Raphael Healthcare Limited (The Farndon Unit)

Quality Report

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Date of inspection visit: 21 and 22 December 2016
Date of publication: 20/03/2017

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

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

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Summary of this inspection

Background to Raphael Healthcare Limited (The Farndon Unit)

The Farndon Unit is registered with the Care Quality Commission as an independent low secure mental health hospital. The hospital, run by Raphael Healthcare Limited, accommodates up to 46 female patients over the age of 18. The Farndon unit is able to offer assessment, care and treatment to meet the needs of individual patients within the following diagnostic groups: mental illness, personality disorder and learning disability.

Regulated activities The Farndon Unit is registered with the Care Quality Commission to provide are:

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

Patients cared for at The Farndon Unit may:

- Be detained under the Mental Health Act (1983), sections 2,3,37, and 41 or informal.
- Have a classification of psychopathic disorder, or are classified as mentally disordered offenders (excluding untreated sex offenders) within the meaning of the Mental Health Act 1983.
- Be detained under Deprivation of Liberty Safeguards, Mental Capacity Act (2005).
- Have a primary diagnosis of mental illness with complex needs.
- Have a history of substance, drug and alcohol misuse.
- Have a history of sexual abuse or domestic violence.

The Farndon Unit consists of a single building built around an internal garden area. The building contains five ward areas; ward A, ward B, ward C and ward D and recovery ward, a low secure rehabilitation/recovery ward. At the time of inspection, 45 female patients were accommodated over the four ward areas and recovery ward. There was a registered manager in post.

We last inspected the Farndon Unit on 15 February 2016. We rated it as good overall; however, we found the service to be in breach of Regulations 9, 15, 18, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The current inspection focused on areas on non-compliance identified in February 2016 and concerns raised by whistle-blowers. This inspection took place five months after the publication of the comprehensive inspection report (in July 2016). We have re-rated the domains that were the subject of this most recent focused re-inspection.

Our inspection team

Team leader: Judy Davies

The team that inspected the service comprised three CQC inspectors, an inspection manager and a specialist adviser (nurse).

Why we carried out this inspection

We carried out this unannounced focused inspection due to whistle-blowing concerns and previous breaches of Regulations 9, 15, and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and as part of our inspection programme.

Whistle-blowing alerts made by staff raised concerns such as the lack of cleanliness of the unit, not enough staff to respond to alarms and increased assaults on staff by patients.

We last inspected the Farndon Unit on 15 February 2016. We rated the unit as good overall; however, we found it to be in breach in Regulations 9, 15, 18, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of this inspection

The actions identified that the provider must take to improve were:

- The provider must ensure the care environment is clean and properly maintained.
- The hospital must maintain staffing levels above the baseline number and within agreed staffing levels at all times to ensure patient safety.
- The hospital must ensure sufficient numbers of staff respond to emergency alarms in a timely way.
- The hospital must ensure it complies with the requirements in relation to the implementation of the Mental Health Act. It must ensure patients are reviewed before detentions lapse.
- The hospital must ensure patient participation in care plans, and care plans should be personalised and reviewed.

The hospital responded to the breaches by completing an action plan to address them. At this inspection, we only followed up the concerns raised by whistle-blowers and breach of regulations identified in the inspection carried out on 15 February 2016.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location, and obtained further information about the concerns raised from whistle-blowers. We spoke to other organisations for information related to these concerns. We looked at information provided to us on site and requested additional information following the inspection visit relating to the service.

During the inspection visit, the inspection team:

- visited wards at the hospital site, looked at the quality of the ward environments and checked the clinic and dispensing rooms
- observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with a family member of person using the service
- reviewed the arrangements for managerial and clinical supervision of staff
- interviewed the clinical director and registered manager with responsibility for the service
- spoke with nine other staff members including nurses and care assistants
- interviewed ward managers for each of the wards
- attended a staff handover and multi-disciplinary meeting
- looked at 11 care records of patients
- carried out a specific check of the medication management on five wards and reviewed 16 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

All patients we spoke with said the service had a good staff team that they received support from staff and were listened to. Seven patients felt safe and one patient felt unsafe due to harassment. They said activities, planned leave and appointments were cancelled due to lack of staff. Patients said they were actively involved in care planning. They told us that there was not enough staff on the ward and that they did not spend time with their named nurse.

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?

In February 2016, we inspected this service and rated the provider as good. We found the hospital had introduced a staffing assurance tool and allocations officer to try to manage staffing issues and developed an audit to assess staff responses to emergency alarms. When we inspected in December 2016 we found:

- Cleaning records showed night staff on a daily basis did not clean ward environments. A patient's bedroom on the recovery ward was not clean, although the patient was discharged from the service the previous week. Staff recorded the reason the ward environment was not cleaned was due to lack of staff.
- Staff had cleaned the en suite patient bathroom on ward A, but this room was not refurbished. Staff and patients reported two pieces of gym equipment and a sofa on ward A were broken. Staff were unsure when these items were due to be repaired or replaced.
- Staff did not record refrigerator temperatures or check emergency resuscitation equipment every day. Staff recorded refrigerator temperatures in the clinic room 13 times during the months of August and September 2016. We saw the last equipment check completed in 2014. On 21 December, we saw staff on ward C had not signed the emergency bag check form on 12 separate occasions. Staff amended this oversight on 22 December 2016.
- Staff said that due to low staff levels, there was not enough staff to respond to alarms during the evening and night shifts. During the evening on 21 December 2016 we saw and heard the emergency alarms continually used during the shift. We saw a reduction of staff on the ward due to staff responding to emergencies on other wards.
- We looked at the allocations rota for the period from 1 to 21 December 2016 and saw 11 staff did not turn up for night shifts; the rota showed the service did not provide staff cover for these shifts. On 6 separate occasions, there were not enough night staff to provide patient care due to staff completing patient observations.
- Staff we spoke with said they did not receive feedback on incidents or receive debriefs from the service. They said they did not receive support from the service when patients injured them.

Summary of this inspection

- Patient observational levels were discussed during staff handover meetings; however, staff said they did not pass observational recording sheets between staff.

Are services effective?

In February 2016, we inspected this service and rated the provider as good. This was because in February 2016 we found a weekly programme of activities was available for patients. Staff completed physical healthcare checks on patients on admission and annually thereafter. We observed positive interactions between patients and staff.

- When we inspected in December 2016, staff and patients said escorted planned leave and appointments cancelled due to the lack of staff. Patients said planned activities were not meaningful and cancelled due to lack of staff. During the inspection, we saw two patients asleep on a sofa instead of completing activities. The activity programme noted no patient activities arranged for the weekend. Nursing staff did not have a budget for patient activities.
- We found five signatures missing from one patient's prescription chart. In two patients' records, we found two occasions where medication given as prescribed was not given correctly.
- We saw two patients' planned leave forms incorrectly dated.
- In the year before this inspection, data we received from the service showed 56% of non-clinical staff received an annual appraisal.

However:

- Care plans we saw showed patient involvement. They were personalised and up-to-date and all detention paperwork we saw was up-to-date. The Mental Health Act administrator completed audits every three months to check detention paperwork.

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. Staff knew who their Mental Health Act administrator was. The administrator, based at the service, offered support in making sure the Act was followed in relation to renewals, consent to treatment and appeals against detention. The Mental Health Act administrator completed an audit of the Mental Health Act every three months. We looked at 11 Mental Health Act records; all paperwork we saw was in order. The service kept clear records of leave granted to patients. Patients, staff and carers we spoke with were aware of the parameters of leave granted. We saw staff completed the service's risk assessment form, which included crisis measures for patients granted leave. However, we saw two leave forms incorrectly dated.

Training on the Mental Health Act and its code of practice was mandatory for staff in the service. At the time of inspection, all of staff had received training on the Mental Health Act and its code of practice. All staff we spoke with was clear on the guiding principles underlying mental health legislation. We saw policies and procedures on the Code of Practice were up to date. All patients at the Farndon Unit were detained under the Mental Health Act. All prescription charts we looked at had consent to treatment authorisation forms attached. People had their rights under the Mental Health Act explained to them on admission and routinely thereafter. Patients we spoke with understood their rights under the Mental Health Act. We saw patients' rights form in patient's files, which showed patients had been informed of their rights. We saw detention paperwork stored in patients' notes.

Mental Capacity Act and Deprivation of Liberty Safeguards

We do not rate responsibilities under the Mental Capacity Act 2005. We use our findings as a determiner in reaching an overall judgement about the provider.

At the time of inspection, all staff had completed training in the Mental Capacity Act, including the five statutory principles. From 1 June 2016 to 21 December 2016, The Farndon Unit reported no Deprivations of Liberty Safeguards applications. Staff we spoke with were able to show their understanding of the basic principles of the Mental Capacity Act and supported patients to make decisions where appropriate. We saw evidence of mental capacity assessments completed on a decision specific basis. For example, staff completed a mental capacity assessment on decision made on understanding their rights. Detention paperwork was stored correctly. Staff wrote this assessment on the patients' rights form. The Mental Health Act administrator completed an audit on the use of the Mental Capacity Act every three months. Staff would obtain advice and guidance about the Act from the Mental Health Act administrator, advocate and social work team.

Forensic inpatient/secure wards

Safe	
Effective	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- Staff on the wards we visited were unable to observe all parts of the ward. Bedrooms on wards A, B and recovery ward were out of view from staff. On ward C, a convex mirror was not in place, which prevented staff from viewing blind spots on the ward. Staff were aware a mirror was not in place and would sit on the ward in order to view patients.
- Staff completed an annual ligature risk audit. A ligature risk audit is a document that identifies places to which patients intent on self-harm might tie something to strangle themselves. We saw staff reviewed the ligature risk audit when new equipment was introduced to patient areas and all fixtures and fittings on the ward were anti-ligature. Ward managers submitted a compliance document weekly, which confirmed the ward environment has been checked for ligature risks.
- The Farndon Unit exclusively provided a service for female patients, therefore was compliant with guidance on same sex accommodation.
- Staff did not check the refrigerator temperatures daily. The service had a central clinic room used for physical examinations. Each ward apart from recovery ward had dispensing areas. We saw the clinic room was equipped with emergency resuscitation equipment and drugs. However, we saw staff completed the last equipment check in 2014. Staff did not record refrigerator temperatures for October 2016 and did not record fridge temperatures every day. Staff recorded fridge temperatures 13 times for the months of August and September 2016.
- Staff did not sign the emergency resuscitation bag form every day. Staff did not always sign to show they checked the emergency bags. Staff said they checked the emergency bags every evening and signed the form. However, on 21 December 2016 we observed staff on ward C did not sign the emergency bag check form from 2 to 7, 11 to 14 and 17 to19 December 2016.
- Staff were unsure whether the service had a seclusion or a de-escalation room. Seclusion is the supervised confinement of a patient in a room. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others. The clinical director said the service had a seclusion room on ward A that had not been used in 10 years. Nursing staff we spoke with said the service did not have a seclusion room and did not seclude patients. However, some staff said the service had a de-escalation room and not a seclusion room. A de-escalation room is a low stimulus room where a patient can go to calm down. National Institute for Health and Care Excellence guidance (NG10 2015) states the de-escalation room should not normally be the seclusion room - a specific room set aside for the purpose of seclusion that must meet the specifications principled in the Mental Health Act code of practice. Some staff were unsure if patients used the de-escalation room. During the last inspection (15 February 2016) a patient told inspection staff she was unhappy with the acoustics in the de-escalation room.
- Staff used least restrictive practices including de-escalation techniques to manage patients' challenging behaviours. De-escalation techniques (including verbal and non-verbal communication skills) aim to defuse patient anger and prevent aggression. Staff said they had an understanding of possible triggers for patients engaging in challenging behaviours and would use verbal and non-verbal communication skills to manage patients' challenging behaviours.
- Cleaning records showed ward environments were not cleaned on a daily basis. Staff said the night staff were responsible for day to day cleaning on wards A, B, C and D. The service employed a hospitality team, who were responsible for completing a weekly deep clean on all wards. We saw the weekly cleaning records for ward B commencing 5 December 2016. On four separate shifts, the night staff recorded they did not clean ward B due to lack of staff and delivering patient care. Staff we spoke with said they did not clean the ward because they were delivering patient care.
- Staff and patients were responsible for cleaning the recovery ward. We saw the cleaning rota for the recovery ward, which noted ward areas to be cleaned. This document was signed by staff and patients and was up

to date. However, during the inspection we saw an empty patient's bedroom, which was dirty. A member of staff said the patient was discharged from the service a week prior to this inspection.

- We saw the en suite bathroom on ward A was clean but not refurbished. We saw there had been evidence of hair dye in the bathroom. The registered manager said patients and staff were not allowed to use hair dye but the hairdresser was.
- There was a sofa on ward A, which was broken. Staff said the gym had two exercise machines that had been broken for months. Patients we spoke with confirmed this and staff were unsure when repairs to the sofa and gym equipment were to be done.
- Staff adhered to infection control principles including hand washing. Staff encouraged visitors to use anti-bacterial gel prior to entering the unit and we saw hand washing posters on the ward.
- Staff regularly completed weekly environmental risk assessments. Management staff added information contained in this assessment to the service's risk register and compared this information with the provider's key performance indicators. The health and safety group used a system that prevented ligature risks to be introduced into the service.
- Staff had access to an appropriate alarm and nurse call system. Staff had a personal alarm, which was used to alert staff in an emergency. During the inspection, on the evening of the 21 December 2016, we observed and heard emergency alarms continually used. We saw staff quickly responded to alarms when used by others but observed a lack of staff on the ward environment. Two staff members said that due to low staffing levels, there were instances where there was not enough staff to respond to alarms on the evening and night shift.
- The service completed an audit every three months on emergency responses. We saw an audit completed on the response to alarms. The audit looked at staff responses to emergency alarms and evaluated staff performance.

Safe staffing

- The provider had estimated and assessed the number and grade of nurses required at the service. Before this inspection, the service completed a staffing level benchmarking exercise with NHS England. The outcome of this exercise showed the service had correctly assessed the number and grade of nurses required for the service. The allocated amount of staff for a day shift was 21 qualified and unqualified nursing staff split between the wards and recovery unit and 19 staff for the night shift. The Farndon Unit operated on a minimum staffing level of 15 staff across the five ward areas.
- Staff worked various shift patterns. Day staff worked from 7.30am to 9pm and night staff worked from 8.45pm to 7.45am. The service allocated staff levels for each ward: wards A and B each had five day staff and five night staff, ward C - four day staff and three night staff and ward D - three day staff and three night staff. Recovery ward had four day staff and three night staff. Wards A and B had one qualified staff member, three care assistants. Wards C and D had one qualified nurse. All wards had ward managers who were supernumerary. The service had one qualified staff member who worked between wards, one driver and one activity co-ordinator. The service completed staffing audits to ensure wards had an appropriate gender mix of staff.
- During this inspection, we found safe staffing levels were not met. We looked at the allocations rota for the period from 1 to 21 December 2016. The allocations officer ensured staff were equally distributed across all five wards. The allocations officer circulated allocations sheets to the wards on a daily basis, which ensured all staff were aware of staff resources and daily planned activities. From the 1 to 21 December 2016, the allocations rota showed the correct amount of day staff allocated to the wards. However, 11 night staff members did not attend their shift. The allocations rota did not indicate whether alternative staff were found to cover these shifts.
- Staff said there was not enough staff to provide patient care. The allocations rota indicated the number of patient on observations for each ward. From 1 to 21 December 2016, we saw the allocations rota did not have the allocated number of night staff on 6 separate occasions. For example on 3 December 2016, ward C had one patient on one-to-one night observations and two members of staff allocated for patient care. Ward D had one staff member on shift due to one staff member not turning up for their shift and one shift not filled.
- A member of staff said the second on call manager was called to work along staff members on a night shift. We looked at the on call rota system for the period from the 1 to 21 December 2016. Ward managers covered the first on call rota and occupational therapists and social workers covered the second on call manager rota. The

registered manager said the role of first and second on call manager was to provide support and advice to the unit coordinator. We saw both the first and second on call managers was called in to the unit twice. For example, on 8 December, the second on call manager was called in to ward D at 11.30 pm. There was one patient on one to one night observations, which meant that two staff members were needed to complete patient care over the shift. The allocations rota did not indicate the reason why the second on call manager was called into the unit and their role during the shift.

- Between 1 September to November 2016, 434 shifts had been filled by bank staff and 424 shifts filled by agency staff to cover sickness, absence or vacancies. Bank or agency staff had not covered 19 shifts where there was sickness, absence or vacancies. The clinical director said the service had recruited 18 care assistants who would complete their induction in January 2017. From March 2016, the service employed seven locum staff on three monthly contracts. Bank staff received an induction and supervision but not appraisals.
- The clinical director was aware of staffing issues. To address the lack of staff, for three weeks over the Christmas period 2016, the service offered a staff bonus scheme to staff who agreed to work an extra three shifts in one month. The clinical director stated staff covered 20 shifts over the three-week period due to responding to the bonus scheme.
- From December 2015 to November 2016, the service had an overall vacancy rate of 19 percent. From 1 September to 30 November 2016, there were 10 qualified and 14 unqualified nurse vacancies.
- The service had 136 substantive staff. It had 35 staff leavers in the 12 months before this inspection.
- The service's total staff sickness rate in the year prior to inspection was 4.7 percent; the permanent rate of staff sickness was 4.3 percent. The service had a key performance indicator of four percent for sickness. Management staff said ward managers closely monitored sickness to transfer short term to long-term sickness and completed return to work interviews promptly with staff.
- Ward staff said agency staff received an orientation of the ward. They met with the unit co-ordinator to go through care plans to ensure staff were familiar with the ward and patients. The clinical director said the service used the same agency to get the same agency staff to ensure consistency wherever possible. Ward staff completed a feedback form with information on the agency worker's performance and fed back to the recruitment agency.
- Ward managers were able to quickly arrange extra staff resources if a patient's needs increased or to cover staff sickness. We saw a ward manager using the staff allocation system to arrange staff resources.
- All patients we spoke to said there was not enough time for patients to spend 1:1 time with their named nurse. They said there were not enough staff on the ward to respond to any immediate needs they had.
- Patients we spoke with said escorted leave was cancelled because there were too few staff. All patients we spoke with and one carer said during the past 12 months, they experienced incidents of cancelled escorted leave and appointments due to low staff levels and ward emergencies. One patient said escorted leave and appointments cancelled four times in 10 months. One staff member said leave and appointments were cancelled due to the unavailability of drivers to take patients to their appointments. Another staff member said escorted leave and appointments cancelled due to staff completing patient observations.
- The service completed an audit every three months to monitor the frequency of planned leave from the unit, leave that was cancelled and the reasons for cancellation. From July to September 2016, there were 2,423 episodes of planned leave, 2,417 episodes of planned leave not cancelled and six incidents of leave cancelled. The reasons for cancellation were two incidents of staffing reallocation, three instances of patients being unsettled and one patient who refused planned leave.
- We saw qualified nursing staff present in communal areas at the wards. Patients and staff we spoke to said qualified staff was present in the communal areas completing observations.
- The Farndon Unit completed various therapeutic patient activities to enable a patient to work towards recovery. Senior staff we spoke with said psychology and occupational therapy provide therapeutic activities. They said patient engagement levels in these groups were good. The service offered patients group work on three levels: led by staff, by staff and patients together, or by patients working with the local community. The service completed audits on patient activities. Staff kept

data on the type of activity completed, for example, one to one sessions with clinicians, educational activity, work-based activity and daily living skills. Staff would record the length of time patients complete the activity, activities cancelled and if the patient was unwell and unable to complete the activity. We saw activity timetables available to patients on all wards. During the inspection, we saw patients completing various activities such as cake decoration, art activities and watching videos with staff.

- However, patients said activities were not meaningful and cancelled due to lack of staff. Patients we spoke with said there were not enough meaningful activities for patients to do and were bored. The service employed one activities coordinator, as there was a vacancy for an activities co-ordinator. The activities timetable noted patient activities not completed on the weekend and from 10 am to 4 pm. On ward B, during the morning period, we saw two patients asleep on the sofas. A patient said she would like to complete more adult activities such as sewing and not activities such as colouring pictures. Staff and patients we spoke with said activities cancelled due to the lack of staff. A member of staff said nursing staff did not receive a budget to support patients to complete activities. Patients on wards C, D and recovery received fewer resources to complete activities than patients on wards A and B. Occupational staff had access to the activities budget but nursing staff did not have access to the activities budget.
- There was enough staff to deal with physical interventions. The service had a physical health lead who oversaw physical health interventions. Care assistants had the opportunity to complete specialist training in physical health care, for example phlebotomy. The Farndon Unit employed a practice nurse, but at the time of inspection, this post was vacant.
- There was enough medical cover during the day and night and a doctor could attend the ward quickly. The Farndon Unit employed three consultant psychiatrists who work on a rotational basis including out of hours cover.
- Staff were trained to safely meet the needs of patients. The Farndon Unit delivered a wide range of face to face and e-learning mandatory training courses. For example, first aid, security, mental health act, safeguarding and management of violence and aggression. The service's data on 28 November 2016 showed an average of 85% completed mandatory and legislative training. This was below the service's compliance level of 90%.

Assessing and managing risk to patients and staff

- From 1 June to 21 December 2016, there were no incidents of seclusion or long-term segregation within this service.
- The service reported 387 episodes of restraint within the last six months. 75 incidents on ward A, 216 incidents on ward B, 77 incidents on ward C, 7 incidents on ward D, 1 incident on the recovery ward, 4 incidents in the court yard and 7 incidents on "other".
- Of the reported incidents of restraint, there were 30 incidents of prone restraint. 5 incidents on ward A, 19 incidents on ward B, 3 incidents on ward C, 1 incident on ward D, no incidents on the recovery ward and two incidents in other areas of the service. Staff recorded all incidents of restraint on an incident report form. The form recorded how staff had restrained the patient and recorded information on the circumstances of this incident. The service completed an audit every three months on incidents of restraints per ward, type of restraint and time of day the restraint occurred.
- Staff completed risk assessments on admission, which were frequently updated. We checked 14 care and treatment records. Staff used Historical Clinical Risk assessment-20V3 and Galatean Risk and Safety Tool. Historical Clinical Risk assessment is a comprehensive set of professional guidelines for the assessment and management of violence risk. The Galatean Risk and Safety Tool reduce assessed risks such as suicide and violence, improve patient wellbeing, and help patients live safely in the community. Staff completed risk assessments within the first week of the patient's admission. There was evidence of multidisciplinary involvement on risk assessments. Patient's risk assessments were reviewed monthly as well as following incidents.
- There were set procedures on how staff should observe patients to promote their safety. The service used the Positive Behavioural Model, which helped staff use restrictive interventions as a last resort and for the shortest possible time. Staff used these procedures for patients who were new to the service and when the clinical team decided, a patient required increased

observation because of their level of risk. Staff made these decisions on a daily basis and regularly reviewed risks to patients at multidisciplinary meetings. They adjusted observational management plans to ensure patient safety. However, a member staff said they would like more training on the Positive Behavioural Model.

- Staff discussed patient observational levels during the handover meeting; however, two staff members said staff did not pass observational recording sheets between staff members. Staff discussed observations with each other as needed. We saw the supportive observational policy that stated, "Observation usually involves a number of nurses, with care being handed over at intervals. Excellent communication among staff must be maintained".
- There were no blanket restrictions used in the service. We saw no restrictive aspects of care such as set bedtimes or access to bedrooms.
- Patients were not subject to mail monitoring; however, staff followed policies and procedures for patient searches. Patients who accessed the community were subject to a "pat down" on return. Most patients had given their consent for pat down searches. One patient had not given consent; staff recorded this issue in the clinical notes. Staff said patients' rooms were search monthly. Staff said two night staff completed bedroom searches. However, staff said bedroom searches were not frequently done, as there were not enough staff on shift to complete bedroom searches.
- Staff said rapid tranquilisation was used by the service. Prescription charts we saw showed prescribed rapid tranquilisation prescribed and reviewed following national institute for health and care excellence guidance.
- The service had arranged for medications management. In order to promote privacy, all wards apart from the recovery ward, had a dispensing area. Medicines were stored securely in a dedicated room and in order. We saw a good selection of medication leaflets for patients. A pharmacist visited the unit weekly and audited medication arrangements.
- At the time of inspection, 86 percent of staff completed safeguarding vulnerable adults training and 86 percent of staff completed safeguarding children's training. The service had a target of 90 percent for safeguarding training. Staff we spoke with knew about the signs and symptoms of the different types of abuse and how to take action to promote patient safety through use of the service's adult safeguarding procedures. The service employed social workers who staff referred to if they needed advice and support on safeguarding. The social work team met monthly with the local authority multi agency safeguarding hub to discuss safeguarding issues. Within the past 12 months, CQC received 17 safeguarding notification from this service. All these notifications were closed.
- Staff were aware of and addressing any outlier issues. The physical health lead nurse completed audits on patient physical health care. These audits identified patients with chronic diseases and patients under the care of specialist services.
- There were safe procedures for children to visit. Staff said the service had a visitors room in the reception area available for children to visit patients. The service stated the visitor's room was compliant with the Department of Health Child Visiting Arrangements guidance, which covered the visiting arrangements for children to visit high secure hospitals.

Track record on safety

- Within the six months prior to this inspection, the service reported one reportable injury to the Health and Safety Executive. We saw the service had carried out an action plan to prevent this injury affecting other staff members.
- From 23 July to 30 November 2016, there had been 52 incidents of staff injuries. Twenty-six staff injuries were due to patient restraint and 26 staff injuries were due to other incidents, which were not restraint. None of these injuries was serious enough to report to the Health and Safety Executive. Examples of non-restraint incidents were patients hair pulling, kicking and scratching staff. Managers we spoke with said injured staff received support after an incident. However nursing staff we spoke with said they did not receive support from managers and the service following an injury.
- The clinical director stated there had been eight serious untoward incidents over the past six months. This included one incident of a patient using a weapon, one patient absent without leave and six incidents of self-harm.
- We read the quarterly audit report for serious untoward incidents. This audit showed a senior team member conducted an investigation and made recommendations to the clinical team and management to minimise the risk of further incidents.

Forensic inpatient/secure wards

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and which incidents to report. All staff we spoke with used examples on the types of incidents they would report and the process for reporting incidents, for example reporting verbal aggression and arguments between patients.
- Staff received feedback from investigations of incidents internal to the service. The registered manager discussed incidents with house managers at the three monthly risk management meeting. Staff received feedback on incidents at monthly team meetings, the managers' morning meeting and via information written in the communication book. However, five staff members we spoke with said they did not receive feedback on lessons learned from other wards and hospitals owned by the provider. Another staff member said requests were made directly to managers for feedback about incidents.
- Staff were open, transparent and explained to patients when things went wrong. Staff we spoke with gave examples of an incident when things went wrong when they were open and transparent with a patient.
- Management said staff were debriefed and offered support after a serious incident. The clinical director said the psychology department was responsible for offering support and staff debrief after an incident. However, six staff members we spoke with said the service rarely gave staff debriefing sessions and the psychology department was not involved.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Staff assessed each patient's needs on admission. We saw evidence in the 14 care and treatment records we reviewed that a comprehensive assessment was completed within 72 hours of admission. In all patient files we looked at, we saw clear admission notes, an assessment of needs and physical health assessment by the medical team.
- Patients had access to psychological therapies. The service had two male and three female therapists who provided Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing, a therapy used to help patients with the symptoms of post-traumatic stress disorder.
- Staff said they supported patients with their physical health needs. All patients were registered with a local GP. One of the ward managers was the physical health care lead for the service and provided specialist guidance to staff on physical health care for patients. Patients we spoke with said they received support and guidance about their physical health needs from their GP and staff.
- Staff supported patients to identify their goals and help plan their treatment and support. Patients and staff completed a document called the Manchester Care Assessment Schedule. This document helped patients identify their needs and plan outcomes. Patients and staff would write down agreed actions on how patients would achieve these outcomes. Patients said they would write down their views with their primary nurse and review these views at monthly multidisciplinary team meetings.
- All care plans we saw were comprehensive, focussed on the patient's individual needs and recovery orientated. Information we found within the care and treatment files reflected the views of the multi-disciplinary team.
- Patient information was stored securely. Patients' notes were paper based and stored in the locked nurses' office. All staff had access to patient medical and nursing notes.

Best practice in treatment and care

- We saw evidence of prescribing doctors following National Institute of Health and Care Excellence (NICE) guidelines. For example, on wards C and D, prescribing doctors used National Institute of Health and Care Excellence CG178 Psychosis and Schizophrenia in Adults when a medication review was completed guidance in relation to the use and dosage of medicines. A pharmacist made regular checks and ensured prescribing regimes were appropriate.
- However, on ward B we found five signatures missing for one patient's medication. One other patient had a continuous pattern of 25 nights of medication to be

given when necessary (prn). On ward A, we saw a high level of prn hypnotic medication prescribed continuously for six nights, stopped for one night then continuously prescribed for a further six nights.

- Patients had good access to physical healthcare including access to specialists when needed. All patients were registered with a local GP and staff supported patients to attend their appointments. Staff offered each patient a physical health care plan. Staff supported patients who had specific physical health concerns to attend appointments with specialists within the community. Staff supported patients to attend physical health appointments. The physical health lead for the service gave the patient's GP monthly data on physical baseline observations.
- Staff completed the Health of the Nation Outcome Scales. The aim of this assessment is to assess the severity of patients' mental health needs and monitor how the patient is progressing. We saw copies of this outcome scale in patients care and treatment files.
- Clinical staff actively participated in clinical audits. For example, the physical health care lead completes the physical healthcare audit report every quarter. Ward managers completed environmental health audits, which contribute to the service's key performance indicators.

Skilled staff to deliver care

- The multidisciplinary team based at The Farndon Unit consisted of psychiatry, nursing staff, psychology, occupational therapy and social work.
- Staff were experienced and qualified. Staff we spoke with had relevant qualifications and had several years' experience of working in a locked rehabilitation setting. The service recruited qualified staff members who had qualifications and experience of caring for people with learning disabilities, mental health and general nursing. Data received from the service showed all care assistants registered to complete or had completed national vocational qualifications in care.
- Staff received an appropriate induction. Newly appointed staff received a six-day face-to-face mandatory training, which included health and safety, introduction to the service, safeguarding, information governance and management of violence and aggression.
- Staff were supervised and received an appraisal. Staff said they received monthly clinical and management supervision. The clinical director supervised occupational therapists, social workers, psychologists and ward managers. Ward managers supervised deputy ward managers, staff nurses. Deputy ward managers and staff nurses supervised care assistants. Social workers and occupational therapists received additional supervision linked to their profession from an external agency funded by the service. The service had a supervision target of 85 percent. However, within the last 12 months, supervision rates for Ward A was 79 percent, Ward B 82 percent, Ward C 80 percent, Ward D 83 percent and Recovery Ward 71 percent. Staff said they attended a monthly team meeting.
- 56% of non-medical staff within this service received an annual appraisal. A member of staff stated not all staff received an appraisal and the staff member had not received an appraisal in two years.
- Staff received specialist training for their role. For example, the psychology team provided training to all staff on Compassion Focussed Therapy. Compassion Focussed Therapy aims to help promote mental and emotional healing by encouraging people in therapy to be compassionate towards themselves and others. Care assistants had the ability to complete courses on phlebotomy and administering electro-cardiograms. However, one member of staff said staff were taken off training courses due to ward staff absence.
- Staff said ward managers promptly addressed any issues of poor staff performance. During the 12 months prior to this inspection, no staff members were suspended or under supervised practice

Multi-disciplinary and inter-agency team work

- We attended a weekly multi-disciplinary team meeting. We observed the patient was involved in this meeting and the team worked in partnership with the patient to make decisions about the patient's care. We saw the multidisciplinary team did not invite health care assistants to this meeting. Health care assistants we spoke with said they would update and receive feedback from the nursing staff regarding multidisciplinary team decisions. They said they would like to attend multidisciplinary meetings as they had the most knowledge about and interactions with patients.
- We saw a handover meeting. Every shift had a handover meeting, prior to the handover meeting; the nurse in charge for each ward completed a 24-hour nursing report. This report contained information for example

names of staff on duty, external visitors to the wards, patient concerns and physical healthcare issues. Staff discussed this form at the handover meeting. During the handover meeting, the nurse in charge completed a handover form, which contained further information for staff such as observations allocated and checks required. We saw these forms were stored in folders on each ward.

- Staff confirmed they attended handover meetings; however, some staff said the handover meeting were too short. A ward manager said the service was aware of this issue and the length of handover meetings was to increase from 15 to 30 minutes.
- Staff said there were effective working relationships with other teams. Staff invited community mental team members to ward rounds and review meetings. However, due to distance, some community mental health staff did not frequently attend multidisciplinary team meetings. To address this, multi-disciplinary team staff would use video conferencing to enable professionals to engage in meetings they could not attend.
- The service developed effective relationships with external organisations. For example, the social work team had developed a good relationship with the local authority safeguarding team. Both staff and patients said patients had a good relationship with the local GP practice.

Adherence to the MHA and the MHA Code of Practice

- Staff knew who their Mental Health Act administrator was. The administrator, based at the service offered support in making sure the Act was followed in relation to renewals, consent to treatment and appeals against detention. We looked at 11 Mental Health Act records and all paperwork we saw was in order.
- The service kept clear records of leave granted to patients. Patients, staff and carers we spoke with were aware of the parameters of leave granted. We saw staff completed the service's risk assessment form, which included crisis measures for patients granted leave. However, we saw two leave forms incorrectly dated.
- Training on the Mental Health Act and its Code of Practice was mandatory for staff in the service. At the time of inspection, all staff had received training on the Mental Health Act and its Code of Practice. All staff we spoke with were clear on the guiding principles underlying mental health legislation. We saw policies and procedures on the Code of Practice were up to date.
- All patients at the Farndon Unit were detained under the Mental Health Act. All prescription charts we looked at had consent to treatment authorisation forms attached. This meant that nurses were able to administer medication under the correct legal framework.
- People had their rights under the Mental Health Act explained to them on admission and routinely thereafter. We saw patients' rights form in patient's files, which showed patients informed of their rights. Patients we spoke with understood their rights under the Mental Health Act.
- Detention paperwork was stored correctly. We saw detention paperwork stored in patients' notes. The Mental Health Act administrator completed an audit of the Mental Health Act every three months.

Good practice in applying the MCA

- At the time of inspection, all staff had completed training in the Mental Capacity Act including the five statutory principles.
- From 1 June 2016 to 21 December 2016, The Farndon Unit reported no Deprivations of Liberty Safeguards applications.
- Staff we spoke with were able to show their understanding of the basic principles of the Mental Capacity Act and supported patients to make decisions where appropriate.
- We saw evidence of mental capacity assessments completed on a decision specific basis. For example, a mental capacity assessment is completed when a patient's rights under the Mental Health Act are discussed. Staff wrote this assessment on the patients' rights form.
- The mental health act administrator completed an audit on the use of the Mental Capacity Act every three months. Staff would obtain advice and guidance about the Act from the mental health act administrator, advocate and social work team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must make sure the care environment is cleaned and properly maintained
- The provider must make sure safe staffing levels at all times to provide patient care
- The provider must inform staff of all incidents and lessons learned reflected in practice.
- The provider must make sure all staff and patients are offered debriefing sessions outcomes on incidents.
- The provider must make sure emergency equipment and clinic room refrigerators are checked daily.
- The provider must make sure sufficient numbers of staff respond to emergency alarms in a timely way.
- The provider should offer support staff following an incident of injury
- The provider must make sure all staff receives an annual appraisal.

Action the provider SHOULD take to improve

- The provider should make sure staff follow the supportive observations policy.
- The provider should include care assistants in the multidisciplinary team and invite care assistants to multidisciplinary team meetings.
- The provider should make sure planned leave forms are correctly completed.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Section 17 leave form dates were incorrectly completed on two forms.** **This was in breach of regulation 9 (3) (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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA Regulation 2014 Safe and Care Treatment** **The emergency bag was checked 12 times in December 2016 and the clinic room refrigerator was checked 13 times during August and September 2016. The equipment check form was last completed in 2014.** **This was in breach of regulation 12 (2)(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 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment**

This section is primarily information for the provider

Requirement notices

A patient's bedroom and bathroom in the recovery ward was dirty and not cleaned. Staff did not clean the ward area on a daily basis.

Cleaning records on ward C showed on four occasions in one week staff did not clean the ward environment.

A sofa was broken on ward A and gym equipment was broken.

This was in breach in regulation 15(1) (a) (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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance

The provider did not feedback to staff on incidents and lessons learned from incidents.

Staff said the service did not provide feedback and debriefing from incidents.

Staff said they did not receive support following restraint and non-restraint injury.

This was in breach of regulation 17 (2) (f)

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 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Staffing levels were not maintained on night shifts to agreed staffing numbers at all times to ensure patients were safely cared for.

Emergency alarms did not always receive a timely and sufficient response, which put patients and staff at risk.

Within the past 12 months, the service provided 56 percent of non-medical staff an appraisal.

This was in breach of regulation 18 (1), (2) (a)