Farmfield

Quality Report

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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 rated Farmfield as **requires improvement** because:

- Risks in the environment were not always managed appropriately in relation to ligatures and the use of outside space, which could put patients at risk.
- Infection control checks were only carried out annually.
- The staffing of the wards was not always increased in response to managing potential risks.
- Section 17 leave entitlement was not being managed appropriately on the wards in accordance with the Code of Practice: Mental Health Act 1983. (Section 17 of the Mental Health Act covers the circumstances in which patients detained for treatment may leave the hospital.)
- The majority of staff had a limited understanding of the Mental Capacity Act 2005 (MCA), and this was confirmed in the records relating to the use of the MCA. (The Mental Capacity Act deals with patients' capacity to take decisions and how decisions made on their behalf must be in their best interests.)
- Patients were not treated with respect and dignity at all times by all staff, and were not always involved in planning their care and treatment. On Capel and Newdigate 1 wards, there were no doors to the en-suite bathrooms in patient bedrooms.
- Patients did not have an individualised timetable of meaningful activities that met their interests and recovery goals. The activity provision did not meet commissioning for quality and innovation payment targets of 25 hours of activities offered per week to each patient.
- Patients did not feel listened to when they made a complaint. Verbal complaints were not acknowledged as complaints and were not recorded or investigated so patients did not receive a response. The provider did not act proactively in response to all patient feedback so this could not be used to make improvements to the service.
- Morale was low among the majority of staff we spoke with and staff did not feel recognised or involved in improvements needed for the service.

However:

- Medicines were managed well, and emergency resuscitation equipment was checked regularly.
- Staff completed risk assessments and developed management plans to minimise risks to patients and staff. The risk assessment of patients was monitored and planned using appropriate tools to make it robust.
- There were clear safeguarding processes.
- Clinical staff assessed patients' needs on their admission to the hospital that were developed into care plans.

Summary of findings

- The physical health needs of patients were supported through regular checks and monitoring.

- Staff had an understanding of the patients and supporting their individual needs. Staff were aware of the diverse needs of patients and made attempts to meet individual needs. The patients generally liked the food provided and cultural needs were catered for.

- There were local governance processes that helped identify where the service needed to improve.

- Staff felt supported at a local level by their peers and ward managers, though not by senior managers.

- Wards had targets for physical health, care planning and risk assessment. Performance was audited.

- Monitoring of incidents of harm or risk of harm and safeguarding incidents was used to make improvements to the service.

Summary of findings

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Requires improvement

Farmfield

Services we looked at:

Forensic inpatient/secure wards

Summary of this inspection

Background to Farmfield

Farmfield is a 52-bed, low and medium secure hospital specialising in treating male patients over 18 who have been detained under the Mental Health Act (1983) and who will benefit from extended treatment and rehabilitation.

The core service provided at the location is: forensic inpatient/secure wards.

There is a registered manager for the service.

Farmfield is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983;
- Diagnostic and screening procedures; and
- Treatment of disease, disorder or injury.

The hospital provides medium and low secure services and has five wards:

Rusper ward provides medium secure forensic inpatient care for men. It has 10 beds.

Capel ward provides medium secure forensic inpatient care for men. It has 11 beds.

Hookwood ward provides medium secure forensic inpatient care for men. It has 10 beds.

Newdigate 1 provides low secure forensic inpatient care for men. It has 11 beds.

Newdigate 2 provides low secure forensic inpatient care for men. It has 10 beds.

The CQC have inspected the services provided by Farmfield three times since April 2010. At the time of the last inspection, Farmfield was not meeting the essential standards relating to involvement of patients in their care planning, staffing levels and record keeping. These areas of non-compliance were inspected as part of this inspection and we found that improvements had been made in all the areas. However, some further improvements were needed in relation to the involvement of patients in their care.

Our inspection team

Team leader: Louise Phillips

The team that inspected the service comprised of six inspectors and a variety of specialists: one expert by experience, one Mental Health Act Reviewer, one nurse and one clinical psychologist.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all five wards at the hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 30 patients who were using the service, and/or their carer
- spoke with the managers of each of the wards
- spoke with 47 other staff members; including doctors, nurses, health care assistants and allied health professionals
- carried out an evening visit to speak with the night staff on all five wards
- carried out four separate focus groups:
- nursing/ health care assistants – 16 staff attended
- doctors/ consultants – three staff attended
- allied health professionals – 10 staff attended
- support services staff – eight staff attended
- attended and observed the patient-run coffee shop within the hospital
- attended and observed five multi-disciplinary meetings, including one risk meeting
- attended and observed two daily ward planning meetings
- carried out a Mental Health Act monitoring visit to Newdigate 1 ward
- collected feedback from three patients using comment cards
- looked at 14 treatment records of patients
- carried out a specific check of the medication management on three wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

With some exceptions, the majority of patients spoke negatively about the attitude and approach of the staff and the language staff used with them. Patients said this came from all levels of staff within the hospital. Some patients described a negative attitude of staff and of being spoken to in a derogatory manner. Some patients described a lack of interaction from staff and said they spent most of their time in the office areas.

The patients' 'have your say' forum minutes for April, May and June 2015 consistently identified that patients raised concerns that they were not being acknowledged and were ignored by staff. Each forum had raised that staff were spending too much time in the office and that when patients tried to get attention they were ignored.

The privacy and dignity of patients was not always maintained. Some patients spoke of the staff entering their rooms without knocking and waiting for an answer. This was also an issue raised with us by patients of Newdigate 1 and Capel wards where there were no doors to the en-suite areas and patients' privacy was not maintained. Some patients told us that they did not always hear staff knock/ enter and this impacted on their privacy.

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?

Requires improvement

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

- The ligature risk assessments were not kept on the wards which meant that information about the management of risks was not readily available to staff.
- Staff audited infection control procedures only once a year.
- The patients of Capel and Hookwood wards were using the immediate outside areas of each ward, which were adjacent to each other, at the same time. This presented a security risk to both wards.
- Sometimes wards were not fully staffed. This was not recorded as an incident so that appropriate actions could be taken.
- Staffing levels were not increased promptly when assessment of risk indicated that it was necessary.
- The seclusion room of Rusper ward presented some risks to patients in the environment in relation to 'snagging' from recent refurbishment works not having been completed.

However:

- Staff regularly checked the emergency resuscitation equipment.
- Medicines were managed well, with appropriate storage and record-keeping. Patients were informed about the medicines they received.
- The wards were visibly clean and generally well-maintained.
- Staff completed risk assessments and developed management plans to minimise risks to patients and staff.

There were clear safeguarding processes to ensure that any safeguarding concerns were reported and investigated appropriately.

Are services effective?

Requires improvement

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

- There was an inconsistent approach to boundary-setting by the staff, which gave patients an unclear message about expectations and the remits of confidentiality.
- Section 17 leave entitlement was not being managed appropriately on the wards in accordance with the Code of Practice: Mental Health Act 1983.

Summary of this inspection

- The majority of staff had a limited understanding of the Mental Capacity Act 2005 (MCA). The MCA records we viewed did not provide a full context of the decision-specific area of capacity to be assessed and there were no records of a best interest discussion to inform the decisions made.

However:

- Clinical staff made an assessment of patients' needs on their admission to the hospital. This included an assessment of physical health needs. Where needs had been identified, these were developed into care plans so that staff knew how to support each patient. The physical health needs of patients were supported through regular checks and monitoring.
- The risk assessment of patients was monitored and planned using appropriate tools to make it robust.

Are services caring?

Requires improvement

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

- Patients were not treated with respect and dignity at all times by all staff.
- Not all patients were involved in planning their care and treatment during multi-disciplinary meetings and care planning.
- On Capel and Newdigate 1 wards, there were no doors to the en-suite bathrooms in patient bedrooms. Some patients told us that this impacted on their privacy.

However:

- Staff had an understanding of the patients and supported them with their needs.

Are services responsive?

Requires improvement

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

- Each patient did not have an individualised timetable of meaningful activities that met their interests and recovery goals.
- The activity provision did not meet commissioning for quality and innovation payment targets of 25 hours of activities offered per week to each patient.
- Discharge planning was not intrinsic in the care planning and recovery goals for each patient.
- Patients did not feel listened to when they made a complaint. The compliance manager confirmed that only written

Summary of this inspection

complaints were investigated. Verbal complaints were not acknowledged as complaints and were not recorded or investigated so patients did not receive a response. Themes arising from verbal complaints were not captured across the ward/ hospital and no action was taken in response to them.

However:

- Staff were aware of the diverse needs of patients and made attempts to meet individual needs.
- The patients generally liked the food provided and cultural needs were catered for.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Staff morale was low amongst the majority of staff. Some staff reported feeling bullied and staff did not feel recognised for their work or involved in improvements needed for the service.
- The provider did not act proactively in response to all patient feedback so this could not be used to make improvements to the service.

However:

- There were local governance processes that helped identify where the services needed to improve.
- Staff felt supported at a local level by their peers and ward managers, though not by senior managers.
- Wards had targets for physical health, care planning and risk assessment and performance was audited. This ensured that care plans were up to date and individual areas of risk were incorporated into care plans.
- Monitoring of incidents of harm or risk of harm and safeguarding incidents was used to make improvements to the service.
- Some innovative practice took place to help improve the service that patients received, such as the patient-run coffee shop.

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.

At the time of the inspection 70% of staff had undertaken training in the Mental Health Act 1983. Staff showed a good understanding of the Mental Health Act (MHA) and guiding principles.

The documentation we reviewed in detained patients' files was generally compliant with the MHA and the Code of Practice: Mental Health Act 1983 (CoP). The MHA administrator carried out audits of the use of Section 132, to ensure patients were routinely kept informed of their rights

However, the use and management of Section 17 leave within the hospital did not fully comply with the requirements of the CoP. We found that this was being used as a way of modifying patients' behaviour.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of the inspection 92.5% of staff had received training in the Mental Capacity Act 2005 (MCA). There was an MCA lead for the hospital and a senior member of staff on each ward was identified as a ward MCA lead.

The leads we spoke with had a clear understanding of the MCA and their responsibilities within this.

However, we found that the majority of staff had a limited understanding of the MCA.

The nurses and healthcare assistants said that MCA issues were the responsibility of the consultant and did not convey an understanding of their roles and responsibilities in relation to the MCA.

We viewed three records where a patients' capacity had been assessed with regard to the MCA. These did not provide a full context of the decision-specific area of capacity to be assessed and there were no records of a best interest discussion to inform the decisions made.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Farmfield was a purpose-built hospital and the layout of the wards enabled staff to observe most areas. The staff told us that any risks presented by blind-spots were mitigated by walking around the ward areas several times an hour. We observed the staff were present in the communal areas and checked on patients' whereabouts during the day.
- The hospital had a maintenance team that oversaw day to day maintenance issues. Staff told us these were generally addressed promptly with little disruption to the service.
- We identified some ligature risk points on the wards. Ligature risk assessments had been carried out for each areas of the ward and were reviewed annually. The ligature risk assessments identified many high and medium risks on all wards. The provider had an action plan to carry out a large programme of works that would address many of the existing risks. In the intervening period the risk assessments summarised how risks would be managed on a day-to-day basis. However, the ligature risk assessments were not kept on the wards and staff were not kept aware of all ligature risks and how to manage them on a day-to-day basis.
- On each ward there was a kitchen area where patients could make hot drinks and snacks. These were kept unlocked and supervised by staff when in use.
- Emergency equipment, including automated external defibrillators and oxygen were situated to be shared across two wards. They were checked regularly to ensure they were fit for purpose and could be used effectively in an emergency. The training records showed that staff had training in life support techniques to enable them to respond effectively to emergencies.
- Patients told us that standards of cleanliness were usually good and any shortfalls in cleaning were promptly addressed. Infection control audits were carried out annually. The frequency of carrying out checks annually could put patients and staff at risk of infections.
- There were call alarms in different areas of the wards and staff carried a personal alarm on them at all times. We observed that where these were activated, staff responded promptly to the emergency.
- During the inspection we observed that the patients of Capel and Hookwood wards were using the immediate outside areas of each ward at the same time. These were adjacent to each other and presented a security risk to both wards where patients could potentially pass items through the adjoining fence.

Safe staffing

- Since the last inspection increases had been made to the staffing levels of the hospital. A ward manager had been introduced for each ward; some of these had been recruited in recent months. A 'floating' member of staff had been introduced for the day and night shift to provide extra support where necessary.
- Most of the wards we visited had staff vacancies that were subject to an ongoing recruitment campaign. As a result there was high use of bank and agency staff.

During the period of the 1 March – 31 May 2015, 112 shifts had been covered by bank or agency staff. The service aimed to use consistent bank and agency staff where possible. However, this was not always possible, which could put patients at risk of inconsistent care. This was identified on the hospital risk register and an ongoing recruitment strategy was in place to work on addressing the vacancies.

- Bank staff were provided with the same level of mandatory training as permanent staff to provide consistency to the service provided.
- The feedback we received from some staff was that they were not always able to get extra staff when they requested this and they felt this put them and the patients at risk. Staff said that they did not feel able to report where they could not get staffing cover, which they felt meant that the senior managers and the provider were not always aware of when wards did not run with a full staff complement. Some staff spoke of lengthy processes to get extra staff, which they felt undermined their professional judgement of situations and potentially put patients and staff at risk.
- We were shown information in relation to two incidents where staff asked for extra cover and this was not agreed by the on-call senior manager.
- The staffing levels of each ward were reviewed each morning at the communication and forward planning meetings. These were kept under review throughout the day. Some staff told us that they were moved to cover other wards at short notice and they did not always receive an introduction to the ward, patients or staff, which they felt meant they could not be as effective on the wards.
- Patients told us that staff were visible and generally available when they needed them, though they sometimes had to wait. Two patients told us that their Section 17 leave had been cancelled due to a lack of staff to escort them. The service did not monitor or record where Section 17 leave had been cancelled/ postponed. However, the staff confirmed to us that patients could not always take their agreed escorted leave, as there were not always enough staff to escort them.
- Doctors told us that there were enough medical staff available day and night to attend the ward quickly in an emergency. At night there was a locum doctor, senior nurse and member of the senior management team on call. The night staff we spoke with said that whenever they had to contact out of hours support, they were always able to talk with someone quickly and any concerns responded to promptly.
- Staff received and were up-to-date with mandatory training and the average mandatory training rate for staff was 85%. The training records showed that staff had received training in areas such as fire safety, basic life support, safeguarding, infection control and therapeutic management of violence and aggression. New staff had a period of induction before being included in the staff numbers. The training helped to support staff to deliver care to patients safely.

Assessing and managing risks to patients and staff

- In the six month period before the inspection there were six episodes of seclusion, four on Rusper ward and two on Hookwood ward.
- There were 20 recorded episodes of restraint. The highest number of these occurred on Hookwood ward. There were no recorded prone restraints.
- Staff completed risk assessments on the admission of new patients to the ward, which incorporated historical and known risks. This information was used to develop risk management plans. These were reviewed regularly and updated after incidents. Staff told us about measures put in place to ensure that risks were managed. For example, the level and frequency of observations of patients by staff were increased when required. We observed staff used appropriate de-escalation techniques to reduce patients' anxieties and potential aggression.
- Staff received training in the 'Prevention and Management of Violence and Aggression' training. Guidance published by the Department of Health in April 2014 called 'Positive and Safe' included information on the use of face-down restraint and the ending of this practice. The aim was to ensure it was only used as a last resort, and that reduction plans were implemented to end this practice. The staff and senior managers told us that they were not taught face-down restraint but that the training they received covered how to support patients who moved into this position during restraint, to ensure their safety.

Requires improvement

Forensic inpatient/secure wards

- Across some wards we looked at the records kept after patients had been given rapid tranquilisation to manage violent behaviours. The National Institute of Clinical Excellence (NICE) guidance stated that the vital signs of patients should be monitored until they are alert. The records of monitoring following rapid tranquilisation we reviewed showed that this happened until the patient was alert and moving about.
- The seclusion rooms were located on Rusper and Hookwood wards. Each room also had an 'extra care area' to support patients who needed a more intensive level of support. The staff told us that if their ward had a patient in the seclusion area then they would provide the nursing support to the area. The records relating to recent seclusion of patients showed that reviews by medical and nursing staff were carried out in accordance with the Code of Practice: Mental Health Act 1983.
- The seclusion room of Rusper ward had recently been refurbished and we found some unsafe areas where 'snagging' had not been completed, such as the flooring and door hinges not being flushed to the walls. When we informed the provider they were aware of these and had a contractor booked to repair this.
- Four patients we spoke with across Hookwood and Rusper wards said they did not feel safe due to having witnessed/ been subject to assaults from other patients. They said that staff spent the majority of their time in the office areas, which they felt enabled situations to escalate.
- The staff we spoke with knew how to recognise a safeguarding concern and how to escalate this to ensure it was reported appropriately. Staff were aware of the provider safeguarding policy and could name the safeguarding lead. They gave us examples of safeguarding referrals that had been made. These showed that safeguarding concerns were alerted promptly in response to allegations or incidents that had occurred. In the office areas there were flowcharts on display of how to raise any safeguarding concerns, to remind staff of actions they needed to take.
- The safeguarding lead told us about their role as a 'filter' for raising safeguarding alerts with the local authority safeguarding team, where they would consider all safeguarding concerns make the alert as necessary. They showed us how they monitored the investigation of these, through to outcome and confirmation of the closure of these to ensure that these had been considered and taken up/ closed to further action by the local authority.
- Appropriate arrangements were in place for the management of medicines. We reviewed the systems for the storage and administration of medicines on several of the wards we visited. Medicines were stored securely. Temperature records were kept of the medicines fridge and clinical room in which medicines were stored, showing that medicines were stored appropriately to remain fit for use. The records relating to the administration of medicines were accurate. The local pharmacist regularly audited medicine records to ensure recording of administration was complete, and this information was provided to the ward managers.
- For patients who wanted to see their children, this was considered with partner agencies and risk assessed to ensure it was in the child's best interest. A separate child visiting room away from the ward and patient areas was available for visits.
- We viewed the recruitment records of 15 staff, approximately 10% of the workforce. We found that recruitment checks had been carried out to ensure that fit and proper persons were employed. This included identification checks, two references from previous employers, a check of any gaps in employment, pre-employment competency assessment, as well as satisfactory checks with the disclosure and barring service. Audits of the recruitment practices took place to ensure that all relevant information was held about each staff member, to minimise risks of unsuitable staff being employed.
- However, we found on one occasion that a staff member had been employed for a post they were not qualified to undertake, as per the job description for the role. The provider was aware of this and demonstrated they had put in place plans to address this, through the introduction of an appropriate job description and training for staff.

Track record on safety

- In the last year there had been two serious incidents involving the patients. One of these had been a patient

going absent without leave (AWOL) where they did not return from leave, and another due to a patient on patient incident. These were investigated and measures had been taken to prevent recurrence.

- There had been a number of safeguarding incidents across the wards that related predominantly to patient on patient aggression. The wards took action in response to these to ensure that management plans were updated to prevent recurrence. However, reports from most patients was that staff spent most of their time in the office areas, which enabled patient on patient incidents to develop, and could have been prevented.

Reporting incidents and learning from when things go wrong

- The hospital was working to fulfil the regulation relating to the duty of candour. This means they operate with openness, transparency and candour, such as if a patient is harmed they are informed of the fact and an appropriate remedy offered.
- Patients were not made aware of safety incidents that did not affect them, but where they were involved in an incident additional support was provided to help them stay safe.
- Local incidents and learning from these was shared amongst the ward managers to cascade to their teams. Some staff spoke of examples where improvements had been made as a result of incidents that had occurred. For example, increased support to staff following incidents, sharing information and providing more information to patients. However, not all the staff felt supported following an incident, and felt they were just expected to 'get on with it'.
- The ward managers told us they were made aware of incidents that had occurred in other areas at meetings of ward managers, as well as incidents from other Priory Secure Services, to share learning and improve practice. However, the staff on the wards had limited awareness of incidents that had occurred outside of their ward areas, or of the learning from these. Despite this, we did see on some wards a folder that contained details of incidents that had occurred in the hospital and the learning from these.
- Following incidents, staff were offered support from their line managers and peers. Staff reported feeling supported by their immediate team and able to discuss incidents and any difficult feelings that arose as a result. Staff did not feel supported by senior managers at these times. Reflective practice sessions for staff took place fortnightly on each ward with a psychologist. However, the records of these were held with the psychologist and not readily available on the wards for staff to reference.
- The majority of staff we spoke with knew how to recognise and report incidents on the electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the compliance manager for the service, who maintained oversight and flagged any safeguarding concerns to the hospital safeguarding lead. The system ensured that senior managers within the hospital were alerted to incidents promptly and could monitor the investigation and response to these.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans. The care records showed that people were assessed and care plans implemented in response to their assessed needs.
- The hospital had recently implemented the 'My Shared Pathway' (MSP) form of multi-disciplinary care planning with the aim of involving patients more in their care. The care records showed the implementation of MSP and the involvement of different members of the multi-disciplinary care team (MDT).
- Where a physical health need had been identified, care plans had been implemented to ensure they were addressed along with plans for routine monitoring. An example of this was where patients had long term conditions such as diabetes. Care plans were developed to enable the patient to maintain as much independence as possible with this, whilst being monitored by staff.

Requires improvement

Forensic inpatient/secure wards

- The patients we spoke with said the service was good at looking after their physical health needs. Physical health checks of all patients were carried out through a system of weekly weight, blood pressure, pulse and temperature monitoring. There was a dedicated member of staff who oversaw the physical health checks and monitored this on all the wards. A GP visited the hospital twice a week to provide primary care input into the physical health of patients.
- The care records were stored on the provider's computerised care planning system. Access to the system was through staff identification card and password login, which ensured confidential information was maintained securely. The computerised records meant that information was available to doctors and nurses as patients moved between wards. From the last inspection of Farmfield there were concerns raised with regard to record keeping. At this inspection we found that improvements had been made to ensure records were appropriately maintained. However, staff highlighted ongoing issues with the IT systems, which would freeze and shut down frequently, affecting their ability to record information onto the care records. We experienced this during the inspection, and were informed of work taking place to address this.

Best practice in treatment and care

- The National Institute of Health and Care Excellence (NICE) guidelines were followed in relation to the safe and effective use of medicines to enable the best possible outcomes.
- The psychological therapies provided were in accordance with those recommended by NICE, such as cognitive behavioural therapy, and dialectical behaviour therapy. A drama therapist also provided sessions at the hospital.
- We found that access to psychological therapies as part of patients' treatment varied between different wards. Psychologists were part of the hospital team and provided input to the care people received during MDT meetings. However, not all patients received psychology and there were limited groups run by the psychology team that patients could access.
- One patient of Hookwood ward said that they were supposed to receive psychology input once a week but the psychologist 'hardly ever turns up'. The psychologist confirmed that the sessions had not taken place and that 'patients don't have set session times'. The clinical notes demonstrated one session having occurred earlier in the month. These findings meant that the psychology provided was not sufficient and consistent to support patients' needs.
- The occupational therapists used the Model of Human Occupation Screening Tool for the assessment of patients and we saw evidence of these in the care records.
- The service had recently introduced the Model of Creative Ability tool for supporting patients with their recovery and focussing on their abilities, and the activity programme was based around this.
- The hospital participated in the high dose antipsychotics audit facilitated by the Royal College of Psychiatrists to ensure that these were appropriately prescribed and patients were closely monitored.
- The hospital received accreditation from the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services. At the last cycle, in October 2014, the hospital gained a score of 90% for both its medium and low secure services. An action plan had been developed to make improvements in response to the recommendations.
- On admission to the wards the staff assessed patients using the Health of the Nation Outcome Scales. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- The service used different forms of risk assessment and management that were appropriate for the setting and needs of the patients. This included Historical Clinical Risk Management-20 (HCR-20) for violence risk assessment and management, Short Term Assessment of Risk and Treatability and Structured Assessment of Protective Factors for violence risk.
- We saw that some patients had worked with staff to decorate the coffee shop and gardens.

Skilled staff to deliver care

- The staff working in the hospital came from a range of professional backgrounds including nursing, medicine, occupational therapy and psychology. An external pharmacist also provided support to the wards.
- Most staff told us they received clinical supervision every month, where they were able to reflect on their practice and incidents that had occurred on the ward. However,

some staff told us that this could be cancelled when the wards were very busy. Fortnightly reflective practice took place across the wards, facilitated by a psychologist.

- Staff said that they did not feel supported by the senior managers to undertake continued professional development (CPD) and some spoke of having to 'earn' training as opposed to it being provided as a part of staff development. The hospital director described that any CPD that staff wanted to do had to be approved by a wider Priory CPD panel and that staff had to provide a 'business case' of why they wanted to enrol on this. Some staff we spoke with outlined they had been asking for extra training for years, others said they had stopped asking as they never got a reply to training requests.
- We were shown the record of CPD undertaken by the staff. This showed that since the beginning of 2015, 13 staff had been approved for professional development courses/ conferences, four requests for training had not been approved by the learning and development team.
- We found that some patients had specific needs that would have required additional training and support for staff, such as in relation to autistic spectrum disorders (ASD) or Huntingdon's disease. Three staff had received training in Huntingdon's disease. More staff had received training in personality disorders and introductory training in Aspergers. However, we observed that staff did not have a clear understanding of supporting patients with individual needs. One patient with specific needs felt the team involved in their care did not understand their needs. Two carers we spoke with also felt that staff did not have the necessary understanding of specialist needs, where they said this was demonstrated in their approach with patients. Our observations also confirmed that staff had a lack of understanding of the needs of people with ASD. For example, staff did not always demonstrate appropriate ways of communicating with patients with ASD.
- Some patients spoke of the negative effect that staff movement between wards in the hospital had on their care. They spoke specifically in relation to staff that had moved from working on the medium secure wards to then working in a low secure environment. They said they felt the staff were more restrictive in allowing them to do things. They said that as a result of this, the messages and approaches used by staff were inconsistent. Some of the staff gave the examples of the smoking breaks, where staff did not enforce these and allowed patients to smoke at any time, which resulted in them running out of cigarettes and conflicting messages from staff. The hospital director described the moving of staff in relation to balancing up the skill mix of the staff, or where staff had been targeted by patients.
- Some of the staff we spoke with had moved between wards and felt they were not skilled to adapt quickly to the different environments to ensure patients were supported appropriately, which could put patients at risk of ineffective care.

Multi-disciplinary and inter-agency team work

- The hospital had recently introduced the 'My Shared Pathway' system of care planning to make these multi-disciplinary in approach and to involve the patient more in their care. We observed in the multi-disciplinary team (MDT) meetings that professional disciplines were involved in the review of patients care and all participated in discussions about the patients.
- There was positive inter-agency working with the GP to support patients physical health needs.
- Staff spoke of positive links with local authority staff in raising safeguarding alerts and the local police liaison officer who visited the service to meet with patients and staff.

Adherence to the MHA and MHA Code of Practice

- At the time of inspection 70% of staff had undertaken training in the Mental Health Act. Staff showed a good understanding of the Code of Practice: Mental Health Act 1983 and guiding principles.
- The use of the Mental Health Act was generally good in the wards. The documentation we reviewed in detained patients' files was generally compliant with the Mental Health Act and the Code of Practice. The MHA administrator carried out audits of the use of Section 132, to ensure patients were routinely kept informed of their rights
- The use and management of Section 17 leave within the hospital did not fully comply with the requirements of the MHA Code of Practice. Prior to visiting the hospital we received information that Section 17 leave was being used as a way of modifying patients' behaviour. During the inspection one person told us that their leave had been cancelled following an altercation with staff, whilst another said that they could not take it if they did not attend the morning meeting.

Requires improvement

Forensic inpatient/secure wards

- Another patient told us their leave was linked to their attending psychology sessions, but that these did not always take place so this had a further impact upon them. The staff we spoke with confirmed these occasions of Section 17 leave not being granted.
- Staff confirmed there was an expectation that patients attended the morning meeting to receive ground leave. If they did not attend without a good reason they would not get allocated ground leave.
- The hospital director told us that expectations of coming to meetings was based around engagement of the patient and the need to assess the risk they presented. However, our findings demonstrated that this was not always the situation and Section 17 leave entitlement was not being managed appropriately on the wards.

Good practice in applying the Mental Capacity Act 2005

- There was a Mental Capacity Act 2005 (MCA) lead for the hospital and a senior member of staff on each ward was identified as MCA lead. The leads we spoke with had a clear understanding of the MCA and their responsibilities within this.
- However, the majority of staff had a limited understanding of the MCA. The nurses and Health Care Assistants (HCAs) said this was the responsibility of the consultant and did not convey an understanding of their roles and responsibilities in relation to the MCA.
- At the time of the inspection 92.5% of staff had undertaken training in the MCA.
- We viewed three records where a patients' capacity had been assessed with regard to the MCA. These did not provide a full context of the decision-specific area of capacity to be assessed and there were no records of a best interest discussion to inform the decisions made.

Are forensic inpatient/secure wards caring?

Requires improvement

Kindness, dignity, respect and support

- We observed some positive and caring interactions between staff and patients, including during challenging circumstances. Discussions between patients and staff were in private and away from other patients on the ward.
- We received mixed feedback from the patients about the staff. Some were positive whilst the majority spoke negatively of their experiences. Patients said this related to all levels of staff within the hospital. Some patients described a negative attitude of staff and of being spoken to in a derogatory manner. Some patients described a lack of interaction from staff, where they said they spent most of their time in the office areas.
- Similarly, the patient 'have your say' forum minutes for April, May and June 2015 consistently identified the issue raised by patients of their not being acknowledged and being ignored by staff. Each forum raised that staff were spending too much time in the office and when they try to get attention they were ignored. Staff told us that efforts had been made to get staff to spend more time with the patient, such as with the removal of a number of chairs from the office areas. On our visit we observed two chairs in each office and more staff in the ward environment, which encouraged staff to spend more time with patients
- The privacy and dignity of patients was not always maintained. Some patients spoke of the staff entering their rooms without knocking and waiting for an answer. On Hookwood ward we observed staff did not always knock on doors before entering. This was also a particular issue raised with us by patients of Newdigate 1 and Capel wards where there were no doors to the en-suite areas and as such patients' privacy was not maintained. Some patients told us that they did not always hear staff knock/ enter and this impacted on their privacy.
- The staff conveyed a caring approach when talking about patients and had an understanding of their mental health needs and the support patients needed.

The involvement of people in the care they receive

- At the last CQC inspection of Farmfield we identified that patients were not always enabled to make or participate in decisions relating to their care or treatment. There was a lack of involvement of patients in the process of care planning and decisions that related to the care and support they received. During this inspection we found some improvements had been made to the care

planning to ensure these were more personalised and holistic. This was through the implementation of the 'my shared pathway' of care. However, we found that the spirit of this was not fully embedded within the MDT and further improvements were needed.

- During the inspection we observed two multi-disciplinary team (MDT) meetings. All the team reviewed each patient's needs and discussed important issues or events that had occurred, as well as ongoing needs and areas of progress. However, we observed that the involvement of the patient was at the end of the MDT meeting, where actions and future plans in relation to areas such as medicines, S.17 leave and gaining independence in aspects of their life had already been decided upon without the involvement of the patient.
- In the MDT meetings we observed that the team generally had a compassionate approach to decision making. However, all decisions were made in the absence of patients and then fed back to the patients who were invited in individually at the end of each meeting. We did not observe any discussion of care plans, risk assessment with the patient present.
- Patients were told of the plans made by the MDT without any discussion. This was further evident in the MSP reviews in the care records, where the clients' views consisted of comments such as 'This is all correct and I'm happy being compliant', 'I am going to follow these goals' and 'I hope to be doing more with MDT'. The staff we spoke with confirmed that patients were invited in at the end of the MDT discussion only.
- The patient 'have your say' forum minutes for April, May and June 2015 consistently identified an issue raised by patients, where they said that they were not able to see their previous ward round minutes before the next ward round. Patients we spoke with said the ward rounds were rushed with the consultant doing most of the talking. Patients stated that they would like to hear from other disciplines present. During the MDT meeting we observed, the consultant was the only professional who spoke with the patient.
- One patient of Hookwood ward told us they felt uninvolved in the meetings about their care due to the MDT 'having discussed everything first' and then they were invited in to hear the decisions made. One patient said that their views were never recorded in the minutes of the MDT ward round, whilst others said there was a focus on areas where they had misbehaved, as opposed to looking at what they did well.
- Some carers we spoke with said they used to be more involved in their relatives care, but since changes to the professionals involved in their care, this no longer happened.
- Of the patients we spoke with, four felt they were not involved in their care and one did not feel that the treatment was focused on recovery. Two patients of Rusper and one of Capel ward were aware they had a care plan, but not told about My Shared Pathway (MSP). Two patients on Hookwood ward were aware of MSP, one said this was only from having been on a low secure ward where they did this. Neither patient spoke of being involved in this.
- Care plans varied in how much they demonstrated the involvement of patients in their implementation. We found that some used direct quotes from the patient, whereas others were written in the first person, or were a set of instructions for the patient, so it was not always clear how people were involved.
- The wards held community meetings with patients to gather their views about the ward. Minutes of the meetings were displayed to remind patients and staff of what had been discussed. The records were brief and did not provide an update of actions taken as a result of previous meetings.
- We observed morning meetings taking place on Hookwood and Capel wards. These were run by an occupational therapist (OT) to plan the days' events. These focussed on seeing who wanted to be involved in the daily OT programme.
- The most recent patient satisfaction survey was carried out in December 2014. The overall results scored lower for satisfaction when compared with other secure services run by the provider. This was except for the quality of choice of food, which scored 65%. The highest scoring areas were for the staff being caring and supportive, the accommodation meeting needs and the service supporting care planning and involving patients in the process. The lowest scoring elements were for the service meeting personal needs and the range of

activities available. Patients of Newdigate 2 gave the most negative results. An action plan had been implemented in response to this and the actions were still being worked through at the time of the inspection.

- A patient 'have your say' forum took place monthly. We viewed the minutes of the April, May and June meetings. We found that issues patients raised over the three months had not been actioned upon, and were repeated in each forum. These related to patients wanting to be more involved in their care and better provision of activities.
- The advocacy services information on display in some of the wards was out of date as we were informed that there was no current advocacy at the hospital and they were in the process of arranging this.

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

Requires improvement

Access and discharge

- The average bed occupancy over the last six months was 100%. All wards had a bed occupancy of more than 85% which demonstrated a demand for the service.
- In the last six months there had been no delayed discharges from the hospital.
- The majority of patients we spoke with did not feel involved in the plans for their discharge and felt their concerns were not taken into account. One patient we spoke with was not aware of their care pathway and what they needed to do to progress. They spoke of the focus of their care plan being around keeping their room clean and avoiding alcohol.
- Patients of Hookwood ward spoke of making no progress and not seeing how they could move on from Farmfield. They spoke of 'going around in circles' having moved from medium and low secure wards, and having been on every ward in the hospital over the time they had been there.

The facilities promote recovery, comfort and dignity and confidentiality

- The wards had a number of rooms for use, including quiet lounges, dining room and a clinic room. Within the hospital, patients had access to a multi-faith room, occupational therapy rooms, a gym and coffee shop. Within the wards there was some equipment available to support patients to occupy their time, such as books or games. However, on most wards, including the low secure wards, these were kept locked away and could not be accessed without requesting these from staff.
- Patients had their own bedrooms where they could have their own equipment and belongings. However, the general ward environments were sparse and did not promote a comfortable environment for patients.
- Patients were able to make telephone calls in private through the use of the phone booths on the wards.
- Each ward had access to outside space.
- Patients were able to make their own drinks when they wanted. Snacks were available outside of mealtimes, such as fruit and biscuits and sandwiches could be prepared on request.
- A Koestler award had been won by a patient for their work. The Koestler Trust is an arts charity working within prisons and secure mental health services to help offenders and patients to lead more positive lives by motivating them to participate and achieve in the arts.
- Patients were able to study and obtain qualifications through the National Open College Network. The records of these showed that some patients had undertaken qualifications in food safety, cooking techniques, working as a team and using the internet

Meeting the needs of all people who use the service

- The hospital director demonstrated a clear knowledge of any specific diversity needs of the patients in the hospital and how their needs were catered for by the wards. She also spoke of the difficulties in gender-mix. For example, there were more female than male staff and on occasions some patients could only be escorted by male staff.
- At the time of inspection 95% of staff had received training in equality and diversity as part of their mandatory training. Farmfield was situated close to Gatwick airport and when necessary, accommodated patients of different nationalities from the airport detention centre with mental health needs. In all of the wards, the staff spoke of different attempts to meet

individual communication needs. Staff had access to interpreters to support patients at meetings and there were phrase books on each ward to support staff to speak phrases in different languages, where needed.

- Similarly, where patients did not have recourse to public funds, efforts were made to ensure that their physical and dental health needs were met, where we were informed that the hospital funded the dental work of a patient who was seeking refuge in the country, but who were not entitled to benefits.
- Some local faith representatives visited patients on the ward, whilst others could be contacted to request a visit. We were informed however that some faith leaders chose not to visit the hospital. Some patients used their time away from the hospital to access places of worship. There was a multi-faith room within the hospital for use by patients.
- Patients were generally satisfied with the food provided and some patients were supported to prepare their own food. The menu provided vegetarian, Halal and lower calorie meals to provide choice to individual needs. However, the patients told us that the provision of Halal food had only taken place in recent weeks. The chef confirmed this and said this was in response to Ramadan. The service held a recent Halal certificate to demonstrate that the Halal food provided was genuine and appropriately prepared by the supplier. The chef acknowledged extra steps needed to ensure this was prepared appropriately on site.
- Farmfield hospital was purpose-built and all the wards were situated on the ground floor. The accommodation facilities supported those patients with temporary mobility problems, though further reasonable adjustments were needed to support patients with longer term needs. The hospital did not cater for older people and would refer to another hospital where they could no longer manage patients' needs.
- Activity programmes were on display on the wards. These covered hospital-wide activities and ward-based activities throughout the seven day week. There was a team of occupational therapy staff for the hospital who worked across the wards. There were no dedicated occupational therapy (OT) or activity workers for each ward, which meant the activity provision on the wards was minimal and unstructured. Patients did not have individual activities/ therapy timetables, and so they did not know what they were doing each day, unless they attended the morning meeting and asked to be involved in the daily activities.
- Of the patients we spoke with, eight said they did not engage in the activities as they felt these were 'boring' and did not interest them. They spoke of these as not being recovery-focussed and so they did not want to be involved in them. Patients spoke of wanting to be involved in groups that supported their recovery and rehabilitation and where they could gain certificates for use with future planning. Others spoke of wanting groups regarding dance, music and individual interests. Three patients were undertaking distance learning courses.
- The activities offered to patients and those they engaged in were monitored by the OT team. The figures for uptake between March and May 2015 showed that across the low and medium secure wards there was an increase in activities for the majority of patients. Of the patients participating in activities, 11 were doing on average less than two hours activities a week. On the low secure wards patients engaged in approximately five hours a week of activities on average. On the medium secure wards this was an average of 4.2 hours activity a week.
- The Commissioning for Quality and Innovation payment (CQUINs) had a target of 25 hours of activities offered per week to each patient. This was to include social, educational and occupational opportunities that is meaningful and supports rehabilitation and recovery. The audit of number of hours of OT intervention showed that the activities offered varied on average from 16 to 21 hours per week across the medium and low secure wards, which demonstrated that further work was needed in this area.
- Patients of Hookwood ward spoke of their being not much to keep them occupied in the ward area. On Newdigate 1, a low secure ward, we observed limited activities accessible to patients, with some board games in a locked cupboard. There was a computer for use, but staff told us that patients did not use it, as they did not know how to.

Listening to and learning from concerns and complaints

- The total number of recorded complaints in the last 12 months was 19. Of these, 10 were partially upheld.

Requires improvement

Forensic inpatient/secure wards

- Patients did not feel listened to when they made a complaint. Verbal complaints were not acknowledged as complaints and were not recorded. The compliance manager confirmed that only written complaints were investigated. As a result verbal complaints were not investigated and patients did not receive a response. Themes arising from verbal complaints were not captured across the ward/ hospital and actions taken to address.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- The staff we spoke with were not aware of the vision and values of Priory Secure Services and there was a general lack of connection to the provider. There were three quality improvement objectives for the hospital although the staff were not aware of what these were.
- The staff were aware of the different members of the senior management team, of their roles and areas of responsibility and knew who to contact regarding specific issues such as safeguarding, support services and maintenance.
- The ward managers had a presence on the wards and staff considered they had a good understanding of the issues facing them on a day-to-day basis.

Good governance

- Some local governance processes were in place. The wards held 'ward based clinical governance committee' meetings with the patients and staff on duty. The records of these showed that they had recently been implemented and areas such as incidents, infection control, health and safety and equipment were discussed. Patient experience was recorded, though this was more an evaluation of how patients were involved in their care as opposed to direct feedback.
- Wards had targets around physical health, care planning and risk assessment and these were audited. The medical director and head of psychology carried out audits of the care plans and risk assessments to ensure these were kept under review. This ensured that care plans were up-to-date and individual areas of risk were incorporated into care plans. However, these audits did not identify that lack of involvement of patients in their care, and this was a missed opportunity for further work in this area.
- Ward managers monitored the incidents, safeguarding training and supervision of the staff at ward level and fed this information into the hospital governance systems. Monitoring of incidents and safeguarding referrals were also undertaken by the safeguarding lead, with learning points developed from these to prevent recurrence and improve safety for patients. However, no monitoring took place of where Section 17 leave had been cancelled/ postponed, or of how this was being used, which was having an impact on the patients care and treatment.
- A monthly hospital clinical governance meeting took place, which viewed information from all the different committees, ward-based governance and in-house meetings between different teams. Action points arose from this for ward managers to action on the wards.
- The ward managers told us that they generally had sufficient time to manage the wards, though worked supernumerary for three out of every five shifts and so did not always manage to focus on managerial tasks as much as they needed. Administrative staff worked on each ward to provide additional support.
- Ward managers were not aware of being able to add items to the provider risk register, and were unclear of what items specific to their area of work were recorded on the register.
- The senior managers did not ensure regular oversight of the infection control risks on the ward and the ligature risk assessments were not held on the ward to inform staff of risks in the environment.

Leadership, morale and staff engagement

- There was evidence of a clear leadership structure from ward manager through to the senior management team/ heads of department to the hospital director. Ward managers were visible on the wards during the day, were accessible to patients and provided support and guidance to staff.
- The hospital director spoke about staff improvement objectives and recent initiatives to increase staff morale. This included aligning nursing staff pay to the same grading as in the NHS, an extra day off for each staff

birthday and plans to shorten the length of long service recognition awards. The staff we spoke with were aware of these but felt that the support in their day-to-day job was lacking and was not being addressed.

- The staff we spoke with were committed to their work. However, the majority of staff spoke of low morale across the staff team. Staff did not feel valued or recognised for their work by senior managers within the hospital. Staff did not always feel supported following an incident and felt they were expected to continue with their work.
- The staff did not feel listened to, or that their concerns were taken into account and addressed. Staff felt supported at ward level, however they spoke of feeling 'bullied' and not supported by the senior managers when it came to their work. They spoke of this in relation to where they raised concerns about the staffing levels, high use of agency/ bank staff and lack of consistent approach to patients. Some staff said they did not raise issues as they feared being victimised/discriminated against and losing their job. Some staff spoke of not having autonomy in their work and of feeling 'controlled' or feeling not valued for their clinical knowledge by senior managers. In relation to this, we were shown records of two incidents that occurred. Prior to these, the ward manager had asked for extra cover and this was not agreed by the on-call senior manager. This put patients and staff at risk.
- Feedback from patients and staff was that the movement of staff around the hospital to cover staff shortages was not managed well. They feedback that there was a lack of acknowledgement of the different skills of the staff and the environments they were expected to work in at short notice, which had an impact on the care they delivered to the patients.
- Some staff spoke of their not being able to do the overtime that they used to and felt victimised for this. We found that in some cases this was due to managing the rota, and making sure that staff had sufficient time off from work
- The staff told us about the 'Your Say' monthly staff forum, where they could speak openly and raise issues directly to the hospital director and deputy director. Some staff felt these were positive and issues they raised were addressed. However, the majority of staff did not feel listened to and they felt that issues they raised were not taken any further or used to make improvements to the service. We looked at the minutes of the previous three Your Say forums. These recorded staff concerns and updated on actions. Some areas, such as the replacement of chairs, new computers and structuring staff breaks had been carried over from previous meetings.
- Senior staff working on the wards did not feel there were opportunities for career development to enable them to progress in their career, with a lack of leadership development programmes in the hospital, or support to undertake continued professional development. Similarly, some ward managers said they had no access to leadership training, which was needed across all the wards.
- During the last 12 months 31% of staff had left the employment of the hospital. Staff who left the hospital had an exit interview. We looked at the records of seven recent interviews and found that staff left for various reasons. Of the exit interviews we viewed, the majority of staff had left due to career progression, taking up educational opportunities or they did not feel suited to the work. Any concerning information arising from the interviews was directed to the Hospital Director to address, though only one of those we viewed was negative about working at the hospital.
- Staff were aware of whistle-blowing processes, however did not feel able to report concerns and improvements needed to managers. They did not feel confident that their concerns would be taken seriously.
- There were processes for engagement and seeking feedback from patients, such as the annual patient satisfaction survey and the monthly 'have you say' forum. However, the findings from these were that feedback was not always acted upon, or where an action plan had been implemented, these were still being worked through some time after the feedback had been received. Patients could not be assured that prompt action was taken in response to areas of concerns raised and they did not always feel listened to.
- The senior managers did not actively monitor the patient experience of being at Farmfield, and use the different forums available to enhance patient involvement and use their feedback to develop the service that each person received. This was evidenced by the lack of involvement in patients in their care and treatment meetings and care planning, as well as the failure to act upon the feedback from patient forums.

Similarly, the activity provision on each ward was not monitored to ensure that each patient was provided with a meaningful timetable of activities that reflected their interests.

- The hospital director was open in her approach to running the service. A policy had been developed by the provider to support staff and managers in the implementation of the duty of candour requirements. The manager described an open culture in the organisation and how they were working to fulfil the regulation relating to the duty of candour. However, some patients we spoke with were unhappy with how their individual concerns had been addressed, particularly in relation to verbal complaints.

Commitment to quality improvement and innovation

- There was a coffee shop within the hospital that was run by two patients and two staff. A patient and staff member had received training to be a barista. The coffee shop had been running for approximately a year and was valued by the patients and staff. The patients appreciated the relaxed atmosphere of the café environment.

Outstanding practice and areas for improvement

Outstanding practice

There was nothing to note.

Areas for improvement

Action the provider MUST take to improve

- Patients must be treated with respect and dignity at all times by all staff.
- The en-suite bathrooms of Capel and Newdigate 1 wards must have doors installed to promote the privacy and dignity of patients.
- All patients must be fully involved in planning their care and treatment. This involvement should be clearly recorded at all stages of decision-making.
- Verbal complaints must be acknowledged as complaints and recorded. These must be responded to and investigated as appropriate.
- The provider must act proactively in response to all patient feedback so this could be used to make improvements to the service.
- All staff must be made aware of the implementation of the Mental Capacity Act 2005 (MCA). The MCA records we viewed did not provide a full context of the decision-specific area of capacity to be assessed and there were no records of a best interest discussion to inform the decisions made.
- Patients were not always facilitated to take their Section 17 leave entitlement, and this must be managed in accordance with the Code of Practice: Mental Health Act 1983.
- The ligature risk assessments must be kept on the wards so staff are kept aware of all ligature risks and how to manage them on a day-to-day basis.
- The seclusion room of Rusper ward must be made safe prior to use with any patients.
- The frequency of carrying out annual infection control audits must be increased to minimise risk of infection to patients and staff.
- Senior ward staff were not always able to increase staffing levels when the risks they assessed to patients and staff required this. The process and timescales for requesting additional staff further increased the risk.

Action the provider SHOULD take to improve

- The management of the patients of Capel and Hookwood wards using the adjacent outside areas at the same time should be reconsidered to ensure there are no security risks.
- Occasions where wards do not operate at full staffing complement should be recorded as an incident to ensure appropriate monitoring and implementation of actions plans to address this.
- Where increased risks are assessed, adaptations to staffing levels should be facilitated promptly.
- Staff should have a clear understanding of supporting patients with individual needs.
- The provider should ensure that ongoing problems relating to the IT system are addressed in order that staff are able to complete care plans in a satisfactory timeframe.
- The general ward environments should be made less sparse and promote a comfortable environment for patients.
- Each patient should be provided with an individualised timetable of meaningful activities that meets their interests and recovery goals.
- The activity provision should increase across the wards to ensure that the average number of hours of activity meets Commissioning for Quality and Innovation payment (CQUINs) targets of 25 hours of activities offered per week to each patient.
- Discharge planning should be intrinsic in the care planning and recovery goals for each patient.
- Information about the current advocacy services should be provided to all patients and clearly displayed in areas accessible to patients.

Outstanding practice and areas for improvement

- Staff should be supported to work in an environment where they can raise concerns and not fear recriminations.
- The provider should ensure the submission of data to the Mental Health and Learning Disability Data Set (and Mental Health Services Data Set from January 2016).

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect · Patients were not treated with respect and dignity at all times by all members of staff. · The privacy of patients was not promoted where there were missing doors to their en-suite bathrooms. This is a breach of Regulation 10(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care · Patients were not fully involved in planning and decisions made about their care and treatment. This involvement was not recorded at all stages of decision-making. · Patients were not always facilitated to take their Section 17 leave entitlement in accordance with the Code of Practice: Mental Health Act 1983. This leave must not be used as a way of modifying patients' behaviour. · The majority of staff had a limited understanding of the Mental Capacity Act. The MCA records we viewed did not provide a full context of the decision-specific area of capacity to be assessed and there were no records of a best interest discussion to inform the decisions made. This is a breach of Regulation 9(2), 9(3), 9(3)(a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints · Patients were not able to make a complaint verbally and could only do this in writing. · Verbal complaints were not responded to and investigated as appropriate. This was a breach of Regulation 16(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance · The provider did not act proactively in response to all patient feedback so this could be used to make improvements to the service. · Senior ward staff were not always able to increase staffing levels when the risks they assessed to patients and staff required this. The process and timescales for requesting additional staff further increased the risk. This is a breach of Regulation 17(2)(b)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The seclusion room of Rusper ward presented some risks to patients and must not be used until fit for purpose. This is a breach of Regulation 15(1)(c)

- The ligature risk assessments were not kept on the wards. Staff were not provided with the information of all ligature risks and the plans to manage these on a day-to-day basis.

- The frequency of infection control audits did not ensure frequent monitoring of risks of infections to patients and staff.

This is a breach of Regulation 12(2)(b)(h)