Garrow House

Quality Report

115 Heslington Road
York
North Yorkshire
YO10 5BS
Tel: 01904 431100
Website: www.turning-point.co.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We are placing Garrow House in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated Garrow House as **inadequate** because:

- The service did not provide safe care. The ward environments were not safe and did not have enough nurses and doctors that knew the patients well. There were high vacancy rates and high uses of agency staff. Skill mix on shifts was not always appropriate for patient needs and there were high numbers of unfilled shifts. The service did not always implement fire safety procedures effectively and staff training, and induction did not keep patients safe from avoidable harm.
- Staff did not manage risks well. They did not manage medicines safely; there were errors and omissions in the prescribing, administering, recording and storing of medicines. The service used restrictive practices, there was no clinical rationale for restrictions and staff did not consistently apply them. Staff did not always check patients' risk assessments and some staff gave items to patients that they then harmed themselves with. Managers did not ensure all service risks were identified on the risk register and control measures were not always implemented.
- The service was not well led, and the governance processes did not ensure that ward procedures ran smoothly. The service had staffing issues that impacted on the safe care and treatment of patients. Systems for record keeping, access to IT systems, mechanisms to monitor incidents, policies, medicines management and audits were not implemented effectively. The service did not manage patient safety incidents well. Incident review meetings to review trends did not occur regularly. Meeting minutes did not clearly record clinical discussion or detail actions. Staff debriefs did not always occur following incidents
- Staff training was not well managed. Eleven of 14 mandatory courses were below provider target. Safeguarding training on how to recognise and report abuse did not meet the expected levels identified in best practice guidance. Only 36% of qualified nursing staff had in date safeguarding training. Staff, including managers, could not confirm if training in the Mental Health Act 1983 and the Mental Health Act Code of Practice was mandatory. Induction training was not delivered consistently. Staff had not all completed all elements of the induction programme, and dialectical behavioural therapy training had not been delivered since 2018.
- Patients said that staff were too busy at night to support them and that some agency staff did not understand their needs or how to care for them. There was limited involvement with families and carers. Staff did not have formal feedback tools to gather feedback about the service from families or carers.
- Staff provided a range of treatments suitable to the needs of the patients, but these could not be delivered in line with national guidance about best practice because of staffing issues.

However;

- Staff understood the individual needs of patients and respected their privacy and dignity. Staff actively involved patients in decisions about the service and their care.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. The service worked to a recognised model of mental health rehabilitation for patients with personality disorder. 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

- Staff included or had access to a full range of specialists required to treat patients on the ward. Staff worked well together as a multidisciplinary team and with those outside the service who would have a role in providing aftercare.
- Managers ensured that staff received supervision and appraisals. The service environment was clean.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Personality disorder services	Inadequate 	

Summary of findings

Contents

Inadequate

Garrow House

Services we looked at:
Personality disorder services;

Summary of this inspection

Background to Garrow House

Garrow House is a specialist tier four personality disorder inpatient hospital that admits female patients from the Yorkshire and Humber region. The hospital has 12 beds.

Garrow House has been registered with the Care Quality Commission since 1 April 2019 and is registered to carry out two regulated activities:

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

Garrow House is part of the Turning Point Group. This is the first inspection of the hospital under this provider following a change in registration. Garrow House had changed from being a joint venture between two organisations to become a registered location of Turning Point Group only.

The hospital had a registered manager and a controlled drug accountable officer in place at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager has a legal responsibility for meeting the requirements and associated regulation in the Health and Social Care Act 2008. An accountable officer is a senior person, required by law, with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse.

At the time of inspection, the hospital was providing care and treatment for ten patients.

Our inspection team

The team that inspected Garrow House comprised of two CQC inspectors, a CQC assistant inspector and a consultant psychologist specialist advisor.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme following a change in the provider's registration.

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:

- looked at the quality of the hospital environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with four carers or families of patients who were using the service;

Summary of this inspection

- spoke with the registered manager;
- spoke with 16 other staff members; including doctors, nurses, support workers, psychologist, clinical lead, wellbeing practitioner, student nurses, administrative support, involvement lead and agency staff;
- received feedback about the service from care commissioners and an independent advocate;
- attended and observed one hand-over meeting, one multi-disciplinary meeting, one referrals meeting, one formulation meeting and one community morning meeting;
- collected feedback from one patient using comment cards;
- looked at six patients' care and treatment records, risk assessments and management plans and Mental health Act paperwork;
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five patients, four carers or families and received one comment card.

Patients raised concerns about the high use of agency staff in the service, particularly at nights when they felt most vulnerable. Patients said that agency staff did not always introduce themselves and that staff that worked nights did not understand their needs.

However, patients told us they contributed to their care plans, risk assessments and were able to input ideas about the development of the service and activities. Patients felt safe and said that most staff were kind and caring.

Families said that their relatives had made progress in the service. They described staff as kind and patient.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated safe as **inadequate** because:

- The service was not safe. Staff did not always react quickly to environmental risks or keep patients safe from avoidable harm. Managers did not ensure that all staff assigned to fire duties had appropriate fire training.
- The service did not have enough nursing and medical staff, who knew the patients well. There were high vacancy rates, high usage of agency staff and a high number of unfilled shifts. Staff training, and induction did not keep patients safe from avoidable harm.
- Staff did not always manage risks to patients well. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff did not always check patients' risk assessments and some staff gave items to patients that they then harmed themselves with.
- There were multiple blanket restrictions that had not been identified by staff. There was no clinical rationale for the restrictions and no guidance as to what restrictions should be applied by staff leading to inconsistencies.
- Staff training on how to recognise and report abuse did not meet the expected levels identified in best practice guidance and only 36% of qualified nursing staff had in date safeguarding training.
- Staff did not have easy access to clinical information. Many staff could not access the electronic record system and paper records were complex and spread out in multiple folders. Information in paper records was sometimes missing, out of date or filed incorrectly.
- The service did not always follow systems and processes to safely prescribe, administer, record and store medicines. Incidents showed that medicines had been administered at the wrong time, to the wrong patient, or had been missed. One incident showed that a patient was unable to access their medicines because they had not been written up by the doctor.
- Staff did not always follow good practice in anticipating, de-escalating and managing challenging behaviour. Staff did not record de-escalation techniques attempted or if they had offered oral medication before giving intramuscular rapid tranquilisation injections.

Summary of this inspection

- The service did not manage patient safety incidents well. Incident review meetings to review trends did not occur regularly. Minutes from clinical meetings, multidisciplinary and incident review meetings did not record the clinical rationale behind decisions or change clinical practice. Managers did not always close incidents on the recording system and some staff were unable to access the electronic system to record incidents leading to delays and errors. Staff debriefs did not always occur following incidents.

However;

- The ward was clean, well equipped, well furnished, well maintained and fit for purpose. Patients and staff had access to call alarms.
- Staff worked well with other agencies to report abuse. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff regularly reviewed the effects of medications on each patient's physical health.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Managers did not ensure they had staff with the full range of skills or experience needed to provide high quality care. Staff inductions were held twice a year. Staff had not completed all elements of the induction programme, and dialectical behavioural therapy training had not been delivered since 2018.
- Staff, including managers, could not confirm if training in the Mental Health Act 1983 and the Mental Health Act Code of Practice was mandatory. The organisation's policy stated this training was mandatory. Only 63% of care staff had in date training.
- Necessary actions to improve patient outcomes, (identified in audits of rating scales to assess and record severity and outcomes) were not always completed in a timely manner.
- Care and treatment interventions suitable for the patient group were not delivered consistently in line with best practice detailed in national guidance because of staffing issues.
- There were gaps in section 17 leave Mental Health Act paperwork. Leave arrangements were not always updated, patients were not always risk assessed before going on leave and staff did not always record when leave was taken, or review leave when patients returned.

However;

Summary of this inspection

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Patients had access to psychological therapies, support for self-care, the development of everyday living skills, and meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The staff team had effective working relationships with other staff from services that would provide aftercare following the patient's discharge.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Requires improvement 

We rated caring as **requires improvement** because:

- Patients said that staff were too busy at night to support them and that some agency staff did not understand their needs or how to care for them.
- There was involvement with families and carers where possible. Staff did not have formal feedback tools to gather feedback about the service from families or carers.

However;

- Staff respected patients' privacy and dignity. Regular staff, including some agency staff, understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients could access advocacy services if they wished.

Are services responsive?

Good 

We rated responsive as **good** because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Summary of this inspection

- The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite 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 ward facilities met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, access to advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. These were shared with the whole team and the wider service.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- Managers were not able to provide high-quality sustainable care due to the high numbers of staffing vacancies and patient acuity.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively, and that performance and risk were not managed well. The service had staffing issues that impacted on the safe care and treatment of patients. Systems for record keeping, access to IT systems and mechanisms to monitor incidents were not fully effective. Neither were processes for managing training and inductions, identifying restrictive practice, policies, medicines management and audits.
- Leaders did not always manage performance by using effective systems to identify, understand, monitor, and reduce or eliminate risks. They did not ensure all service risks were identified on the risk register and control measures were not always implemented.
- Some staff did not understand, or did not access, information they needed to provide safe and effective care.
- There were limited opportunities for career progression for staff.

However;

- Leaders were visible in the service and approachable for patients and staff. Staff felt respected, supported and valued by the local management team. They felt able to raise concerns without fear of retribution.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Patients were aware of their rights under the Mental Health Act. They said staff informed them of their rights regularly. Informal patients were able to leave the service and were aware of their rights.

Staff in the service contacted the Mental Health Act leads in the local and wider organisation if they needed advice. Mental Health Act leads checked Mental Health Act paperwork and renewals and completed audits. Information from audits was shared at team meetings.

Patients had access to advocacy services. Advocates were invited to, and attended, care programme approach meetings. There was advocacy information on the ward.

However, there were gaps in section 17 leave Mental Health Act paperwork. Leave arrangements were not always updated, patients were not always risk assessed before going on leave and staff did not always record when leave was taken, or review leave when patients returned.Organisational expectations on the completion of Mental Health Act training was also inconsistent. Staff, including managers, said that training was only for qualified nursing staff and that 90% of staff had in-date training. However, the Turning Point policy, which was submitted by Garrow House, stated all care staff should complete training every two years. In this case, only 63% of all care staff at Garrow House had in date Mental Health Act training. This meant that some care staff may not fully understand the legal powers that they were acting under.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the principles of the Mental Capacity Act. They received regular training and had suitable policies to support their understanding. When staff needed advice, they contacted the Mental Health Act leads in the service and larger organisation.

Staff understood the Mental Capacity Act definition of restraint and recorded episodes on the incident management system.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. They considered consent and capacity issues as a multidisciplinary team and recorded consent in the notes on the electronic record system.

The service had not made any Deprivation of Liberty Safeguards applications to deprive any service users of their freedom because patients were either informal or admitted under the Mental Health Act. Deprivation of Liberty Safeguards is the procedure, prescribed in law, that legally deprives a person of their liberty when they lack capacity to consent to their care and treatment in order to keep them safe from harm.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Personality disorder services	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate

Inadequate

Personality disorder services

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

Are personality disorder services safe?

Inadequate

Safe and clean care environments

The ward was clean, well equipped, well furnished, well maintained and fit for purpose. However, it was not always safe. Managers did not ensure that all staff assigned to fire duties had appropriate fire training and risks from the environment were not addressed quickly.

Safety of the ward layout

Staff completed and regularly updated risk assessments of the ward area. Staff described higher risk areas, such as blind spots, and explained how they used observation to mitigate risk. Staff knew about potential ligature anchor points and minimised the risks. A ligature point is a place to which patients' intent on self-harm might tie something to strangle themselves. However, staff did not always make the environment safe following incidents. For example, it had taken four months to remove notice board pins following multiple self-harm episodes.

We reviewed ligature and environmental audits that included the garden areas. Patients at risk of absconding were accompanied in the garden. Patients had key fob access depending on their levels of risk. For example, informal patients were able to enter and exit through all doors, but patients at greater risk of harm were limited in their access.

Staff had easy access to alarms and patients had easy access to nurse call systems. Both patient and staff alarms were checked regularly. Some patients also used a red, amber, green traffic light system on their bedroom doors to indicate when they felt at increased risk from themselves. Although this was identified in handover notes, one agency member of staff we spoke with was not aware of this system.

The service did not always implement fire safety procedures effectively. The service had a fire procedure to safely evacuate the service. There were two staff allocated as fire wardens each shift. The role of fire warden one was always assigned to the nurse in charge of the shift. However, staff assigned to the second fire warden role were not always trained. Between 31 December 2019 and 27 January 2020, there were six occasions where the role of fire warden two was assigned to Garrow House staff that had neither received fire safety mandatory training, nor signed to confirm that they had read the fire policy walk through sheet. Fire safety was completed as part of agency staff induction.

However, staff completed regular fire safety checks including drills and checks. Fire safety certificates were in order and the service had a clear fire safety procedure that staff could follow in an emergency.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Cleaning records were up-to-date, and the premises were clean.

Staff followed infection control policy, including handwashing. There were posters to remind staff displayed throughout the ward.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Medicines were in date and checks were completed for medicines and fridge temperatures.

Staff mostly checked, maintained, and cleaned equipment. There was no record of the blood glucose monitoring machine having been calibrated.

Safe staffing

The service did not have enough nursing and medical staff, that knew the patients, to keep people safe from avoidable harm. Staff had not completed and kept up-to-date with their mandatory training.

Nursing staff

The service did not have enough permanent nursing and support staff to keep patients safe.

Between 1 April 2019 and 31 July 2019, the provider confirmed that 15 staff members had left. They reported a vacancy rate of 43%. There were 35 substantive staff in the service during the inspection.

Between 1 July 2019 and1 October 2019 the Garrow House qualified nurse establishment was 12, with four vacancies; and the support worker establishment was 15, with four vacancies. During the inspection, the qualified nursing vacancies had increased to six. Support worker vacancies had remained at four. Staff said colleagues had left for promotion or because they found the role too stressful.

The service had high rates of bank and agency nurses and support workers and a high number of unfilled shifts. Between 1 July 2019 and 1 October 2019, (a 92 day period) Garrow House reported that 92 shifts had been worked by bank staff to cover sickness, absence or vacancies; 114 shifts had been worked by agency staff to cover sickness, absence or vacancies; and 73 shifts had not been filled.

Staffing levels were regularly adjusted according to the needs of the patients. Rotas were completed six weeks in advance. Managers calculated and reviewed the number and grade of nurses and support workers for each shift. Each day managers checked the staffing requirements for the next three shifts. Where there was a shortfall, out of numbers staff could help or agency staff were used. Staff also said they stayed longer hours to ensure there were enough staff on shift. However, when they worked overtime, they found it difficult to take the time owing back. Clinical team meetings were also held twice a week to review the staffing needs and managers were always available via on call to support the shift. Staff completed a safer staffing tool. This reviewed the numbers of staff per shift but did not identify agency staff or ensure the skill mix was appropriate. Only one of nine safer staffing tools had been completed in line with the guidance. The others had no action plan completed to address the risks on the shift.

The skill mix and experience of staff did not always meet the needs of the patient group. Where possible, the manager used bank and regular agency staff that were familiar with the service. For example, the service had two regular qualified agency nurses booked for a three month period and seven regular agency support workers on the rotas we viewed. One of the nurses had worked on the ward for six months. Agency staff completed a brief induction before starting their shift. However, agency staff were not always experienced enough to care for the patient group and keep them safe. Patients said that they self-harmed more when there were unfamiliar agency staff on shift. We witnessed agency staff giving mail to a patient without checking their safety plan and saw examples of agency staff giving banned items to patients that they then harmed themselves with; staff keys had been left in the kitchen and patients picked up sharp objects which they then harmed themselves with while on arm's length observations. Patients were uncomfortable approaching unfamiliar staff for help when they felt the urge to harm themselves. Many staff felt that staffing issues were impacting on patient safety.

Day shifts for qualified nurses and support workers were from 07:30 to 20:00hrs. They had a minimum of two qualified nurses and three support workers. Night shifts were from 19:30 to 08:00hrs. They had a minimum of one qualified nurse and three support workers.

We reviewed four weeks rotas between 30 December 2019 and 29 January 2020. Staff numbers on each shift exceeded the minimum requirements because some patients on the unit were on one to one, arm's length observations. This meant that staff had to be physically close enough to prevent a patient from harming themselves. However due to the staffing vacancies and increased observations required, agency staff were necessary to meet the staffing requirements. Of the 35 night shifts that qualified nurses had worked, the nurse in charge was either the only agency nurse on (or, one of two agency nurses) on 24 of the shifts (69%). In the same period, 164 of 200 support worker shifts were filled by agency staff (82%) and 6 of 200 shifts were filled by bank support workers (3%).

The skill mix of staff was not always sufficient. Agency staff completed similar mandatory training as regular staff. However, they did not have the same additional training. Additional training, pertinent to the delivery of care, included personality disorder awareness, seclusion, boundaries and self-harm. Over the 31 days between 30 December 2019 and 29 January 2020, three night shifts had no permanent Garrow House staff on the entire shift from 19:30 to 08:00hrs; 16 shifts had only one Garrow House member of staff per full shift; ten shifts had two members of Garrow House staff and two shifts had three Garrow House staff. Four shifts had a new member of staff that had only worked in the service for six weeks as the only Garrow House staff member on the full night shift. They had no previous experience of working with the patient group and had only completed one training course because they had no login for the IT system. On 16 shifts the service also added a 10:00 to 22:00hrs or 11:00 to 23:00hrs shift. Although this increased the presence of permanent Garrow House staff; this was not enough to ensure the skill mix for the duration of the entire night shift.

During the day the service also used additional agency staff. One of the regular agency nurses had no previous experience of working with patients with personality disorder or experience of patients that self-harmed. However, there were additional experienced, permanent staff from 9:00 to 17:00hrs and a provider qualified nurse on day shifts. Additional Garrow House staff included the involvement coordinator, wellbeing practitioner, activity coordinator, three managers that were qualified nurses, psychologist, psychology assistant, social worker and an occupational therapist.

The service had enough staff on each shift to carry out physical interventions safely. Each shift had an identified response team with trained staff. The service trained one of their regular agency nurses in prevention and management of violence and aggression because they were regularly the allocated nurse in charge.

Levels of staff sickness in the service fluctuated. Between April 2019 and December 2019, the long term sickness rate averaged 1% and short term sickness, 8%. The lowest short term sickness rate was 0% in October 2019; the highest 15% in August 2019. Managers supported staff who needed time off for ill health including a graded return to work when appropriate. Staff with physical health conditions were not part of the rapid response team.

Patients could access one to one sessions with their named nurse. The service held a daily morning meeting where patients could request to speak with staff and request leave. One to one sessions were recorded in the daily nursing notes on the electronic record system. The service could not always accommodate trips out and escorted leave when the ward was busy. Staff said that this frustrated patients.

Staff shared key information to keep patients safe when handing over their care to others. We attended an effective handover and saw comprehensive handover notes that considered patients' risks and care. However, we were not assured that all staff on shift fully reviewed or understood these. There was evidence of agency staff not following patient safety plans and one member of agency staff we spoke with was unaware of a patient's safety strategy that was referenced in the handover notes.

Medical staff

The medical provision into the service was not consistent. Since April 2019 the service had three psychiatrists in post as the responsible clinician; another two consultant psychiatrists covering the responsible clinician when they were ill or on leave, and the speciality doctor. This meant that in eight months patients in the service had been treated by six different doctors. The service had been unable to recruit a permanent psychiatrist. They had a service level agreement with another local mental health provider to provide a locum doctor qualified in psychiatry on a one year contract. The consultant psychiatrist started in September 2019 and was available for face to face contact three and a half days a week and via email or telephone one and a half days a week. The service also had a speciality doctor that started in late December 2019. They worked two and a half days a week on a three month contract. The speciality doctor did not have experience of working with this patient group.

During the inspection the responsible clinician was absent. There was a locum psychiatrist covering their role. They had arranged a thorough handover and the new locum understood the needs of the patients.

Patients and staff both spoke positively about the current consultant psychiatrist that was contracted for the year. However, patients did comment that there was not as much direct contact with them.

Psychiatry cover was available during the day and at night. A doctor could attend the ward quickly in an emergency. The local mental health trust provided out of hours cover between 17:00 and 9:00hrs. Managers at the service spoke highly of the on call staff.

Mandatory training

Staff had not completed and kept up-to-date with their mandatory training. Staff completed a combination of e-learning and face to face training. The provider compliance target for mandatory and statutory training courses was 80%. Of the 14 training courses, 11 did not meet the provider target; and of those, three were below 75%. Training figures were lower than the provider expected because there had been an administrative error when collating the figures.

- Administration of Medication Awareness - 78%
- Duty of Care and Handling Incidents Awareness – 78%
- Infection Control Awareness - 78%
- PREVENT training- 78%
- Equality, Diversity Awareness – 75%
- First Aid Awareness - 75%
- Food Hygiene Two – 75%
- Fire Safety Awareness - 72%
- Introduction to Governance - 72%
- Introduction to CIM e-learning - 71%

Staff also received additional face to face training in immediate life support, basic life support and the prevention and management of violence and aggression. Training compliance for these courses exceeded 80%.

The mandatory training programme did not fully meet the needs of patients and staff. Staff responsible for managing training were unclear of what training was mandatory and what staff roles were expected to complete it. For example, staff said that training in the Mental Health Act was for qualified nurses only, but the Turning Point policy stipulated all staff providing care. Also, as of 30 January 2020, 81% of staff had competed children's and adults' level one safeguarding. This level of training was not appropriate for allied health professionals and support workers in the service. Provider data showed that only 36% of qualified staff had in date safeguarding training and this level was also not appropriate for their role.

We reviewed the Turning Point training policy. It did not meet the specific needs of Garrow House staff or patients. The policy was generic and used by the different business areas within the Turning Point organisation who specialised in the delivery of substance misuse services. Senior managers confirmed that there was a review of all Garrow House policies to identify which historical policies should become local protocols within the service. The training policy was not listed for review.

Managers, with support from administration staff, monitored mandatory training and alerted staff when they needed to update their training. We saw reminders in meeting minutes and administrative staff contacted staff with outstanding training. However there had been an administrative error when calculating training figures. The service had calculated the compliance figures with the incorrect total of staff. This meant that training rates were lower than the provider had identified when submitting the figures.

Assessing and managing risk to patients and staff

Staff assessed but did not always manage risks to patients well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment to facilitate patients' recovery. Staff had not identified blanket restrictions and had no clinical rationale for many of the restrictions in place. However, staff 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.

Assessment of patient risk

We reviewed six care records during the inspection. Staff completed risk assessments for each patient on admission using a recognised tool. Staff reviewed risk assessments regularly, including after incidents, but did not always manage to keep patients safe from harming themselves. The service used a positive risk taking approach with patients in the service. This approach focuses on what people can do, not just how they are limited. Positive risk taking involves consideration of what can go wrong, and what to do if something does, so that the patient has the confidence that the risk is worth taking.

Management of patient risk

Informal patients could leave at will and knew that. Staff asked that patients sign out so that they could account for everyone in the building in an emergency. If nursing staff had concerns about a patient's safety, they would use their holding powers to prevent them from leaving the ward.

Staff updated patients' safety plans following changes in risk and discussed safety plans at daily meetings. Most staff knew about the risks to each patient, but they did not always prevent or reduce risks in a timely way. For example, in the ward environment, notice board pins were removed four months after multiple patients had used them to self-harm. Staff did not always respond to risks posed by patients. We saw examples of agency staff giving items to patients without checking their safety plan and giving banned items to patients that they then harmed themselves with.

Staff followed procedures to minimise risks where they could not easily observe patients. The service had an organisational policy that detailed the expectations of each level of observation. Observation levels were recorded on the board in the staff office, in care plans and on handover notes. We observed agency staff checking notes to confirm the observation level of the patient they were looking after. We also saw a reminder in handover notes that emphasised the expected standard from all staff working on the ward.

Staff followed organisational policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were only searched when there was a risk to patient safety or concerns over banned items such as alcohol.

Staff had not identified all restrictive practices on the ward as restrictive practice. The service did not have a register that identified, assessed and reviewed the need for blanket restrictions. During the inspection we saw that the service had house rules. Many of these were blanket restrictions. There was no way to assess and review if there was a clinical need for the rules and rules were not individually assessed for each patient. Restrictions included no pyjamas at morning meeting, an 11pm curfew for all patients (including informal patients), no takeaway food before 6.30pm, meals had to be eaten in the dining room and no eating in bedrooms. Two rules were particularly punitive, for example, patients had to pay for a taxi to A&E if they self-harmed and to pay for breakages. The rules had been created collaboratively with patients in the service in 2017. House rules were referred to or documented in staffing handbooks, nursing notes and community meeting minutes. Staff confirmed that all the rules were not enforced, however the rules were referenced in multiple documents which could lead to confusion for new or agency staff and intimidate new patients. People with personality disorder can experience difficulties in communication, building trusting relationships and respecting boundaries. Therefore, a lack of consistency in the application of house rules could be detrimental to patient care.

The house rules had been discussed at the 15 January 2020 patient involvement group and taken to the January 2020 governance meeting. Minutes showed that the rules were to be merged with another mutual expectations document and the wording reviewed.

Use of restrictive interventions

Between 1 February 2019 and 31 July 2019, the provider recorded 67 incidents of restraint on seven service users. They reported no prone restraint was used. There had been no instances of mechanical restraint, seclusion or long-term segregation between April 2019 and January 2020. The service did not have a seclusion room. Managers sought psychiatric intensive care beds for patients that could not be managed in the service.

Managers discussed restrictive interventions at monthly incident review meetings. However, when we reviewed meeting minutes we saw that three months, (from September 2019 to November 2019), had been discussed in December 2019. Managers said this was because they had not managed to have their regular monthly meeting because of the acuity of the patient group and staff sickness. There were seven restraints in September 2019 and no rapid tranquilisation used. There was no data available for October. There were 29 restraints in November and 15 uses of rapid tranquilisation.

Managers provided December's data which showed an improvement. There were 14 restraints and five uses of rapid tranquilisation recorded. The service had closed to new admissions in January 2020. This was in response to patient complexity, risk and staffing issues.

Patients had restraint plans in place. These collaborative documents detailed patient preferences and provided suggestions of how to de-escalate before resorting to physical restraint. We saw occasions recorded where patients used self-sooth boxes, used music and the chill out room to calm themselves. Staff made every attempt to

avoid using restraint by using de-escalation techniques. They restrained patients only when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Additional face to face training included the prevention and management of violence and aggression and breakaway training. The service confirmed that 84% of staff had completed the course. All agency staff were expected to have completed the same training. We reviewed six agency staff files and saw that they did. However, we also saw one complaint where agency staff had not used the correct holds on a patient. They hurt the patient being restrained. A full apology was given, and the agency staff were no longer used.

Staff did not always follow The National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We reviewed six episodes of rapid tranquilisation. We saw no evidence in the records we reviewed, that de-escalation had been attempted or that any oral medication had been offered to the patients before they were given an intramuscular injection. Four of the records showed that patients had refused physical health checks.

Safeguarding

Staff training on how to recognise and report abuse did not meet the expected levels identified in best practice guidance. However staff described how to protect patients from abuse and the service worked with other agencies to do so.

Staff did not receive training, appropriate for their role, as specified in good practice guidance on how to recognise and report abuse. The guidance identifies the minimum expected safeguarding training requirements. Level one applies to all staff working in health settings; Level two is required by all practitioners that have regular contact with patients, their families or carers, or the public; Level three is for all registered health care staff who engage in assessing, planning, intervening and evaluating the

needs of adults where there are safeguarding concerns and level four is for specialist roles, including named professionals. As of 30 January 2020, 81% of staff had competed children's and adults' level one safeguarding. This level of training was not appropriate for allied health professionals and support workers in the service. The social worker and qualified nurses attended additional level two safeguarding training, every two years. Provider data showed that only 36% of qualified staff had in date safeguarding training and this level was also not appropriate for their role. One qualified agency nurse did not have the appropriate level of training for their role and neither did the hospital's social worker, who was the designated safeguarding lead. This meant the service had not ensured that staff had the expected level of safeguarding training to keep patients safe from harm.

However, staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. They described contacting the hospital social worker, the police and local authorities to raise concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff also received equality and diversity training. Safeguarding incidents were recorded on the incident reporting system. This allowed for data to be anonymised if necessary.

Staff followed clear procedures to keep children visiting the ward safe. Families used a visitor's room off the ward that had restricted access.

Staff access to essential information

Staff did not always have easy access to clinical information. It was not always possible for them to maintain high quality clinical records (paper-based and electronic).

Patient notes were not comprehensive, and not all staff could access them easily. The service used a combination of electronic and paper records, and they were not always up-to-date and complete. All patient information was recorded on the electronic record system. However, in practice, not all staff could access this system, so they used the paper files that were kept in five different folders. Additional information was also available on a shared drive on the computer.

Not all staff could log on to the IT systems. This included long term and short-term agency staff, the speciality doctor, locum psychiatrist and one of the support workers. This meant that they had to write their comments down or read aloud to another member of staff to add their notes to the system. This was a duplication of effort that could lead to inaccuracies in recording or a loss or delay of information. The incident reporting system and patients'

safety plans were also electronic so staff without logins could not report incidents or update safety plans. Again, this meant that they had to write their comments down or read aloud to another member of staff to add their notes to the system.

We saw a current safety plan in the archived folder, a missing approved mental health professional report and incorrect section 17 leave documentation. Leave had been suspended for one patient following an incident but had not been updated in their leave folder. We also queried section 17 leave with an agency worker who did not know where to locate this information. Staff completed retrospective entries on the electronic record system. For example, one update was completed 14 days after the shift.

However, records were stored securely in the staff office and when patients were discharged to a new team, there were no delays in regular staff accessing their records.

Medicines management

The service had systems and processes to prescribe, administer, record and store medicines. However, these were not always followed by staff. Managers did not always document that learning took place following medicines incidents and incidents were not always raised or reviewed in a timely way. Staff did not record de-escalation techniques attempted or offer oral medication before giving intramuscular rapid tranquilisation injections. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

The service had systems and processes for prescribing, administering, recording and storing medicines. However, these were not always followed. Staff did not always check patients had the correct medicines before administration. Between 1 June 2019 and 27 January 2020, the provider recorded 19 medicines incidents. Eight of these incidents related to medicines being given incorrectly. Medicines were administered at the wrong time, to the wrong patient, or had been missed. We also saw one incident where a patient was unable to access their medicines because this had not been written up by the doctor.

We reviewed six rapid tranquilisation nursing care plans. Nursing care plans did not record if patients had been offered oral medication before being given an intramuscular injection. There was no record of de-escalation techniques attempted prior to medication in the records we viewed. This meant that the service could not be assured that all medication given was necessary. In four of the six care records we checked the patient had refused physical observation checks post rapid tranquilisation.

Managers did not always document that learning took place following medicines incidents. In six of the eight incidents we saw no confirmation of any discussion with the nurse who had made the error to improve learning and prevent the error from occurring again. Although permanent Garrow House staff were assessed and supported with medicines competencies, there was no process recorded to support agency staff. Medicines incidents were not always raised or reviewed in a timely way. Two incidents had been queried by the risk and assurance department following a delay in reporting. One incident, involving controlled drugs, had been reported after ten days, and another after five days. Managers responded that the latter delay occurred one weekend when there was no manager presence. Additionally, managers reviews were not always timely; one medicines incident that occurred in October was still awaiting final review on 27 January 2020 and one incident from the end of December was awaiting a service review in on 27 January 2020.

Decision making processes were in place to review if people's behaviour was being controlled by excessive and inappropriate use of medicines. This was reviewed at clinical team meetings. However, we observed that many patients requested take as required medication at night without alternative options being discussed.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. Medicines were recorded in handover notes, including reminders when patients needed high dose antipsychotic treatment monitoring. Medicines were also discussed at multidisciplinary and clinical team meetings.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We saw one example where the wrong medication had been sent home with the patient on leave and another stored incorrectly. The medicine was labelled for a different patient.

The service had recently changed pharmacy providers. Senior managers had ordered the new stock until all qualified nursing staff had completed training in the new system.

The service had systems to ensure staff knew about safety alerts and incidents. The pharmacy providers shared this information with Garrow House staff.

Track record on safety

Organisational polices did not support staff to provide a safe service.

The provider submitted no data for serious incidents as part of the CQC pre-inspection information request. We reviewed incident data between 1 June 2019 and 27 January 2020. There were 16 incidents categorised as high. The most frequent types of incidents were self-harm by ligature, self-harm by cutting and absconding which is common for patients with a diagnosis of personality disorder.

We reviewed the Turning Point incident management policy and found it unsuitable for the patient group. It did not provide information to staff on how to categorise incidents. Staff said that they used Garrow House policies. We requested a copy of this policy however it was not returned by the provider. The management team were reviewing the applicability of Turning Point policies to Garrow House. Where a policy was unsuitable, Garrow House were creating local protocol. However, the incident management policy was not listed on the documents to review.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Managers did not always investigate and act to minimise incidents. Incident review meetings to review trends did not occur regularly and minutes from clinical meetings did not record the clinical rationale behind decisions or change clinical practice. Managers did not always close incidents on the recording system and some staff were unable to access the electronic system to record incidents. Staff debriefs were not always timely following incidents. However, staff recognised incidents and reported them appropriately; either on the incident reporting system or with another member of staff who had access. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service had an electronic incident reporting system. However, some staff, including agency, the locum psychiatrist, speciality doctor and one support worker could not log in. Managers reviewed incidents. Patients were involved in these investigations when appropriate. Incidents were reviewed by the managers at twice weekly clinical team meetings, incident review meetings and by the risk assurance team at Turning Point. Clinical team meeting minutes did not record discussion and there were limited changes made to patient care. Actions lacked detail. For example, review observations, update safety plan or safety plan to be discontinued. There was no clinical rationale or plan detailing what specifically needed to be reviewed or why the identified actions were to be taken. The service also held monthly incident review meetings. However, during the inspection, we identified that these did not always take place. In December's meeting minutes we saw that they reviewed September, October and November's incidents. This meant that managers were not reviewing incidents for trends. Although staff discussed incidents, there was no learning, actions identified or changes to practice in the incident meeting minutes we viewed. We also reviewed an audit completed by the risk and assurance team. This identified that there were outstanding incidents from 2018 that needed final approval and closing.

Between 1 June 2019 and 27 January 2020, the provider reported 486 incidents. Of these 332 were self-harm and 309 were when the patient was on the premises. The service had 47 attendances at A&E and 39 calls or attendances by urgent care practitioners. There was an increase in self-harm incidents reported in November 2019 and January 2020. Between June and October incidents averaged at 33 incidents per month. In November and January incidents rose to 57 and 58 respectively. December had a lower than average rate at 27 incidents.

Staff were debriefed after serious incidents. However, this did not always occur immediately. Staff said debriefs

previously occurred at the end of each shift but that this no longer happened. The service's psychologist held formal sessions with staff every two weeks. Staff could also access flash supervision if needed.

Incidents reported on the electronic system were recorded clearly. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff received training on duty of candour, and we saw apologies being given to patients in complaints documentation.

Staff mostly received feedback from investigation of incidents, both internal and external to the service.

Meeting minutes were available on the shared drive and incidents were a standing agenda item for discussion at team meetings. When changes occurred, for example a new process implemented, staff were updated in person, at handovers and via email. However, we observed a multidisciplinary team meeting where staff were not aware of the incidents that had occurred at the weekend.

The service had no never events. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Are personality disorder services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

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 patients' assessed needs and were holistic, personalised and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed six care records and saw that all patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A practice nurse attended the unit within a week of admission to do a full physical check. Patients all had physical health care plans that were reviewed every three months, or more as required. Mental health assessments were started at the point of referral. Staff visited patients prior to admission to assess their needs and this informed the patient's care plan. Staff continued to assess patient's mental health needs throughout their admission.

Staff developed care plans for each patient that met their mental and physical health needs. Patients had multiple care plans that included living skills, mental and physical health needs, safety plans, restraint plans and psychological formulation. Staff reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group, but these were not delivered consistently in line with best practice because of staffing issues. Staff participated in clinical audit, benchmarking and quality improvement initiatives. However, actions from audits were not always completed. Staff supported patients with their physical health and encouraged them to live healthier lives. They used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions met recommended National Institute for Health and Care Excellence guidance. Garrow House used cognitive analytic therapy as an overarching clinical model to develop a shared understanding, language and way of working with patients using the service. However, cognitive analytic therapy relies on relationships to be fully effective and the changing staff team meant that this was not always possible. Garrow house also held dialectical behaviour therapy groups and mindfulness and relaxation groups.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, health of the nation outcome scale, the recovery star and the Liverpool University neuroleptic side effect rating scale for medication. We also saw that the service used the short term assessment of risk and treatability tool to measure outcomes. However, care records, including ratings scales, were not always actioned in a timely way. We reviewed three file audits from September, October and November 2019. There were multiple points identified in the September audit that had

not been actioned by the last audit in November. These included updating the short term assessment of risk and treatability tool from March 2019, updating the recovery star from January 2019 and the need for a restraint plan identified in September but still not actioned in November 2019. All staff had outstanding items that had not been completed. Managers had asked staff to update care plans, however staffing pressures on the service meant that there were outstanding items.

Staff identified patients' physical health needs and recorded them in their care plans. The service had a wellbeing practitioner that attended the weekly physical health clinic with the practice nurse. They ensured that any specific needs were communicated with the rest of the staff team and updated patient's care plans. They also completed monthly monitoring of physical observations for each patient.

Staff made sure patients had access to physical health care, including specialists as required. Each patient had a local GP and had access to specialists such as diabetes clinics or substance misuse specialists when needed. Patients also attended optician and dental appointments throughout their admission.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients attended the health and wellbeing group and weekly activities including walking groups, yoga and swimming. Patients also accessed training and work opportunities to help acquire living skills. Some patients volunteered at local organisations and attended colleges. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The service had a catering project worker who planned meals with the patients, and they could access a dietician for any specialist needs.

Staff completed and mostly acted on data from clinical audits in line with their commissioning arrangements. They took part in benchmarking and quality improvement initiatives. The service worked closely with the regional Personality Disorder Pathway Development Service and the forensic pathway group to benchmark their service. However, we did not see timely action taken and improvements made following the records keeping audits.

Staff used technology to support patients. One patient described how they had not wanted to have their physical health monitored following medication and their nurse had suggested they use a smart watch to get the results.

Skilled staff to deliver care

Vacancy rates in the service were high and the service used agency and locums to cover the shortfall. Managers had not ensured that they had staff with the full range of skills and experience needed to provide high quality care. Not all staff had completed all elements of the induction, and dialectical behavioural therapy training had not been delivered since 2018. However, the staff team included or had access to the full range of specialists required to care for patients. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

The service had a full range of specialists to treat the patients on the ward. These included a consultant psychologist, psychology assistant, occupational therapist, activities coordinator, social worker, wellbeing practitioner, catering project worker, service user involvement co-ordinator, pharmacy team, nurses and support workers. All staff contributed to patients' care and treatment. However, medical cover was inconsistent. Since April 2019 the service had three responsible clinicians in post for varying durations as well as another two consultant psychiatrists covering the responsible clinician when they were ill or on leave. The speciality doctor had no previous experience of the patient group or specialist training provided. In eight months, patients in the service had been treated by six different doctors excluding on call doctors.

Staff inductions were held twice a year. However not all staff had completed all elements of the induction. The provider confirmed that the last induction had been completed in September and October 2019. Induction training requirements and data provided by the service was unclear and inconsistent. Analysis of induction figures based on the information provided was:

- Seclusion training - 81%
- Therapeutic Programme – 52%
- Short-Term Assessment of Risk and Treatability - 77%
- Self-Harm - 85%
- Personality Disorder Awareness - 81%
- Boundaries – 85%

- Staff also received additional training pertinent to the treatment provided to patients with personality disorder.
- Cognitive Analytic Therapy – 73%
- The Four P's Model – 69%
- Dialectical Behavioural Therapy Awareness – 46%

Although dialectical behavioural therapy was one of the treatments provided, staff training had not been delivered since August 2018. This meant that in addition to high use of agency staff, Garrow House staff did not have the expected skills to meet the needs of the patient group.

Managers prioritised the use of agency that had experience of working with personality disorder patients. However, this was not always possible. Managers requested that agency staff had basic training. Training included the prevention and management of violence and aggression, basic life support, moving and handling, health and safety, infection control, fire safety, safeguarding of vulnerable adults and equality and diversity. All agency staff completed an initial induction sheet to ensure that they were aware of the basic requirements of the service, including fire safety and observations, orientation to the unit and an introduction to the service users. However, because of the high use of agency in the service, their skills and experience didn't always meet the specific needs of the patient group. For example, we observed one agency staff member giving a letter to a patient, without checking if there were restrictions. There were also examples of agency staff allowing patients' access to items that they harmed themselves with. Agency staff did not complete the full suite of additional specialist training that Garrow House provided for their regular staff.

Managers supported staff through regular, constructive appraisals of their work. All staff had received a formal appraisal since April 2019. New starters had an interim probationary review three months after starting and a final probationary meeting at six months.

Managers supported staff through regular, constructive clinical and line management supervision of their work. Between 1 April 2018 and 31 July 2019, the provider recorded a supervision rate of 80%. Qualified staff within the service attended one to one clinical supervision, fortnightly reflective practice groups with the service's clinical psychologist and multidisciplinary case formulation. Support workers also attended the reflective practice and formulation sessions. All staff were able to request flash supervision. Flash supervision was supervision that was arranged when staff identified a need. Senior managers also attended their own reflective practice group facilitated by an external psychologist.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meetings were held once a week. All meetings were recorded. Notes were available in the staff office and electronically on the shared drive. Meetings followed a standard agenda that provided updates including complaints, incidents, training and service developments.

Managers gave staff the time and opportunity to develop their skills and knowledge out with the mandatory and induction training programs. Some staff were trained to take bloods and the clinical lead had completed their non-medical prescriber qualification. One member of staff had completed the prevention and management of violence and aggression train the trainer course.

Managers mostly recognised poor performance and could identify the reasons and deal with these. For example, when patients shared concerns about agency staff, managers would not ask for them again. However, we did not see managers documenting that they had discussed medicines errors with staff in six of the eight medicines errors that were reported as incidents. These errors had been made by permanent, bank and agency nurses. We were not aware of any process for managing medicines competencies for agency staff.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to care for patients. They had effective working relationships with staff from other services providing care following patients' discharge and engaged with them early on. However, meeting minutes did not record the clinical rationale behind decisions or clearly identify the actions and next steps to be taken.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All patients were reviewed fully twice a month. However, if an incident occurred, the multidisciplinary team would review them sooner. Patients attended multidisciplinary team meetings. We reviewed three sets of multidisciplinary team meeting minutes. Minutes did not record the clinical rationale behind decisions or clearly identify the actions and next steps to

be taken. Additionally, minutes did not always record a decision. For example, it was unclear if patients had access to razors, because the Yes/No options had not been deleted and decisions about leave were not recorded. Patient observations were always recorded.

Staff shared information about patients and any changes in their care, including during handover meetings. Nursing staff held a 30 minute handover at the start and end of each shift where staff discussed each patient. They considered their risks, incidents, physical health, concerns, medication, observation levels and any required interventions and safety plans. Minutes were kept from the meeting and shared with staff. Additional staff, including the managers, involvement worker, wellbeing practitioner and allied health professionals also had a daily meeting to plan the day. They covered some patient leave that could not be managed by the nursing team.

In addition, staff would attend the clinical team meetings twice a week. Service users were also able to attend. These meetings reviewed any incidents, use of restraint, compliments and the patients' needs. However, we did not see clinical discussion recorded in the meeting minutes and planned actions were not specific. For example, actions included 'update safety plan' but there was no specific detail as to what needed updating.

The staff team had effective working relationships with external teams and organisations. Staff invited care coordinators and community mental health teams to care programme approach meetings. Staff worked with other organisations to facilitate discharge. This included staff from new placements, the clinical commissioning group and pathway development service for Yorkshire and Humber. Staff also worked closely with the local emergency care services and GP.

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

Staff, including managers, could not confirm if training in the Mental Health Act 1983 and the Mental Health Act Code of Practice was mandatory and training figures were below the organisational target. There were gaps in the section 17 leave recording process prior to and following leave. However, managers made sure that staff could explain patients' rights to them.

Qualified nursing staff received and kept up-to-date with, training on the Mental Health Act and the Mental Health Act Code of Practice. They could describe the Code of Practice guiding principles. Support workers also understood the Mental Health Act and Code of Practice.

However, staff were unclear if Mental Health Act training was considered mandatory by the organisation. We were informed by staff, including managers, that Mental Health Act training was considered additional training and only qualified nurses completed the training every two years. Training data submitted showed that 90% of qualified nursing staff had completed this training. However, when we reviewed the Turning Point Mental Health Act Policy provided by Garrow House, this stipulated that all care staff in the organisation's independent hospitals were required to attend face to face Mental Health Act Training at least every two years. In this case, only 63% of all care staff in the organisation had in date Mental Health Act Training. It is important that services are assured that all care staff understand the legal powers which they are acting under.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They had a Mental Health Act lead who checked section paperwork and renewals and another within Turning Point who completed audits. They ensured the service applied the Mental Health Act correctly by completing audits and discussing the findings. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had access to information about independent mental health advocacy. There were information leaflets in the communal areas and an explanation of their role in the patient welcome pack. However, there were no contact details in the welcome pack. We saw that advocates attended the ward and were invited to meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. One patient described how their named nurse had made being read their rights more enjoyable by creating a quickfire question and answer game.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when there was enough

staff and when this was agreed with the responsible clinician and/or with the Ministry of Justice. Although the legal Mental Health Act paperwork for section 17 leave was in order, there were gaps in recording. We observed a multidisciplinary team meeting where staff realised that the leave arrangements from the previous meeting had not been updated. Patients were not always risk assessed before going on leave, staff did not always record when leave was taken, or review leave when patients returned.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. The service stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the organisational policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. As of 27 January 2020, 84% of the workforce in this service had received training in the Mental Capacity Act.

The service had a policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act. They could approach the Garrow House or Turning Point Mental Health Act leads.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw an example of the on call doctor being called to discuss and ascertain a patient's capacity when capacity was questioned.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff always tried to accommodate the patients' wishes.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Audits were completed by the Mental Health Act team and learning from across Turning Point was discussed at operational group meetings and cascaded to staff.

Deprivation of Liberty Safeguards was not applicable to patients in the service.

Are personality disorder services caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. At night, patients felt unsupported by staff. Patients had concerns about staffing levels and the subsequent use of unfamiliar agency staff. However, staff respected patients' privacy and dignity. Familiar staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with five patients that were using the service. Three patients said that staff were too busy at night to support them and that some agency staff didn't understand their needs or how to care for them. Patients felt that regular staff understood and respected their individual needs. Staff mostly gave patients help, emotional support and advice when they needed it.

Patients said most staff treated them well and behaved kindly. Some patients spoke positively of regular agency staff that were working at the service. Staff were discreet, respectful, and responsive when caring for patients.

Staff supported patients to understand and manage their own care, treatment or condition. Patients felt involved and said care was fully collaborative between staff and themselves.

Inadequate

Personality disorder services

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to contact the police and women's groups when needed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed the relevant policy to keep patient information confidential.

Involvement in care

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 access to independent advocates. The service did not do all that it could to involve families or carers or gather their feedback. Staff informed and involved families and carers with patients' permission.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients transitioned into the service. They progressed from daytime visits to weekend stays before being fully admitted to the service. New patients were allocated a peer buddy.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were offered copies of their care plans and were fully involved in reviewing their risk assessments.

Staff made sure patients understood their care and treatment. The patients regularly attended collaborative one to one sessions, care program approach meetings and ward review meetings. Even with staffing pressures, managers always ensured that Garrow House qualified nurses were the named nurses for all patients.

Staff regularly involved patients in decisions about the service. For example, patients had attended the clinical governance meeting and suggested the inclusion of general observations which were then implemented. Patients interviewed prospective employees. Patients had also reviewed the engagement and locked doors policies and the format of the multidisciplinary team meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could attend a weekly drop in session with the managers, complete annual satisfaction surveys, attend the monthly therapeutic team meeting to feedback on activities, attend six monthly workshops to gather new ideas for groups and review existing groups, feedback at community meetings, fill in the ideas book to offer suggestions and add feedback to the compliments and complaints box.

Staff supported patients to make advanced decisions on their care. Most patients had completed a 'my future plan' document on admission. This identified the patients' wishes in terms of their care and treatment, the level of family and carer involvement, religious or spiritual needs, dietary requirements and how staff could help if they became unwell. For example, we saw staff using soothing boxes for patients.

Patients could access advocacy services if they wished. There were leaflets and posters on the ward. However, there were no contact details in the patient information pack.

Involvement of families and carers

We spoke with four families or carers. Families and carers visited their relatives and attended care program approach and multidisciplinary team meetings. Families said that staff provided them with information, including medicines, but that staff were led by the patients' wishes.

The service had no carers groups or meetings, but the psychologist offered family sessions. Staff said that carers did not always want to actively participate in their relatives' care and that patients did not always want their families involved.

Staff did not provide ways for families or carers to give feedback on the service. Families and carers said they would feedback to staff and there was a comments book in the reception.

Are personality disorder services responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare

and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

Between 1 April 2019 and 1 October 2019, the service reported the average numbers of days from referral to initial assessment as 15 days; and days from initial assessment to the onset of treatment as 103 days.

Between 1 October 2018 and 1 October 2019, the provider reported the average length of stay of patients discharged in the last 12 months as 595 days. The anticipated length of stay was approximately 18 months to two years so this was in keeping with the therapeutic programme.

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. Staff attended and reviewed discharge at weekly referrals meetings and staff and patients attended weekly multidisciplinary team meetings. Managers and staff worked to make sure they did not discharge patients before they were ready. Patients were fully involved in the decision making process.

Between 1 April 2019 and 1 October 2019, the provider reported the mean percentage bed occupancy as 92%. When patients went on leave they always returned to their own bedroom.

Patients were moved to other services when there were clear clinical reasons, or it was in the best interest of the patient. Managers always managed to arrange transfers to psychiatric intensive care units when a patient needed more intensive care, and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service reported no delayed discharges between April 2019 and July 2019.

Managers monitored the number of delayed discharges. Discharge and admissions were discussed in the weekly referrals meeting. The staff team reviewed progress made and identified actions to secure placements. They also kept other admitting organisations informed when delays affected new admissions. For example, in January 2020 the service had stopped new admissions indefinitely until the service was more settled. Staff from the Personality Disorder Pathway Development Service attended meetings and worked with staff to secure appropriate placements for patients.

Reasons for delaying discharge from the service were normally clinical. It was not uncommon for patients' mental health to deteriorate when preparing for discharge. However, staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients visited prospective placements and worked towards full discharge. Patients also visited other hospitals, supported living accommodations and met with community teams so that they felt supported and safe.

Staff supported patients when they were referred or transferred between services. Staff helped patients prepare. They helped patients buy essential items for new homes and were available by telephone to support patients until they were settled.

The service followed national standards for transfer. Staff did not move or discharge patients at night or very early in the morning.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite 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. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. Patients that were higher risk had bedrooms located downstairs, close to the staff office.

Patients had a secure place to store personal possessions. They had key fob access to their bedrooms and a lockable cabinet in their rooms.

Staff used a full range of rooms and equipment to support treatment and care. The service had activity rooms for arts and crafts, a chill out room, clinic room for medications, lounge areas for socialising and watching television; and garden, kitchen and laundry facilities.The service had quiet areas and a room where patients could meet with visitors in private. Patients used a room off the ward area that had

access to a courtyard. Patients could make their own hot drinks and snacks and were not dependent on staff.Patients could make phone calls in private. The service had a cordless phone that they could take to their room and access to personal mobile phones. Patients could access the internet via the ward computer. However, Wi-Fi in the service was only available to staff. This had not been identified as a restriction in the service. We saw an example of one patient using their internet allowance on their mobile device to stream a program to watch with their friends.The service offered a variety of good quality food. There was a two weekly menu that was regularly updated. The service had a trained chef that did cookery demonstrations, cooked meals with the patients and met with the patients each day to confirm their meal choices. There was also additional food available, such as sandwiches, toasties and jacket potatoes, if patients preferred on the day.Patients were able to choose special birthday meals and cakes that the chef cooked for them and the service hosted themed events such as celebrating Chinese New Year. Patients could also cater for themselves following an assessment with the service's occupational therapist.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients volunteered at local charity shops and pursued their own interests off site. Patients attended, local colleges or universities and support groups.Staff helped patients to stay in contact with families and carers. Staff respected patients' wishes and involved families and carers appropriately. Carers said that staff provided updates about their relatives' care.

Meeting the needs of all people who use the service

The service met the additional needs of patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service supported and made adjustments for disabled people and those with communication needs or other specific needs. The service had an accessible bedroom downstairs for patients with limited mobility and staff described how they would support patients with written work.Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service had a welcome pack for patients that explained how to feedback and what to expect while in the service. They also had an equality and diversity board that included information on different religions and LGBT events.The service had information leaflets available in languages spoken by the patients. Additional information leaflets were also available from the Turning Point intranet. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients had access to spiritual, religious and cultural support if they wished. Patients were supported to attend local churches.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. There was a comments box and posters in communal areas, information in the welcome pack and discussion at community meetings and multidisciplinary team meetings. Patients were also asked for their feedback on the complaints process during their exit interview and provided with a contact address if they wished to feedback out with the immediate service. Patients could also attend a weekly drop in session with the manager. However, there had not been a session in the three weeks before the inspection.

Staff understood the policy on complaints and knew how to handle them. Staff completed complaints handling as part of their induction and complaints were discussed at multiple staff meetings. Managers shared feedback from complaints with staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation

into their complaint. Managers investigated complaints and identified themes. Themes related to dissatisfaction with staff in the service, including interactions, boundaries and training. Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff could anonymise patients in the electronic recording system to ensure their privacy.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were recorded in meeting minutes and on the walls of the service.

Are personality disorder services well-led?

Inadequate

Leadership

Patients and staff knew who they were and could approach them with any concerns. However, managers were not able to provide high-quality sustainable care due to the high numbers of staffing vacancies and current patient acuity.

Leaders did not have all the skills, knowledge and experience to perform their roles. The acuity of the patients, staffing challenges and periods of illness amongst senior managers had impacted on the operational effectiveness of the service. For example, actions from audits were not completed and incident review meetings were not happening regularly. Managers had responded appropriately and taken the decision to stop new admissions to the service until the ward was more settled.

Patients and staff knew local managers in the service by name and spoke highly of them. They said they were approachable and supportive. However, staff spoke less positively of senior leaders out with Garrow House. They felt there was a disconnect with senior managers at Turning Point.

Managers had reviewed the recruitment strategy for the organisation. In addition to advertisements on websites, the service had a poster campaign at local universities and bus stops. They also offered refer a friend bonus. The manager had weekly calls with the recruitment team at Turning Point and had streamlined the preemployment check process so that candidates could start in post more quickly. There was one nurse and one support worker having pre-employment checks during the inspection. However, information on the service's website was out of date and lacked detail on the model of care. This meant that potential candidates could not find current relevant information on the service.

There were limited leadership development opportunities available, including opportunities for staff below team manager level. The manager was aware of this and was reviewing the introduction of a new team leader role to allow nurses to develop. Staff also said that there were limited options for support workers. They said that some staff left to pursue psychology assistant roles in other organisations because there were limited roles available at Garrow House.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them. However, the strategy had not been actioned to ensure patient safety while being treated in the service.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The service had created local values with patients, and these were a standing agenda item at team meetings. Staff felt this helped new staff to better understand the organisation. Annual appraisals also linked staff performance to the provider values.

Staff had the opportunity to contribute to discussions about the strategy for the service. Managers encouraged staff to contribute ideas at team meetings.

Culture

Staff felt respected, supported and valued by their local managers. They felt the service promoted equality and diversity and they could raise concerns without fear.

Staff felt respected, supported and valued by their local managers. They were positive and proud about working for the provider and their team. They felt supported by their colleagues.

Staff were able to raise concerns without fear of retribution. They knew about the role of the Speak Up Guardian and how to use the whistle-blowing process.

Managers dealt with poor staff performance when needed. They supported staff with supervisions and appraisals. Staff appraisals included conversations about career development and how it could be supported. If needed, managers supported staff to gain the skills to do their roles more effectively. Where agency staff were involved, the service no longer used them. However, although the service assessed medicines competencies annually, we did not see managers documenting that they had discussed medicines errors with staff in six of eight medicines errors that were reported as incidents.

Staff reported that the provider promoted equality and diversity in its day to day work. The service provided training to staff and audited equality and diversity within the organisation for staff and patients. They reviewed how the service responded to differing needs of patients in the service. For example, cultural and religious beliefs and how the environment met the physical needs of disabled patients. The audit also identified reasonable adjustments made for staff. All Turning Point policies included an equality impact assessment.

The service's staff sickness and absence rates fluctuated. Short term sickness averaged 8.1% and long term 1.2% from April 2019 to December 2019. 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. Managers asked staff to nominate colleagues for the Inspired by Possibility Award when they displayed the organisation's vision and values. Winners received a certificate, £100 voucher, acknowledgement and an invitation to the event. The provider also rewarded long term service by paying staff a bonus.

Governance

Governance structures, processes and systems of accountability for the performance of the service were not always implemented effectively.

Governance systems were not effective. Staff did not maintain complete and contemporaneous records. Some staff were unable to access the IT systems that stored patient information such as nursing notes and safety plans. Paper files were available, but information was spread across multiple folders and sometimes missing or filed incorrectly. The service's website was out of date and lacked detail on the model of care.

Decisions taken in relation to the care and treatment provided were not clear. Clinical team meeting minutes and multidisciplinary team meeting minutes did not record clinical rationale for decisions or identify clear actions to change clinical practice.

Governance processes did not ensure that the service continually assessed, monitored and improved the quality and safety of the service provided. The service did not learn quickly from incidents and make changes to the environment to improve patient safety. Managers did not ensure that agency staff fully understood the risks posed by patients. Agency staff gave banned and risky items to patients. They were not always aware of information shared at handover. There were gaps in documentation including section 17 leave and safe staffing assessments. Managers had not recognised that staff assigned to the role of fire warden two had not received appropriate training. Managers did not have monthly incident review meetings to identify patterns and trends to prevent harm. Staff had not recognised the blanket restrictions in the service. It was not clear how staff would know what restrictions to impose because there was contradictory information available and no clinical rationale for the restrictions in place. There was limited carer involvement and the service lacked a formal route for carers to feedback.

Staffing issues in the service were not managed effectively and impacted on patient care. Managers did not ensure that there were enough staff physically present for all shifts, or ensure the skill mix of staff on shift. Night shifts were predominantly staffed by agency and there were occasions where there were only inexperienced staff members or no permanent Garrow House staff on shift. Medical provision was inconsistent. There had been three responsible clinicians in a nine month period.

Governance processes were not managed well. Policies were out of date and not fit for purpose. It had been agreed that staff follow local historical policies until an assessment of the policies had been completed. All policies were not identified on the document we reviewed. We requested confirmation of what progress and actions had been completed. Managers explained that the action plan fed into the wider organisation with further plans to identify

working party for policies with a completion date of 31 March 2020. We were not assured that the provider would have policies in order by this date. Managers did not ensure all service risks were identified on the risk register and control measures were not always implemented. Managers did not ensure that actions identified in record keeping audits had been completed.

The service had not identified gaps in training and inductions. Ten of 14 mandatory training courses failed to meet the organisational target and managers were unclear if Mental Health Act training was mandatory. Staff did not receive safeguarding training that was appropriate for their role, in line with best practice guidance on how to recognise and report abuse. Managers provided an induction programme for new staff. However, some additional training within the induction programme had not been delivered since 2018 and two training courses had under 55% completion rates.

Staff did not always follow The National Institute for Health and Care Excellence guidance for medicines. There was no evidence that de-escalation had been attempted or that any oral medication had been offered to the patients before they were given an intramuscular injection in any of the records. Medicines had been administered at the wrong time, to the wrong patient, or had been missed. Another patient was unable to access their as required medicines because this had not been written up by the doctor. Managers did not always document that learning took place following medicines incidents and incidents were not always raised or reviewed in a timely way.

However, the service engaged well with patients, staff, and local organisations. It collaborated with partner organisations to help improve services for patients and to facilitate discharge. Patients were partners in their care and were involved in service decisions.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.Care plans reflected patients' assessed needs and were holistic, personalised and recovery-oriented. Staff supported patients with activities outside the service, such as work, education and family relationships.

The care and treatment provided was based on national guidance and best practice. Staff had opportunities to participate in research.

Staff understood and were supported when using the Mental Health Act and Mental Capacity Act. They had regular appraisals, team meetings and supervision. However, managers were unclear as to what staff were to complete Mental Health Act training. Consequently only 63% of Garrow House staff had received this training.

There was a clear framework of what must be discussed at a ward, team and organisational level meetings. Team meetings followed a set agenda that provided staff with organisational updates, complaints and important patient information such as recent incidents.

Staff undertook and participated in local clinical audits. However, managers did not ensure that staff acted on the results to improve. Over a three month period staff did not make changes that had been identified in care record audits.

Management of risk, issues and performance

Leaders did not always manage performance by using effective systems to identify, understand, monitor, and reduce or eliminate risks. The did not ensure all service risks were identified on the risk register and control measures were not always implemented.

Staff maintained and had access to the hospital risk register. Staff at ward level could escalate concerns when required. The risk register was a standing agenda item at team meetings and was stored electronically on the shared drive. Staff concerns matched those on the risk register.

We reviewed the risk register. It did not identify high agency use or the increasing levels of self-harm within the service. It identified nurse vacancies and that it could be challenging to find additional staff quickly. The risk register identified controls and sources of assurance for each risk. However, these were not always implemented. For example, the staffing tool was not always completed accurately, incident review meetings were not happening every month, there were limited numbers of zero hours contract staff that could provide cover and only 73% of staff had completed cognitive analytical therapy training. Issues around staff training were exacerbated because agency staff covering vacancies did not have the additional specialist training provided on induction.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Inadequate

Personality disorder services

Information management

The information systems including patient information systems could not be accessed by all staff and staff did not keep all patient information up to date.

Some systems used by the service to collect data were over-burdensome for frontline staff. A file audit completed by staff showed that outstanding actions identified in September 2019 continued as outstanding in November 2019. This included outcomes data for patients, recovery start plans, risk assessments and restraint plans.

Staff did not have access to the equipment and information technology needed to do their work. Some staff were not able to log on to the IT system. This meant that they could not see or update electronic patient records, access additional information on the shared drive, access the provider intranet or log incidents. Staff without logins had to ask another member of staff to add their comments to care records. To view patient information, staff used paper records within five folders. Paper records were not always complete.

However, the information technology hardware, including the telephone system, worked well and information governance systems included confidentiality of patient records.

Managers did not always have access to information to support them with their management role. Organisational policies were not clear. However, managers could access information on the performance of the service, staffing and patient care. Managers could also ask the Turning Point information management team to provide bespoke reports on operational data.

Management information was in an accessible format, and was timely, accurate and identified areas for improvement. For example, managers were able to access performance data including length of stay, occupancy information, admissions and discharge data and staffing information such as staff sickness, Managers held governance meetings to review data. Managers submitted regular performance data to their commissioners and made notifications to external bodies, including the Care Quality Commission, as needed.

Engagement

The service engaged well with patients, staff, and local organisations to plan and manage the service. It collaborated with partner organisations to help improve services for patients.

Staff had access to up-to-date information about the work of the provider and the services they used. Staff attended team meetings, received emails and the managers printed out key information for staff.

However, information about Garrow House, including its care and treatment, was not easily accessible or informative on the Turning Point website. The information was out of date. It referred to the previous organisation and lacked any detail as to the purpose of the service and the model of care provided.

Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients completed annual surveys and attended multiple groups and meetings. Carers said they were able to feedback to staff and the service had a comments book in reception.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. The service had an involvement lead that worked with patients on projects. For example, patients had completed the secure quality improvement benchmarking tool from the Yorkshire and Humber Involvement Network. They had identified areas to improve such as merging the house rules and having different staff disciplines attend the community meetings.

Patients were involved in decision-making about changes to the service. Patients interviewed new members of staff and reviewed the format of the multidisciplinary team meeting and local policies.

Patients and staff could meet with members of the provider's senior leadership team to give feedback. The management team held weekly drop in sessions for patients.

Managers engaged with external stakeholders such as commissioners and Healthwatch. Staff also worked with the Personality Disorder Pathway Development Service and the forensic pathway group to benchmark their service. They worked with other organisations to arrange discharge for patients.

Inadequate

Personality disorder services

Learning, continuous improvement and innovation

Staff were committed to improving the service for patients. Leaders encouraged staff and patient participation. Staff participated in research that was published at recognised events and in journals.

Managers worked collaboratively with staff and patients to improve the service. Patients fully participated in service decisions. Staff were supported to consider opportunities for improvements and innovation within the service.

Staff had opportunities to participate in research and innovations were taking place in the service. The service's evaluation of multidisciplinary case formulation was presented as a poster at two conferences and the full evaluation was published in the Mental Health Review Journal in May 2019.

The hospital did not participate in accreditation schemes or national audits. However, managers submitted performance data returns to commissioners regularly.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

A rating of requires improvement will result in an action the provider MUST take.

- The provider must ensure that the environment is safe for patients in a timely way following incidents.
- The service must always ensure fire safety procedures are implemented effectively on all shifts.
- The provider must ensure that all relevant safety information is shared and understood by all staff including agency.
- The provider must ensure that it has suitable safety processes in place to reduce self-harm incidents in the service. **Regulation 12: Safe care and treatment**

- The provider must ensure that staffing issues are addressed and resolved.
- The provider must ensure there are appropriately trained and skilled staff working day and night shifts.
- The provider must ensure that they can provide consistent medical input for patients in the service.
- The provider must ensure that mandatory and induction training meet provider target to ensure staff are fully skilled to work with the patient group. **Regulation 18: Staffing**

- The provider must ensure that all staff receive safeguarding training that is relevant, and at a suitable level for their role.
- The provider must identify, monitor and review all blanket restrictions on the ward. Restrictions must be individually assessed and have a clinical justification. **Regulation 13: Safeguarding service users from abuse and improper treatment**

- The provider must ensure that staff can access all IT systems necessary to perform their role.
- The provider must ensure that paper records and electronic records are well organised, accurate easy to understand, complete and contemporaneous.
- The provider must ensure that all information recorded prior to and post 17 leave is completed.
- The provider must ensure that actions identified in audits are completed.
- The provider must ensure that all policies used are suitable and understood by all staff.
- The provider must ensure that incident review meetings occur when they are meant to.
- The provider must ensure that meetings have a clear purpose, discussion and detailed actions.
- The provider must ensure that all organisational risks are captured on the risk register and that controls and assurances are implemented effectively. **Regulation 17: Good governance**

Action the provider SHOULD take to improve

- The provider should ensure that staff accurately follow national practice to check patients have the correct medicines before administration.
- The provider should ensure that learning takes place and is recorded for all staff involved following medicines incidents.
- The provider should ensure that staff offer and record de-escalation techniques and oral medication attempts before administering intramuscular rapid tranquilisation.
- The provider should ensure that incidents are raised, reviewed and closed in a timely way.
- The provider should review and improve carer involvement and engagement with the service.
- The provider should ensure that the organisation's website reflects the new provider and the service that is being delivered.
- The provider should continue to review staff development opportunities.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes were not established or operated effectively to prevent abuse of service users. Systems to control patients were not necessary to prevent, or not a proportionate response to, the risk of harm posed to the patient (or another individual) if the service user was not subject to control. This was a breach of regulation **13(2)(4)(b)**

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 How the regulation was not being met: The provider did not ensure that they assessed, monitored and improved the quality and safety of the services. They did not monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress is not achieved as expected. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Where risks were identified, providers did not introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

This section is primarily information for the provider

Requirement notices

The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This was a breach of regulation **17(2)(a)(b)(c)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment were not provided in a safe way for service users. The provider did not do all that was reasonably practicable to mitigate any such risks or ensure that persons providing care or treatment to service users have the competence, skills and experience to do so safely. A section 29A warning notice was served to the provider for a breach of regulation **12(1)(2)(b)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure that there were enough suitably qualified, competent, skilled and experienced persons to meet patients' care and treatment needs. The provider did not ensure staff received appropriate training to enable them to carry out the duties they were employed to perform. A section 29A warning notice was served to the provider for a breach of regulation **18(1)(2)(a)**