including after an incident, to reflect the most up to date assessment of each patient's risk.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The hospital had positive behaviour support champions throughout the hospital who offered advice to staff about how best to use this model.
- The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff had conducted risk assessments with patients to determine their level of observation requirement during the day and at night. However, staff did not follow the provider's policy around completing and recording patient observations. On all observation records reviewed, we did not see any evidence of staff observing patients at irregular intervals, as outlined in the provider policy. This meant that patients may predict when the staff were due to conduct their observations, leaving them vulnerable to engaging in risk-related or self-harming behaviour. Additionally, it suggests that all patients were seen across the hospital at the same time. As this is unlikely, this indicates that patient observations were not being recorded in real time.
- Staff did not consistently record patient observations in line with their level of risk. For example, we saw several gaps in the recording of patient observations for a patient who was on five-minute observations on Adanac ward.
- When patients were observed to be sleeping, staff did not consistently record whether they had checked for signs of breathing as outlined in the provider's policy. This should be done by listening out for snoring, observing the chest to see if there is chest movement or feeling for breath.
- One staff member reported to us and we observed that they back dated patient observations. For example, we saw staff recording patient observations at 11:30 for four patients who they had observed at 11:10, 11;15, 11:20, 11:25. This was contrary to the provider's observation policy and presented a serious risk to patient safety. Staff said this was necessary to allow them to engage with patients rather than continuously writing the whereabouts and wellbeing of the patients.

Requires improvement

Are services safe?

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

- Restrictions were based on individual risks and not blanket restrictions. For example, staff had risk assessed some patients to not be safe to have access to their bedroom during the day or be allowed unsupervised access to the kitchen, whilst others had been risk assessed as safe to do so.
- Staff risk assessed patients individually for access to high risk items. Staff followed the authorisation and control of high risk items policy by being as least restrictive as possible in their decision making about what items patients could have. Each patient had an individual tool access sheet at the front of their paper folder that was replicated within their electronic clinical notes. Staff reviewed each patient's tool access at their monthly ward round or more frequently where there was a clear change in risk. This meant that patients' access to risk items was risk assessed by each patient's multidisciplinary team. We saw evidence that staff frequently reviewed patients' tool access and that staff exercised the least restrictive practice wherever possible. Wards also had a sharps checklist that staff completed six times a day which included bedrooms, utensils, windows to ensure patients did not have unsupervised access to sharp items that they may use to harm themselves.
- Staff risk assessed patients individually to decide whether they needed to be searched when leaving and entering the unit and whether they required bedroom searches. Staff discussed this with the patients, obtained their consent and care planned this appropriately. Patient searches were carried out by a female member of staff with another staff member present and this was done in a private area, usually the de-escalation room. Staff made the decision to search a patient and/or their bedroom on an individual basis and in response to a change in patient risk and recorded this rationale appropriately. This had improved since our last inspection.
- Staff identified and responded to changes in patients' behavioural risks. For example, following an increase in incidents where patients had self-harmed using pens, the hospital had introduced a policy that all staff used specific bendy pens that if obtained by a patient for self-harm, would not result in serious injury. However, during our inspection, we observed a visitor entering the ward environment with standard pens and they were not asked to remove these or use a bendy pen. This presented a risk to patient safety. We also had feedback from external agencies that this was the case when they had visited the ward and that staff did not apply this policy consistently.
- Staff did not consistently respond appropriately to deterioration in patients' physical health. We reviewed the national early warning scores (NEWS2) charts for two patients who were subject to enhanced physical observations based on concerns noted in their initial physical health assessment. We found staff had not consistently completed or scored the NEWS2 charts and did not complete follow up observations as indicated in the NEWS2 escalation procedure. Staff also did not consistently record patients' physical observations in the correct place.
- The hospital had recently introduced a procedure for staff to input patients' physical observations on the electronic system, rather than the paper system. However, this change in procedure meant that staff were not calculating the NEWS2 scores for patients' physical observations and therefore were not monitoring the patients appropriately for any deterioration in their physical health. For example, staff took the observations of one patient who required their physical observations to be taken at least once per day at 19:36 on 25 November 2018 and recorded this on the electronic system. The patient's NEWS2 score indicated staff should retake the patient's physical observations within four to six hours. However, there were no further NEWS2 scores inputted onto the electronic system. We located this patient's paper records and found that staff had taken the patient's physical observations 19 hours later. In the same patient's records, we found there were several omissions in the daily recording of their physical observations and staff had not consistently scored the NEWS2 charts. We raised this issue with the hospital director and since our inspection, the hospital director shared a hospital-wide email to clarify the service was no longer using the electronic system for recording NEWS2 scores. Staff have also been reminded where to record when patients refuse observations and to ensure that there is a record of the judgement and discussion with the responsible clinician or GP when observations are discontinued.
- Staff adhered to best practice implementing a smoke free policy. Records and posters displayed around the wards showed that patients were given support to stop smoking.

Requires improvement

Are services safe?

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

- Between 31 March 2018 and 30 September 2018, there were 271 incidents of restraint used for 34 patients. The number of restraints reflected the level of need of the patients on those wards. This had reduced since our last inspection, where there had been 514 incidents of restraint across the same time period. During this inspection, 52% of the incidents of restraint were on Adanac ward and 35% were on Bolero ward. Of the total incidents of restraint, eight involved prone (face-down) restraint and two of these resulted in rapid tranquilisation. Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. The provider had updated their training to include new techniques for medication administration to avoid prone restraint and rapid tranquilisation.
- The hospital did not use long-term segregation or seclusion.

Safeguarding

- Although the provider had trained 96% of staff in safeguarding adults and children and had a framework in place to support staff to know how and when to make a safeguarding referral to the local authority, not all of the staff we spoke with knew how and when to report a safeguarding concern or referral.
- As part of our information gathering prior to the inspection, we spoke with the local authority safeguarding team. They reported staff at The Farndon Unit did not keep them up to date with what actions they had taken around outstanding safeguarding incidents. Although the local authority team said there had been a fall in the number of section 42 safeguarding investigation referrals made by The Farndon Unit, we did not find any incidents that should have resulted in a section 42 investigation that had not been referred to the local authority team. The hospital held monthly meetings with the local authority safeguarding team to review all open and ongoing safeguarding investigations and monitor progress against agreed action plans.
- At the time of our inspection, there were two vacant social worker positions and as a result, the lead nurse was responsible for safeguarding training and referrals. The lead nurse had implemented updated safeguarding training which was detailed and comprehensive. In addition, staff received annual safeguarding adults and children training and three yearly Prevent training. Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. The Prevent Programme is designed to safeguard people in a similar way to safeguarding processes to protect people from gang activity, drug abuse, and physical and sexual abuse.
- Managers discussed safeguarding at the morning meeting and logged any incidents on a safeguarding database to allow the service to monitor the number of incidents occurring and identify trends and themes. We saw examples of how managers had done this and actions taken to reduce the likelihood of these incidents recurring in the future. Staff shared this information in the lessons learned briefing which took place monthly. The director of nursing had recently completed a safeguarding audit and the wards were awaiting feedback from this.
- The service had discussed the possibility of having a safeguarding nominee for each ward, but decided that sharing safeguarding amongst the multidisciplinary team worked most effectively.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. For example, the service had approached the local minor injuries unit to deliver some training and develop some shared learning around the needs of the patients at The Farndon Unit.
- Staff followed safe procedures for children visiting the ward and this was included as part of the new safeguarding training delivered by the lead nurse.

Staff access to essential information

- Overall, staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, whether paper-based or electronic. Information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it and was in an accessible form. This included when patients moved between teams.
- We observed that the introduction of the electronic recording of patients national early warning scores (NEWS2) created confusion amongst staff and some staff were recording this on the electronic system whilst others continued to use the paper formats. This presented a clinical risk to patient safety and well-being

Requires improvement

Are services safe?

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

as staff were not able to quickly access each patient's last physical health observation. We raised this issue with the provider during our inspection and they immediately addressed this so that staff only use paper records for this recording.

Medicines management

- We looked at 10 patients' prescription charts across the different wards. We found the quality of the medication cards varied. On Cortland ward, in all five medication cards we looked at, there were several missing signatures and the cards were not always clear about whether patients had received medication to help them sleep for more than seven nights. The medication charts indicated that patients' medication had not been reviewed for more than 14 days. However, on Darcy ward, we saw that staff followed good practice in medicines management; that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication and did so in line with national guidance.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose of antipsychotic medication.
- An external pharmacist visited the hospital monthly to review and audit the hospital's medicines management. We saw two examples where the pharmacist had identified medication errors and these had not been rectified by hospital staff.
- The provider had developed a hospital's clinical standards governance group who maintained oversight of the medicines management across the hospital.

Track record on safety

- There had been 34 serious incidents between 23 October 2017 and 30 September 2018. The number of incidents had decreased since our last inspection, where we reported 40 serious incidents in a similar period. The most common types of serious incident were patients engaging in apparent/actual/suspected self-inflicted harm, near misses and disruptive/ aggressive/violent behaviour.
- We saw evidence that the provider had taken action to reduce the likelihood of these events recurring in the future. For example, in response to the high number of serious incidents relating to patients engaging in self-harm to try to seek general hospital admission, the provider had reviewed its protocol for managing medical support. Staff were encouraged to call 111 earlier in the process (in a non-emergency), even if the patient's observations were stable, to ensure that physical healthcare partners were engaged at an earlier stage. This was to reduce the number of out of hour's attendances at the local accident and emergency department and make sure that patients access the right level of treatment in a timely manner.

Reporting incidents and learning from when things go wrong

- All staff knew when and how to report incidents internally. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers shared lessons learned through emails, supervision and reflective practice. We also saw posters around the wards and in bathrooms about lessons learned within the hospital. However, staff reported sometimes the managers shared so many emails with lessons to be learned that they were unable to keep up with them and put this learning into practice.
- When things went wrong, staff apologised and gave patients honest information and suitable support. However, two patients told us staff had not debriefed them following an incident.
- Staff received a debrief after incidents and feedback from investigations of incidents and there was evidence that changes had been made because of this feedback. However, one staff member reported that debriefs only took place after serious incidents, rather than as and when staff required them, for example, after a challenging shift.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at 18 sets of care and treatment records. Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The care plans included specific safety and security arrangements and a positive behavioural support plan.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included medication and both one to one and group-based psychological therapies and activities, training and work opportunities intended to help patients acquire living skills. We saw evidence of activities taking place on all wards.
- Activities available on the wards included both formal and informal group and individual sessions, such as arts and crafts, cooking, social groups and fitness activities. The hospital provided a range of voluntary work opportunities for patients to engage in.
- Staff ensured patients had access to specialists as and when required. For example, we saw patients had access to neurologists when required. The hospital was in the process of recruiting a general nurse to take the lead on physical health across the hospital.
- Within five days of admission, staff ensured all patients were registered with the local GP. There was a planned visit to the GP service every Monday that patients could attend if they had complaints/concerns.
- All but one of the patients we spoke with reported poor access to physical healthcare and felt that this part of their care and treatment was not taken seriously, particularly in relation to times when they had engaged in self-harming behaviour. The provider had made changes to their physical healthcare policy to manage occasions when patients engaged in self-harming behaviour. We reviewed incidents where this had occurred and were assured that the provider ensured patients had access to the appropriate physical healthcare.
- All patients had access to the local acute hospital as and when required. We saw all patients had section 17 emergency medical leave forms in place to allow this to happen. All patients had a physical health briefing form that contained basic information about their current physical health status, including any known conditions or allergies. The hospital monitored any cancelled hospital appointments to make sure patients were accessing acute medical care as and when required. There had been no cancelled hospital appointments since July 2018. Staff reviewed patients' attendance at local acute hospital at the recovery and outcomes group.
- All patients were booked in for a flu vaccine at the time of our inspection.
- Staff assessed and met patients' needs for food and drink. There were some patients within the service who had difficulties with their eating habits and managing their weight. When required, the multidisciplinary team made referrals to a dietician who provided monthly input to the service.
- Staff supported patients to live healthier lives. For example, we saw leaflets containing information about support to stop smoking displayed on patient notice boards and patients were encouraged to maintain healthy eating habits. During the month of October 2018, staff delivered smoking cessation programmes to six patients within the hospital and supported two patients to attend a diabetic clinic.
- Staff used recognised rating scales to assess and record severity and outcomes, including the health of the nation outcome scales secure (HoNOS- Secure) and more specific outcome measures for different disciplines such as the trauma symptom inventory for the psychology team. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Skilled staff to deliver care

- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group.
- Managers made sure they had staff with a range of skills needed to provide high quality care. The

multidisciplinary team consisted of forensic psychologists, occupational therapists, psychiatrists, mental health nurses, healthcare assistants, occupational therapy assistants, activity coordinators, an art therapist, assistant psychologists and trainee psychologists. The hospital had access to speech and language therapy and nurse specialists as and when required. There were two social worker vacancies that were in the process of being recruited to at the time of our inspection. A locum social worker was due to start working at the hospital the week after our inspection. The hospital had used a social worker from another hospital to support with writing a patient's care programme approach meeting report.

- Managers supported staff with appraisals, supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and opportunities to update and further develop their skills.
- As of the 30 November 2018, the percentage of non-medical staff that had had an appraisal in the last 12 months was 90%. All wards and clinical teams achieved compliance above 75%, except Darcy ward whose appraisal rate was 69%. As of the 30 October 2018, 98% of staff had received regular supervision. Ward managers audited staff supervision to make sure staff have regular supervision and that staff are satisfied with the quality of the supervision. An audit completed in September 2018 indicated that staff were satisfied with the quality of supervision.
- We reviewed one supervision record and saw that is contained prompts to discuss key topics such as safeguarding, performance issues, training needs, lessons learned, named nurse one to ones, observations and sickness/absence.
- Managers provided an induction programme for new staff.
- The provider had tried to introduce ward staff team meetings but had found there was low staff attendance. Instead, the provider had introduced focus sessions that were led by the psychology team, monthly lessons learned bulletins shared through email and weekly bulletins to provide hospital-wide updates to all staff. The hospital director shared urgent messages through emails to all staff as and when required. Although agency staff did not have access to emails, ward managers printed key messages off and these were stored in ward offices to ensure these were communicated.
- The occupational therapy and psychology teams had separate professional team meetings and were in the process of developing regional meetings with other multi-disciplinary professionals from other sites to share learning and best practice.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. For example, healthcare workers who wanted to pursue their nursing training were supported to work towards this and the provider trained some healthcare workers in phlebotomy.
- The provider had introduced a scheme to support psychology graduates who were employed as healthcare workers to engage with the psychology team to enable them to gain experience in this area for progression into assistant psychologist roles.
- The provider encouraged members of the multidisciplinary team to undertake further professional training to support their professional development and offer an extended portfolio of therapeutic approaches to the patients in their care. For example, members of the psychology team had been supported to complete training in compassion focused therapy.
- Managers dealt with poor staff performance promptly and effectively. We saw examples of how they had done this.
- The provider recruited volunteers when required, and trained and supported them for roles they undertook.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings. We observed an individual care review multi-disciplinary meeting and saw that the team communicated effectively with each other and the patient.
- Staff shared information about patients at effective handover meetings within the team. We reviewed the handover book and saw that handovers included information about safe staffing, observations, risks, incidents, safeguarding, upcoming appointments and leave.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We observed a daily ward manager's planning. Managers reviewed the clinical activity for the previous and upcoming day, including medical appointments, home leave visits, manager's hearings and planned visits to the service.
- The ward teams had effective working relationships, including good handovers with other relevant teams within the organisation. We spoke with a case manager from NHS England as part of our inspection process who reported positive changes within the hospital with regards to staffing, management of incidents and stability in management.
- The occupational therapy and psychology teams worked with other sites to share good practice and make improvements to their local working practice.
- Prior to our inspection, we liaised with several teams outside of the organisation to ask about working relationships with the hospital. We received mixed feedback about the hospital's approach to working with external organisations. Two of the organisations we spoke with said the hospital was unresponsive to attempts to engage with them. During our inspection, we saw evidence of effective working relationships with Nottingham and Nottinghamshire Sustainability and Transformation Partnership and the East Midlands forensic pathway. Sustainability and Transformation Partnership plans are plans drawn up in local areas that set out practical ways to improve healthcare services and population health. The East Midlands forensic pathway encourages healthcare providers to work with a range of NHS and independent providers to establish effective clinical pathways.

Adherence to the Mental Health Act and the Code of Practice

- At the time of our inspection, 88% of staff had received training in the Mental Health Act. Overall, staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. However, staff we spoke with on Cortland ward were unsure on some of the key principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrator was.
- Staff had access to local Mental Health Act policies and procedures and to the Code of Practice which reflected the most recent guidance.
- Patients had access to independent advocacy and information leaflets about advocacy and their rights were displayed on the wards.
- Staff explained to patients their rights at the correct frequency and in a way they could understand and recorded this.
- Staff ensured that patients could take section 17 leave (permission for patients to leave hospital) when this had been granted. Patients were given a copy of this leave form before leaving the hospital.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records, for example, section 17 leave forms correctly and so that they were available to all staff that needed access to them.
- Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

- At the time of our inspection, 83% of staff had had training in the Mental Capacity Act. Overall, staff showed a good understanding of the Mental Capacity Act, in particular the five statutory principles. However, staff we spoke with Cortland ward were unsure on some of the key principles.
- The provider had not made any deprivation of liberty safeguards applications between 31 March 2018 and 30 September 2018.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. We reviewed the quality of capacity assessments recorded in patient's notes and saw they were detailed and demonstrated clear recognition of patient's fluctuating capacity. Staff discussed patients' mental capacity as part of the multi-disciplinary team meeting.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff supported patients to develop advanced statements and crisis plans. These were plans to outline how the patient would like to be treated in the event of them losing capacity or becoming unwell. However, all four of these plans we looked at had not been reviewed for over a year.
- The provider completed regular Mental Capacity Act audits and acted upon any findings.

Requires improvement

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff attitudes and behaviours when interacting with patients and saw they were discreet, respectful and responsive. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity.
- Regular hospital staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, patients raised concerns about agency and bank staff who were often unfamiliar with their care and treatment plans and told us this impacted on their dignity. For example, two patients on Bolero ward said that agency staff did not knock on bedroom doors before entering at night and several patients reported that agency staff did not engage with them and instead stared at them when conducting observations. The hospital had recently developed a ward based agency aide memoire around expectations. This was available on the wards and included: Agency staff prompt sheet for essential documentation, safe supportive observation policy, fire precautions & fire safety policy, fire precautions green, medical emergencies, ligature cutters protocol and operational policies.
- Patients said some staff treated them well, particularly healthcare assistants. However, most patients we spoke with said the majority of staff were rude, hostile and did not treat them with respect. Patients said there were often staff working on the wards who they did not know and all the patients we spoke with said there was not enough female staff. Patients told us that unfamiliar staff on the ward were not aware of the patients' risks and this had resulted in patients being able to engage in self-harming behaviour.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.
- Staff maintained the confidentiality of information about patients by not leaving records unsecured and logged off computers after use.

The involvement of people in the care they receive

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. During our inspection, staff received a new patient to Bolero ward. Staff showed the patient around the ward, explained what care and treatment was available within the hospital and began to develop initial care plans for the new patient. Staff told us another patient would be allocated as this patient's 'buddy' during the next community meeting.
- Staff involved patients in care planning and risk assessment. The service had recently introduced a new care plan agreement sheet to evidence that the patients had participated in the development of their care plans and had been offered a copy of them. All the care plans we reviewed had been signed by a patient to indicate their involvement or staff had documented where a patient had refused to be involved in or receive a copy of their care plan.
- We observed a patient's individual care review meeting and saw that staff communicated with the patient so that they understood their care and treatment. Staff projected the information that was being discussed on a screen so that the patient could see this and the patient was included in the discussion and decision-making about their care.
- Staff involved patients when appropriate in decisions about the service. For example, patients were involved in the recruitment of staff as part of the interview panel.
- We attended a community meeting on Bolero ward. A patient on this ward chaired the meeting and we saw the atmosphere of the meeting was positive and calm. We also reviewed the community meeting minutes from Adanac ward that documented discussions about an improvement in activities on the ward. However, there were issues about staff not knocking on patients' doors before entering and staff sleeping on night shifts. The hospital director said they did walk arounds during night shifts and this poor practice had reduced as a result.
- Patients were encouraged to give feedback through the patient survey questionnaires, community meetings and one to one meetings with staff. Ward managers held weekly drop in sessions where patients could ask

Requires improvement

Are services caring?

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questions directly to the ward managers and give feedback on the service. We saw staff encouraged patients to feedback on activities and groups at the end of these sessions. This ensured activities were tailored appropriately to the patients' needs and preferences.

- The provider encouraged patients to make advanced decisions (to refuse treatment, sometimes called a living will) when appropriate. However, staff had not reviewed the four plans we looked at for over a year.
- Staff ensured that patients could access advocacy.
- The provider had organised a first aid trainer to attend the unit and deliver training to patients in first aid.

Involvement of families and carers

- Staff did not inform or involve families and carers appropriately or provide them with support when needed. Patients and the family members we spoke with told us there was poor communication between hospital staff and patients' families and carers and staff did not support them to organise visits. Two of the family members we spoke with told us there had been occasions where their family member had been in the local acute hospital and staff did not inform them of this until their family member had been discharged back to the Farndon Unit. However, the hospital staff explained that they were sometimes unable to share information with patients' families due to the patient not giving their consent to this information sharing.
- Patients and the family members we spoke with reported that all information was communicated verbally through the patient rather than through letters, invites or other communication by staff. Patients told us their family members were not always invited to their meetings.
- Patients and their families told us visits were difficult to book in as there was only one primary visitors' room if children were visiting. Patients said one room was not enough for up to 48 patients.
- The family members we spoke with did not have a primary contact for the hospital and said it could often take up to an hour to get through to somebody at the hospital via telephone.
- The hospital managers told us the service had worked to improve engagement with carers since our last inspection and acknowledged there was further work to be done. For example, the hospital director had invited carers to meetings in September and November 2018. These meetings focused on discussions about where carers felt there were gaps in communication and suggestions for improvements in care and treatment. There was a planned carers event for December 2018. There was very poor attendance at the most recent carer's meeting.
- The hospital had issued a carer's survey to families and carers but had so far received few responses. Staff said they would use the carers meetings to promote participation in this.
- Staff had recently developed a new service user and carer's information booklet about the hospital. We noted this booklet did not contain information for carers about how to arrange a visit, where the visit will be, phone numbers or how to arrange a carer's assessment.
- The three family members we spoke with told us they had not been given the opportunity to feedback on the service.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Bed management

- All referrals came from NHS England as the Farndon Unit is a national low secure service. From 1 April 2018 to 5 December 2018, the hospital had admitted patients to the Farndon Unit from locked rehabilitation units, prisons, medium secure and low secure services.
- Between 1 October 2017 and 30 September 2018, the average length of stay of patients discharged in the last 12 months by ward was 2.8 years. This was similar to the average length of stay reported at our last inspection in November 2017.
- Bed occupancy rates between 31 March 2018 and 30 September 2018 were between 95% and 100%.
- There was always a bed available when patients returned from leave.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. The hospital rarely moved patients without orientation to the new ward. However, when a safeguarding issue arose and it was felt an urgent move was required, staff consulted with the patient's responsible clinician to authorise this move for the safety of the patient.
- When patients were admitted or discharged from the hospital, staff ensured this happened at an appropriate time of day.

Discharge and transfers of care

- Between October 2017 and October 2018 there was one delayed discharge from The Farndon Unit. This was due to the patient awaiting transfer to a medium secure unit bed.
- At the time of inspection, there were two patients on the waiting list for admission to the service.
- Staff planned for patients' admission and discharge, including good liaison with care managers/co-ordinators. We spoke with a case manager from NHS England who said that the organisation was addressing the issue of patients staying at The Farndon Unit for longer than clinically necessary.
- We saw evidence in clinical notes that staff across the multi-disciplinary team worked with patients to develop proactive discharge plans with clear goals for patients to work towards.
- Staff supported patients during referrals and transfers between services – for example, when patients required treatment in an acute hospital.
- The clinical director was in the process of reviewing the current model of care with a view to reducing patient length of stay within the hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms. Patients could personalise their bedrooms. Depending on their individual risk assessment, some patients had access to items they had brought in from home and could keep these in their bedroom.
- The hospital provided somewhere secure for patients to store their possessions. Staff risk assessed patients for their access to lockable space in their bedroom on some of the wards.
- There was a full range of rooms available and equipment to support treatment and care. There was an occupational therapy hall, kitchen, computer room, art room and a hairdressing room on the hospital site.
- There was a quiet area on the ward, a de-escalation room on all wards except Ruby Frost and a room in the main reception area off the wards where patients could meet visitors. Patients said one visitors' room was not enough for 48 patients. We noted the visitors room was small, but saw that adult visitors could use the occupational therapy hall for their visits.
- We observed the wards to be calm and staff were engaging with patients at the time of our visit.
- Patients could make a phone call in private and staff assessed risk regarding patients' access to their own mobile phones. The hospital was in the process of liaising with their legal team around patients' access to smart phones on Ruby Frost (recovery) ward. The hospital manager told us this would be individually risk assessed. This was part of the hospital's least restrictive practice principle.
- Patients had access to outside space. The wards were built around a courtyard that was part of the low secure environment. We noted this layout could mean that if

Are services responsive to people's needs?

Good

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

staff needed to restrain a patient whilst in the courtyard, all other wards would be able to see this taking place. This presented possible privacy and dignity issues for patients.
- Patients could make hot drinks and snacks dependent on their risk assessment. Where patients were not risk assessed as safe to do so, staff supported patients to make hot drinks or snacks.
- Patients gave mixed feedback about the quality of the food within the hospital. Two patients reported there was limited choice on the menu and another was not happy with the quality of the food.

Patients' engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities. For example, patients were engaged in A level qualification courses, some patients attended community colleges and the open university, and there were plans to link in with local trusts to develop links with local recovery colleges and voluntary work opportunities. This had improved since our last inspection, but some patients reported they did not have access to this.
- The hospital had trained several patients within the hospital to work within the patient café to encourage patients to develop social skills, responsibility and transferable work experience to support them when they move on.
- Staff organised events for patients throughout the year that involved working with the community including patient entries into a nationwide art exhibition, participation in national Macmillan coffee mornings and other events suited to the calendar year such as Halloween and decorating a local Church Christmas tree.
- Patients worked alongside a theatre company who presented interactive theatre and facilitated drama-based groupwork. Patients at the hospital completed a film around moving on from hospital to support other patients to view this in preparation for moving on. The premier was held at the hospital and was a great success. Patients who were involved in this project attended the Elysium service user conference to present their work on the film. One of the patients who was involved in this project was discharged and returned to the unit to deliver a paid session on the programme to the current patient group.
- Staff supported patients to work alongside a learning disability charity that supported people with learning disabilities in Nottinghamshire. They charity ran courses, social activities and projects to help people get the life they want in their own community. Supported by the occupational therapy assistant, patients within the hospital co-facilitated groups for the charity's clients. As a result of this engagement, the charity attended the hospital as a guest presenter to deliver cooking and computer skills sessions for patients at The Farndon Unit.
- Patients and the family members we spoke with said staff did not support patients to maintain contact with their families and carers. Although staff told us Skype was available for patients to use to maintain contact with their families, none of the patients or the family members we spoke with were aware of this facility and had not been encouraged to use this to support long distance relationships.

Meeting the needs of all people who use the service

- The provider made adjustments for patients who required disabled access. Some wards were on the ground floor and there was lift access to the first floor. There was a bedroom located on Bolero ward that was suitable for patients who required disabled access. Staff supported patients who required disabled access to use the assisted bathroom. The occupational therapy team completed pre-admission mobility assessments of patients with specific needs and the hospital pre-ordered specialist equipment to support the patient on admission and thereafter.
- For patients who required a wheelchair to mobilise, the hospital had a larger bedroom and a shower chair to allow ease of access. However, patients told us it was difficult to mobilise a wheelchair on the carpeted areas of the ward. We reviewed the personal emergency evacuation plan of a patient who used a wheelchair to mobilise and saw that it stated the patient could evacuate independently. We raised concerns that staff were unable to locate these plans in a timely manner, which could put patients at risk during the event of a fire. We raised this with the hospital director and have received an updated copy of this patient's emergency evacuation plan which clearly outlines her needs.
- During our inspection, we found the assisted bathroom located between Cortland and Darcy ward was full of

Are services responsive to people's needs?

Good

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

storage boxes and not accessible for patients to use. We raised this with the hospital directors who confirmed that this had been inappropriately used for storage and that a message had been sent out to make sure this did not happen again.

- Staff had not developed care plans to address the specific needs of patients who identified as transgender or gender fluid. We raised this with the provider who assured us this would be reviewed with the patients.
- One patient on Cortland ward told us they felt they were subject to racist remarks from other patients on the ward and staff did not respond to this appropriately. We did not observe this during our inspection and could not find any record of this being discussed within community meetings or in the patient's care plan.
- Patients we spoke with told us they had not been given information about treatments on offer at The Farndon Unit and we received mixed feedback from patients about whether they had received information about advocacy and how to complain. Two patients we spoke with reported that the information they received was not in an accessible format.
- The hospital ensured that patients had access to interpreters and/or signers.
- The service provided access to appropriate spiritual support for patients. The occupational therapy team linked in with local spiritual leaders to support patients' spiritual needs. However, patients told us they did not have regular access to spiritual or religious leaders such as a vicar, a priest or an Imam. Patients told us they had requested this but it was not available. Patients had access to a quiet room on the first floor of the hospital that had been identified as the multi-faith room.

Listening to and learning from concerns and complaints

- Between November 2017 and September 2018, the service received 34 complaints. Seven complaints were upheld and none referred to the ombudsman. The number of complaints had reduced from the figure reported in a similar period during our last inspection. In the same period, the service received 16 compliments.
- We reviewed the hospital's complaints log and Adanac ward's informal complaints log. These showed evidence of local resolution and escalation where required.
- Patients knew how to complain or raise concerns. Most patients told us that they received feedback when they had raised a complaint. Patients had the opportunity to feedback via the Recovery and Outcomes Group and the patient's satisfaction survey.
- Staff protected patients who raised concerns or complaints from discrimination and harassment and knew how to handle complaints appropriately. We saw evidence that staff investigated complaints thoroughly and in a timely manner. Staff received feedback on the outcome of investigation of complaints and acted on the findings to reduce the likelihood of reoccurrence.
- Staff could feedback learning from complaints through the staff consultation committee, via line managers, hospital director drop-in sessions and the meetings arranged to feedback on the staff concerns action plan. the hospital had developed a formal feedback form for this but were working on improving the response rate.

Are services well-led?

Requires improvement

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

Our findings

Leadership

- Senior leaders had the skills, knowledge and experience to perform their roles. Staff were positive about the leadership across the service and reported the visibility of the senior management team had greatly improved since our last inspection. The latest staff engagement survey, completed in September 2018, demonstrated an improvement in staff's perception of the leadership and management of the organisation.
- Patients told us and we saw that the senior leadership team had improved their visibility with patients and had a good rapport with patients.
- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

- Staff we spoke with did not know the provider's vision and values or how they were applied in the work of their team.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The hospital had developed a staff consultation committee that represented the staff voice across the hospital. This group allowed staff to provide feedback on service developments and oversee the progression of the hospital's action plan to address staff concerns.
- Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

- Staff we spoke with felt respected, supported and valued. The most recent staff survey was completed in September 2018. The results indicated staff felt there had been an improvement in the culture of the organisation, specifically around openness and honesty. However, there had been a slight decline in staff reports of feeling valued and treated well by the senior team at the hospital. We saw examples where the provider's senior leadership team had provided hands on support and comfort to staff at difficult times.
- Staff felt positive and proud about working for the provider and their team. The staff engagement survey showed an improvement in staff's response to the question "I am proud to work for Elysium" and staff were more likely to recommend Elysium to friends and family if they needed care or treatment.
- Staff reported an improvement in morale amongst the teams, but that this was sometimes affected by low staffing levels which resulted in staff being stressed.
- The most recent staff engagement survey completed in September 2018 demonstrated a significant decline in staff's response to the question, "I have sufficient time to do my job well". Staff we spoke with talked about this and frequently mentioned issues relating to staffing levels as the main reason for this.
- The hospital was in the process of recruiting a staff member to support staff members reporting assaults to the police through attendance at court.
- Staff knew how to use the whistle-blowing process and most felt confident to do so. We saw posters displayed around the hospital outlining how to use the whistleblowing process. The management team had responded proactively to whistle-blowing concerns raised about the hospital. For example, they had appointed an external manager to investigate the concerns, arranged regular drop-in sessions to hear staff views and had developed a comprehensive action plan that was regularly shared with staff. Overall, staff we spoke with were positive about how this had been managed and felt heard when they raised their concerns. However, two staff members told us they were too anxious to raise concerns as they felt they would be unfairly dismissed. Staff we spoke with were not aware of the role of the Speak Up Guardian.
- Managers dealt with poor staff performance when needed. We saw evidence this had happened and this had been managed professionally. The organisation had invited an external reviewer to examine cases of bullying and harassment within the team and the recommendations had been embedded within the staff teams.
- Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Staff appraisals and supervision records included conversations about career development and how it could be supported.

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Requires improvement

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- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- The provider recognised staff success within the service and had introduced input from the provider's well-being team for staff. This included massages, pamper packs in staff bathrooms and drop in sessions with the team as part of the hospital's recognition for staff's hard work. The provider also offered awards for staff including a monthly raffle prize where a staff member had previously won £1000 prize.

Governance

- The provider did not have effective systems and procedures in place to ensure that wards were consistently safe and clean or that there were always enough staff to keep the ward safe. The provider had not ensured clear processes were in place to ensure safeguarding procedures were correctly followed. The systems did not provide assurance about agency staff's knowledge of the patients they provided care to, patients' physical wellbeing and staff did not follow procedure in escalating a deterioration in patients' presentation. Staff did not consistently follow the provider's policy around the use of observation and this had not been identified as part of the provider's audit schedule. The hospital did not always use audits effectively, including those completed by external pharmacists.
- Ward managers and hospital director had access to staff training figures and maintained good oversight through this.
- There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- Although the hospital had an adequate governance structure for reporting information from the ward to the provider board, actions from audits were not addressed consistently or in a timely manner. Several groups including the health and safety group, clinical standards group and the operational review group, met regularly and fed into the regional governance group which shared key findings with the board.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.
- Staff undertook or participated in local clinical audits. However, whilst the audits identified concerns, for example, in medicines management, they did not always lead to effective improvements.
- Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.
- The service had plans for emergencies as part of its business continuity plan. On the first day of our inspection the computer systems were down and we saw there were contingency plans in place for staff to access electronic information whilst offline from the server. The hospital director also shared the back up plans in the event of a power outage, which included having a buddy site that would access and share essential electronic information.

Information management

- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.
- Staff had access to the equipment and information technology needed to do their work.
- Information governance systems included confidentiality of patient records.
- Ward managers had access to a dashboard which gave an oversight of each patient's electronic records, including when their care plans, risk assessments, legal paperwork and medical appointments were due for review. This allowed managers to maintain an oversight of each patient's care and treatment and support staff to address any required updates in a timely manner. This also included information on the performance of the service, staffing and patient care.
- Information was in an accessible format, and was timely, accurate and identified areas for improvement.
- Staff made notifications to external bodies as needed, including the Care Quality Commission.

Engagement

- Staff and patients had access to up-to-date information about the work of the provider and the services they

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used. The clinical director held a weekly drop-in session for staff to discuss any concerns or raise issues about clinical practice or culture within the hospital. The hospital director attended training sessions to improve engagement with staff. Doctors had monthly meetings with the hospital director to discuss service issues and development. However, family members and carers did not have up to date information about the work of the provider.

- Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. However, the family members we spoke to said they had not been given opportunities to give feedback on the service they or their family members received.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Managers used staff, patient and carer feedback surveys to identify areas for improvement, reflected on why these areas were identified for improvement and developed detailed action plans to address these issues.
- Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback through the staff consultation committee and the recovery and outcomes group.
- Directorate leaders engaged with external stakeholders as and when required.

Learning, continuous improvement and innovation

- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, the hospital director engaged with ward managers around the recruitment of nursing staff from overseas to identify which staff members wanted to be involved in supporting staff.
- Elysium Healthcare held a 'Sharing of Best Practice Day' for staff to engage with other services within the provider to share areas of good practice.
- Managers ensured they completed exit interviews with staff who left the service to understand their reasons for leaving and reduce the likelihood of future staff leaving for similar reasons.
- Staff had opportunities to participate in research and present their findings at national conferences. For example, the forensic psychologist had presented their work with patients around anger management and compassion focused therapy at a compassion focused therapy conference.
- Innovations were taking place in the service. The clinical director was involved in developing new care pathways to reduce the length of stay for patients and the hospital director had engaged with the recruitment team to evaluate and improve the service's use of advertising strategies to use in the hospital's local recruitment plan. Patients had recently attended a national service user conference.
- Staff participated in national audits relevant to the service and learned from them.
- The hospital was accredited by the Quality Network for Forensic Mental Health Services Wards. The Quality Network for Forensic Mental Health Services (QNFMHS) is a quality improvement network for low and medium secure inpatient forensic mental health services in the UK. The network's service standards provide the basis for the annual review process and are used by member services to benchmark themselves nationally against peers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The hospital did not complete patient observations in line with the provider's policy. **This was a breach of regulation 12 (2)(a)(b)** Staff medicines management practices did not ensure that the storage and administration of medicines was safe. **This was a breach of Regulation 12 (2)(g)** The hospital did not use tools to monitor deterioration in patients' physical health accurately. **This was a breach of Regulation 12 (2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The hospital did not keep families and carers adequately informed about patients' care and treatment or support them appropriately to maintain regular contact with their family members. **This was a breach of Regulation 9 (3)(c)(d)(e)(f)(g)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The hospital did not ensure effective governance structures were in place to monitor the safety of the ward environment. **This was a breach of Regulation 17 (1)(2)(a)(b)(e)**