Garrow House

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

Are services safe?	
Are services well-led?	

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.

Overall summary

Inspected but not rated

Summary of findings

We inspected Garrow House on 12 and13 June 2017. This was an unannounced, focused inspection looking at the well led and safe domain to find out whether the hospital had made the required improvements since our last focused inspection on the 09 November 2016.

Following our inspection in June 2017 we did not rate the safe and the well led domains we found:

- Staff used a safe staffing tool to ensure there was always enough staff to provide 1:1 time. Planned activities both on and off the unit were rarely postponed as the occupational therapist and activities co-ordinator were not counted in the staffing numbers.
- Staff compliance with their mandatory training was at 97% overall. This was above the mandatory training compliance target of 80%. Managers ensured staff received regular and comprehensive supervision.
- We reviewed weekly and monthly medication audits and found the provider had detected some gaps in administration records. Staff documented clear actions to make improvements where there were identified shortfalls. The hospital had made improvements to staff compliance with the recording of physical health checks for patients who received rapid tranquilisation and monitoring side effects for patients who received high doses of anti-psychotic medication.
- The hospital had maintained improvements needed to ensure that the equipment used for providing care and treatment was safe for use.

However:

- There was no record of an initial risk assessment for patients who administered their own medicines. Although this had not affected patient's safety, it meant staff had not fully followed the hospital policy for self-administration of medicine.
- Following the administration of rapid tranquilisation Staff had not consistently recorded the level of consciousness in particular when a patient had refused to have their observations taken. Although this had not affected patient safety, it did mean that staff had not always followed the hospital policy for the recording of observations.
- During inspection we found that two of the five medicine records we reviewed had gaps in administration signatures. This meant that staff had not always maintained an accurate record of the treatment patients had received.
- The hospital had an environmental ligature risk assessment completed in February 2017; this risk assessment did not include the study room on the second floor. This meant that not all potential ligature points within the hospital had a completed risk assessment. The hospital had a separate environmental risk assessment that included cables and wires. We were concerned that having two separate risk assessments addressing ligature risks could be confusing for staff.
- The hospital emergency 'grab bag' was cluttered and felt heavy to lift. Although this was accessible in the clinic room the equipment in the bag included an oxygen cylinder, we were concerned that staff might have difficulty finding and carrying equipment they needed in an emergency.
- Patients we spoke with felt agency staff did not always respect their privacy and sometimes sat reading or using their personal phones in communal areas.
- The hospital did not have an identified seclusion room and had when necessary used the 'chill out' room to seclude patients. The hospital had considered if a dedicated seclusion room was necessary for the hospital in the future, as the 'chill out' room does not comply with the Mental Health Act 1983 and it's code of practice which states what the specifications of a seclusion room should be.

Summary of findings

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Tier Four Personality Disorder Services

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Background to Garrow House

Garrow House is a specialist, personality disorder service providing a 12 bedded, inpatient facility to patients living in the Yorkshire and Humber region. The hospital provides care and treatment to women only and NHS England commissions the service. Garrow House is run by Northern Pathways Limited, which is part of a partnership organisation between the Turning Point Group and the Retreat hospital York.

The hospital sits in the grounds of a neighbouring hospital on the outskirts of York in North Yorkshire.

Garrow House has been registered with the Care Quality Commission since 13 December 2010 and is registered to carry out three regulated activities.

- assessment or medical treatment for persons detained under the mental health act1983
- diagnostic and screening procedures
- treatment of disease, disorder, or injury.

Following inspection the registered manager informed us the hospital were in the process of updating their registration as they no longer need to be registered for the regulated activity diagnostic and screening procedures.

The hospital had a registered manager and a controlled drug accountable officer in place at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager has a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations regarding how the service operates.

An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

At the time of inspection the hospital were providing care and treatment for 10 patients.

The Care Quality Commission has inspected Garrow House on five previous occasions. The last comprehensive inspection took place in January 2016. We rated the hospital good overall. We rated effective, caring, responsive and well led as good and safe as requires improvement. We issued two requirement notices following this inspection as the hospital did not meet safe care and treatment regulation (regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

In November 2016, we carried out a focussed, unannounced inspection to follow up on the requirement notices from the comprehensive inspection in January 2016. At the November 2016 inspection, we found that the provider had not made all the required improvements identified within the requirement notices.

Following that inspection in November 2016, we issued the registered manager with a warning notice under regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good Governance. This was because we found continued issues with staff compliance with hospital policies and procedures related to medicines management.

At our focused inspection in November 2016 we did not fully inspect the safe and the well-led domain. However, our findings at this inspection in November 2016 changed the overall rating from good to not sufficient evidence to rate

Our inspection team

Team leader: Jacqueline Bond, Care Quality Commission.

Summary of this inspection

The team that inspected the service comprised of one member of the CQC medicine management team, one CQC inspector, one CQC inspection manager, and one nurse specialist advisor.

Why we carried out this inspection

We undertook this inspection to find out whether Garrow House had made improvements to the service since our last focused inspection of the hospital in November 2016.

We last inspected Garrow House in November 2016, where the overall rating was suspended. We rated the service as requires improvement for safe and not sufficient evidence to rate for well led, we found one breach of the following regulation:

Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good

Governance.

As a result, we issued a warning notice and told the hospital it must take the following actions to improve their services

- The hospital must adequately assess, monitor, and mitigate the risks relating to patients health, safety, and welfare when patients receive medication for rapid tranquillisation, anti-psychotic medication and when patients administer their own medication.
- The hospital must maintain accurate, complete, and contemporaneous records for patients prescribed 'when required' medication.
- The hospital must have effective systems or processes to ensure that all staff complies with the hospitals medicines management policies and procedures.

The provider sent us an action plan setting out the steps they were taking to meet the legal requirements of the regulation. During our focused unannounced inspection in June 2017 we checked for evidence against this action plan and found that although improvements had been made shortfalls in the documentation related to medicine management were identified.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following two questions:

- Is it safe?
- Is it well-led?

Before the inspection, we reviewed information that we held about Garrow House. This information suggested that the ratings of good for effective, caring and responsive that we made following the comprehensive inspection in January 2016 were still valid. Therefore, during this inspection, we focused on the safe and well led key questions. We did not review all of the recommendations we made following our January 2016 inspection. We will follow these up at the next comprehensive inspection and through engagement with the provider.

During the inspection visit, the inspection team:

- toured the hospital and looked at the quality of the environment
- spoke with six patients who were using the service
- spoke with the registered manager, clinical lead and consultant psychiatrist
- spoke with seven other staff members including; nurses, health support workers, occupational therapist and psychologist
- toured the clinic room and observed one medication round
- looked at six care and treatment records of patients
- carried out a specific check of the medication management on the ward and reviewed five patient prescription charts
- looked at 11 staff personnel files
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with six patients during our visit to Garrow House. All patients spoke positively about permanent staff, they felt staff were helpful and caring. Patients said they felt safe and described high staff presence within communal areas. Patients expressed concern regarding agency staff and felt they did not always respect their privacy and sometimes sat reading or using their phones.

Patients felt involved in the development of their care plans and those who wanted to had a copy of their care plan.

Patients spoke positively about the practice nurse who attended the hospital weekly to meet their physical health care needs. Patients also spoke positively about their relationship with the consultant psychiatrist.

Patients expressed they felt involved in decisions relating to the service and the development of the group programme, recruitment, and involvement in the governance group. They also felt advocacy involvement at Garrow House was good, there was easy access to advocacy and the hospital worked well with the advocacy service.

Some patients said they would like a more proactive approach from staff when encouraging individuals to attend activities.

Two patients expressed disappointment with the hygiene in the downstairs kitchen and felt it was not as clean as it should be.

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?

We found the following areas of good practice:

- The environment appeared clean and tidy; we observed domestic staff cleaning the hospital during both days of the inspection. We observed staff following hand hygiene/infection control measures as they moved around the hospital. Health and safety files contained up to date health and safety information and policies. There was evidence that the registered manager had monthly oversight and took action where there were identified shortfalls.
- Patients had individual key fob access to the different areas of the hospital and garden dependent on their individual risk assessment. Staff completed an evidence based risk assessment tool called the short-term assessment of risk and treatability (START). We looked at six patient records and found that risk assessments were completed and up to date for all patients.
- Staff used a daily safe staffing tool to ensure there was always enough staff to provide 1:1 time. Planned activities both on and off the unit were rarely postponed as the occupational therapist and activities co-ordinator were not counted in the staffing numbers.
- Staff compliance with their mandatory training was 97% overall. This was above the mandatory training compliance target of 80%. All staff had received training in safeguarding. Staff we spoke with had a good understanding of safeguarding and were able to provide examples of when safeguarding applied. We looked at staff training records and found that there was an annual requirement for medication training; all staff had completed this training.
- Medicines were stored securely with access restricted to authorised staff. There were adequate supplies of equipment for use in a medical emergency. We reviewed five prescriptions for 'when required' medicines and found there was adequate information to enable staff to administer them safely. We reviewed weekly and monthly medication audits and found the provider had detected a small number of issues, including gaps in administration records. Staff documented clear actions to make improvements where there were identified shortfalls.
- Incident reporting by the provider was good and shared learning from incidents happened across the service.

Summary of this inspection

- Staff received weekly group supervision where they shared learning from incidents. The psychologist facilitated formal de-brief sessions following serious incidents.
- All staff were able to describe the duty of candour. They recognised they needed to be open and honest with patients when things go wrong.

However:

- Staff completed an environmental ligature assessment report datedFebruary 2017. This report identified and mitigated any areas highlighted as a concern by staff. We did not see that this risk assessment included the study room that was between the bedrooms on the second floor. Staff told us this was a locked room that was used for one to one time with patients. This meant that not all potential ligature points within the hospital had a completed assessment. The hospital had a separate environmental risk assessment that included cables and wires. We were concerned that having two separate risk assessments addressing ligature risks could be confusing for staff.
- The hospital emergency 'grab bag' was cluttered and felt heavy to lift. Although this was accessible in the clinic room the equipment in the bag included an oxygen cylinder and although staff did not report any difficulties with this we were concerned that staff might have difficulty finding and carrying the equipment they needed in an emergency.
- There was no record of the initial risk assessment carried out in multidisciplinary meetings regarding self-administration of medicine. This meant that staff could not see decision making regarding the implementation of self–administration.
- During inspection, we found that two of the five medicine records we reviewed had gaps in administration signatures. This meant that staff had not always maintained an accurate record of the treatment patients had received.
- Following the administration of rapid tranquillisation staff had not consistently recorded the level of consciousness in particular when a patient had refused to have their observations taken. This meant staff had not always followed the service policy for recording observations following the administration of rapid tranquillisation.
- The hospital did not have an identified seclusion room and had when necessary used the 'chill out' room to seclude patients. The hospital had considered if a dedicated seclusion room was necessary for the hospital in the future, as the 'chill out' room does not comply with the Mental Health Act 1983 and it's code of practice which states what the specifications of a seclusion room should be.

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Are services well-led?

We found the following areas which required improvment:

- There was no record of the initial risk assessment carried out in multidisciplinary meetings regarding self-administration of medicine. This meant that staff where not following the policies and procedures for the safe management of medicine.
- Following the administration of rapid tranquillisation staff had not consistently recorded the level of consciousness in particular when a patient had refused to have their observations taken. This meant staff had not always followed the service policy for recording observations following the administration of rapid tranquillisation. During inspection, we found that two of the five medicine records we reviewed had gaps in administration signatures. This meant that staff had not always maintained an accurate record of the treatment patients had received.

However:

- Staff we spoke with were able to describe how the organisational values affected their practice and made them meaningful in their own words although they did find it difficult to recite the values of the organisation in full.
- All staff received an annual appraisal with reviews. We were able to see that appraisals linked to the organisations vision and values. Senior manager's ensured staff received regular and comprehensive supervision.
- All staff we spoke with were able to name the management team within the hospital, they told us the names of those in leadership positions. Staff described managers as being highly visible and approachable. Staff and patients we spoke with felt they could raise concerns if required and managers would take action. They spoke positively regarding the senior management team, their accessibility, support, and feeling valued. All staff spoke about a strong, supportive team culture within the hospital. The staff survey completed in April 2017 showed that all staff felt they were treated with dignity and respect at work and all staff felt Garrow House was a well-led service.
- All staff received training in the Mental Health Act 1983 and the Mental Capacity Act. Staff we spoke with had a good understanding of both Act's and their responsibilities.
- There was sufficient numbers of staff on duty at all times. There was a minimum of one registered nurse on each shift; however, it was normal for two registered staff to be on duty throughout the day.
- The service undertook a recruitment drive which included targeted advertisement and a review of staff nurse posts and

Summary of this inspection

salaries. The service was successful in recruited two new senior nurses and two preceptorship nurses. Managers informed us they planned to continue with this recruitment drive until all vacant posts were filled.

- Staff were able to tell us what was on the risk register and their concerns reflected what we saw when we reviewed the risk register.
- We saw good systems in place concerning patient involvement. Garrow House employed an involvement co-ordinator who facilitated a weekly patient involvement meeting which all the women could attend.

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.

Garrow House last had a Mental Health Act monitoring visit in October 2016. The hospital has always provided timely action plans in response to the Mental Health Act review visits. The service carried out an internal Mental Health Act audit in April 2017 and put in place Mental Health Act documentation-monitoring forms following this audit. At this inspection in June 2017, we required to see evidence of the governance processes that assure the service of completed and sustained actions for improvement. Our findings will be reflected in the well-led domain.

- All certificates of capacity and second opinion certificates (T2 and T3) authorising medication were located with the medication charts so staff knew the legal authority and parameters of medication administration. Staff had recorded patient's capacity to consent to treatment.
- All patients knew about and had access to the advocacy services. Patients spoke to us about the involvement of advocacy and we saw information displayed around the hospital promoting this service.
- The hospital had a service level agreement with a neighbouring hospital to receive support from a Mental Health Act officer; staff knew how to contact the officer for support when needed.
- All staff received face-to-face training in the Mental Health Act 1983 and its code of practice. Staff we spoke with had a good understanding of the Mental Health Act and how it applied to their practice.
- We completed a Mental Health Act code of practice policy review and found that up to date policies were in place.
- The ward displayed a notice informing informal patients of their right to leave the building this was also included in the patient induction information about the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff were required to complete Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training as part of the mandatory training package. Staff completed this training face to face and demonstrated a good understanding of how it applied to their role.
- The multidisciplinary team considered and documented evidence of capacity assessments and consent in patient records.

Tier 4 personality disorder services

Safe	
Well-led	

Are tier 4 personality disorder services safe?

Safe and clean environment

- Access to Garrow House was through the front entrance via a reception area. Reception staff made patients and visitors aware of a list of restricted and prohibited items displayed in reception. All patients, staff, and visitors completed a signing in and out book in this area to support the fire safety arrangements. We saw fire procedure posters placed on the wall throughout the building. Thirty-three out of 39 staff had signed to say they had read and understood the fire safety risk assessment.
- During inspection, we completed a tour of the ward; all areas appeared tidy and clean. On both days of our visit, we observed domestic staff on the unit cleaning different rooms. The hospital had a service level agreement with a local hospital for 30 hours of domestic cover. In addition, the service had employed a domestic to provide 25 hours of cleaning per week.
- We reviewed all the Health and Safety files for the hospital, including risk assessments, fire records, premises, equipment, risk assessment, and safety records. All files contained up to date health and safety information and policies. There was evidence that the registered manager had monthly oversight and that action happened where there were identified shortfalls. The hospital had identified three health and safety leads who regularly attended the regional health and safety committee meetings.
- The furnishings were in good condition and looked comfortable. The hospital had recently purchased some new seating and the patients had been fully involved in choosing the furniture, fabrics and colour scheme.
- Patients had individual key fob access to the different areas of the ward and garden dependent on their individual risk assessment. There was a CCTV placed in the staff office that monitored the entrance and garden areas.
- The hospital had a schedule of work planned that included a new downstairs kitchen area. At the time of inspection, an order was in place and the service was awaiting delivery.
- There were poor lines of sight throughout the building. We observed a high presence of staff in communal areas and a member of staff completing observations dependent on individual patient observation levels. Staff were aware of the observation policy and described the different levels of observations which patients were on. There were mirrors placed in communal areas that supported staff observing blind spots.
- All bedroom doors had viewing panels and were fitted with anti-ligature furniture. Patients who presented with high-risk risk assessment ratings slept in a downstairs bedroom so they were closer to communal areas. The downstairs bedroom and bathroom doors had sensitivity strips on the top to limit potential ligature points. A ligature point is a place, which individuals might tie something to strangle themselves.
- A downstairs bedroom had been adapted for individuals with mobility problems this meant that a patient who used a wheelchair could access the service. The hospital also had a lift fitted so individuals with a disability would not be restricted to the ground floor.
- Staff completed an environmental ligature assessment report in February 2017. This report identified and mitigated any concerns highlighted by staff. The risks from the free hanging lights in the dining area, the cables from the TV in the lounge area or the telephone wire from the pay phone available for patient use were not included in this assessment. However the organisations health and safety general risk assessment included risks associated with suicidal behaviour and identified cables and wires. Staff rated the risks according to the level of severity and recorded the action to manage the risks. The assessment dated February 2017 did not include the study room that was between the bedrooms on the second floor, staff told us this room was locked as it was used for 1:1 time with

patients. We observed that there were three ligature cutters available in different areas of the building. Staff knew where these ligature cutters were and how to access them.

- There was a personal alarm system in place with call systems in all rooms. At the beginning of each shift all staff checked their fob to ensure they were in working order. Staff identified three individuals at every shift as the response team. If an incident occurred, the staff member involved activated the alarm using their fob and the response team attended the area identified on the pager. During inspection, we heard staff activate the alarm and observed the response team quickly attend an incident.
- The ward had an identified chill out room that contained a sofa and mattress. There was a viewing panel in the door and a mirror located in the top corner of the room to ensure good visibility of the environment. The door opened from the inside therefore patients could move freely out of the room. Staff told us that individual patients used the room as a quiet place to go if they did not feel safe and staff supported patients during this time. Staff told us patients were free to leave the room at any point. The hospital did not have a seclusion room, staff told us that when necessary the 'chill out' room had been used to seclude patients.
- There were hand-cleaning gels situated around the building, we observed notices at sink areas demonstrating how to clean your hands. We observed staff using the gel as they moved around the building.
- There was a fully equipped clinic room with an emergency "grab bag". There was a list of items that the grab bag should contain and staff checked the contents regularly. We noticed that although the bag was accessible it was cluttered and heavy. This was due to the equipment including an oxygen cylinder. The clinic room fridge was within the recommended temperature range and this was reflected in the daily medication audits for April and May 2017. The fridge temperature was within the recommended range of between two to eight degree Celsius for each day.
- We checked the calibration certificates for diagnostic devices such as the defibrillator, medical scales, blood pressure monitor, thermometer, electro-encephalogram, vaccine fridge and the pulse oximeter all the certificates were in place and in date. There was a first aid box checklist, we saw evidence of regular checks made by staff, and documented actions taken to replenish the box.

Safe staffing

- The service had a full multidisciplinary team, which consisted of a locum consultant psychiatrist, one full time activities co-ordinator, one occupational therapist, one psychologist and assistant psychologist. Nursing staff included one clinical lead, one nurse development lead, six registered nurses and 13 health support workers.
- The service had advertised for a specialist doctor as part of a shared post with another local service. At the time of inspection, there were two registered nurses due to commence employment in August 2017. A further registered nurse had received an offer of employment; with a final nurse recently interviewed, references for this nurse were outstanding.
- The establishment level for Garrow House was 12 qualified nurses and 18 support staff. There were five support staff vacancies, one of these vacancies had been appointed to and were in the recruitment process and four registered nurse vacancies. The four registered nurse vacancies were all in the recruitment process at the time of inspection. The remaining vacancies that had not been appointed to were out to advert. The hospital planned to continue to advertise these posts until they were filled.
- In the last 12 months Garrow House report 294 lost working days due to sickness this is 2.24% of the total working days. There was a high use of agency staff, between January and April 2017 there was an average of 29% of shifts covered by agency workers. This peaked over May and June 2017 to 56 % in May and 46% in June. This reflected increasing demand on the service from two challenging patient admissions. The increase in agency workers were due to the observation levels which needed to be completed. The hospital responded to the high use of agency staff by providing a three-month contract of employment with three individuals to improve consistency. Staff told us that it had felt safer on the ward since this arrangement was in place, as these individuals knew the environment and patients.

- We reviewed the safe staffing tool that nurses and managers used daily. This document recorded all staff on shift and those not included in the numbers such as the managers, the multidisciplinary team, clinical development specialist nurse, and the activities co-ordinator. The minimum staffing levels required through the day were two qualified nurses and six support staff. One member of nursing staff also worked 11.00am to 11.00pm shift. Minimum staffing required at night was one registered nurse and three support staff. The document also took into account any escorted planned appointments, off site activities, how many incidents had occurred in the last 24 hours and individual appointments.
- Staff we spoke with told us this tool worked well and that they did not feel under staffed. Staff told us they planned one to one time with patients into the day and planned activities on and off the unit were rarely postponed, as the occupational therapist and activities co-ordinator were not counted in the numbers.
- We carried out a review of the staffing levels during May 2017 and June 2017. The rotas showed compliance with minimum establishment levels for both registered and unregistered staff. The safe staffing tool used at daily handovers reflected that managers maintained safe staffing levels during the period we reviewed. We could also see how staffing was adjusted daily to meet the needs of the patients and in response to incidents. For example, the use of the 11.00am to11.00 pm shifts to cover escorted appointments, meetings, and individual time for patients. We observed both registered and non-registered staff in communal areas at all times and there was additional support available from members of the multidisciplinary team not counted in the daily staffing numbers.
- Staff told us that medical staff were accessible within the hospital. The consultant psychiatrist was available during working hours and the hospital had access to the on call doctor outside of working hours. The on call Dr was provided through a sub contract with a neighbouring NHS trust. As part of this contract the NHS trust were responsible for ensuring all staff have up to date registrations, have an enhanced disclosure and barring service form in place (DBS) and are suitably skilled. All staff we spoke with said that the on call doctor always attended when called in a timely way. The hospital also had access to the emergency care team who would attend the hospital out of hours to respond to any physical health care needs. The emergency care team are provided by a external provider based in the York area.
- Managers monitored compliance with mandatory training, we saw evidence of staff training records, and all staff we spoke with told us managers supported them to access training. The mandatory training compliance target was 80% and staff training levels were above this in each of the identified modules with overall compliance at 97%.

Assessing and managing risk to patients and staff

- We reviewed information about incidents of restraint and seclusion. From December 2016 to May 2017, there were 91 incidents of restraint involving 11 different individuals. Three of these incidents involved the use of prone restraint and involved two different individuals. Prone restraint is when staff restrain a patient in a face down position. All staff we spoke with described least restrictive practice and that de-escalation techniques were always used in the first instance. Staff spoke about their relationships with patients and how they used these to calm down an incident.
- Garrow House used a dedicated seclusion recording book to record episodes of seclusion. We looked at seclusion records from June 2016 to June 2017 and found that there had been seven episodes of seclusion recorded over the 12 month period. From 01 March 2017 to 09 June 2017, staff documented three seclusion records. These records related to one individual who was assessed to need alternative services. At the time of our inspection, this individual was transferred to an alternative provider. All three records had completed documentation in keeping with the Mental Health Act code of practice. Documented details included the date and time of seclusion, a clear reason for seclusion and evidence that de-escalation had taken place but failed. There was evidence of initial medical reviews, records about food and fluid, care plan reviews and documentation that staff offered a de-brief. The document showed that the patient was not alone in the room, details of the staff involved and details of when seclusion ended that confirmed the decision maker.
- Garrow House did not have a dedicated seclusion room but recognised that staff might need to seclude patients. When seclusion had taken place the dedicated chill out room was used as safe environment to do this.

The service had an up to date policy that followed National Institute for Health and Care Excellence guidelines and supported staff to follow best practice. All staff we spoke with understood what seclusion was and that implementation of seclusion would only take place when other de-escalation techniques had failed. Garrow House provided in house seclusion training to all staff. There was no compliance target set for this training, as it was not mandatory however compliance was 97 %.

- Staff completed an evidence based risk assessment tool called the short-term assessment of risk and treatability (START). We looked at six patient records and found that risk assessments were completed and up to date. All records we looked at had an up to date care plan and risk assessment. Staff we spoke with told us that the named nurse discussed both the risk assessment and care plan at the multidisciplinary team meeting and updated the records to reflect discussions. Any restrictions placed on patients were individually risk assessed and care planned. All informal patients were aware of their right to leave the building if they wished. The hospital had a signing in and out book which patients needed to sign to support fire regulations.
- All staff we spoke with were able to describe the observational policy and the different levels of observation used dependent on patient risk. Nurses were able to increase the individual patient level of observation dependent on risk assessment and the multidisciplinary team agreed any decrease to observation levels.
- We saw training records, which showed all staff had completed Positive Management of Violence and Aggression training. This provides staff with the skills to manage actual or potential incidents of aggression. Staff we spoke with told us they felt confident dealing with aggression and always used their de-escalation techniques to try to calm down an incident.
- An up to date policy supported staff to search patient's belongings. All staff we spoke with were aware of this policy and based the decision to search a patient on individual risk assessment. Staff gave examples of implementation of this policy. The decision to search was care planned for and agreed with the patient.
- All staff had received training in safeguarding. The mandatory training programme included safeguarding awareness and staff received face-to-face training on an annual basis. Staff we spoke with understood safeguarding and were able to provide examples of when safeguarding would apply. Staff understood their responsibility in reporting safeguarding issues both internally with their safeguarding lead and externally with the local authority. The safeguarding lead for the hospital was a social worker and had strong links with the safeguarding team at the local authority.
- There were separate visiting facilities available for children who visited Garrow House. The ward had a room available; accessible through the front door, which meant visitors would not need to go through the ward to access this room. There were glass doors, which opened out into a small private courtyard, and the room had a box of toys available for children to use. Staff at Garrow House could also book the family room available at a nearby hospital.
- At our last comprehensive inspection in January 2016, we found that staff did not follow policies and procedures for the safe management of medicines. Staff did not document risk assessments for patients who were self-administering their medication and staff did not document details of 'as required' medication in patient care plans. Staff did not routinely carry out side effect monitoring for patients prescribed antipsychotic medication. We found nurses had not carried out the required physical health monitoring consistently after one patient had received an injection. There was an excess amount of medication. At this inspection in June 2017, we checked again to see what improvements had been made. We reviewed five patient records and spoke with nursing staff responsible for medicines. We found that although improvements had been made staff were not fully following procedures for the safe management of medicine.
- We saw a review of medicines policies in December 2016, including the self-administration of medicines policy. At the last inspection, we identified staff did not always complete documentation to support patients to safely administer their own medicines in accordance with the service policy. At this inspection we checked records for two patients who were administering their own medicines and found staff had completed the required assessments. However, there was no record of initial risk assessment carried out in multidisciplinary meetings regarding self-administration of medicines. We were concerned that no documentation of the decision making relating to self-administration by the multidisciplinary team was available, including any

identified risk and mitigation of those risks. We found staff had completed administration records correctly to reflect that patients had administered their own medicines, and a regular review of each patient's progress took place to ensure self-administration remained safe and appropriate.

- At our last inspection in November 2016, we identified staff did not always keep accurate records of the medicines they had given. During this inspection in June 2017, we found two of the five records we reviewed had gaps in the documentation of administration of medicines. However, a weekly medication audit was in place and we could see this had been successful in identifying these gaps. We also saw a record in a staff file of medicine related supervision notes directly related to medication errors and missed signatures. We reviewed prescriptions for 'when required' medicines and found there was adequate information to enable staff to administer these safely.
- At our last inspection in November 2016 we had identified nurses had not carried out the required physical health monitoring after patients had received injections as set out in the rapid tranquilisation policy. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. During the most recent inspection we reviewed records for two patients who had received rapid tranquilisation. Whilst there had been improvements in the recording of observations, we found staff did not always record all of the information specified in the policy. For example, a record of the level of consciousness, in particular when the patient had refused to have their observations taken. This meant staff had not followed the service policy for recording observations after administration of rapid tranquilisation.
- Medicines were stored securely with access restricted to authorised staff. There were adequate supplies of equipment for use in a medical emergency, and a procedure was in place to ensure it was fit for use. However, we found one medicine listed in the rapid tranquilisation policy that was not available on the day of our inspection. The registered manager told us the service had decided they would no longer stock this medicine and the policy would be updated at the earliest opportunity to reflect this.
- We looked at patient records for those prescribed antipsychotic medication and found that staff were completing The Liverpool university neuroleptic side effect rating scale for those patients receiving high doses of medication. This meant that staff were able to identify side effects experienced by the patient and respond to this in a safe way.
- At our last inspection, we found audits had failed to detect some shortfalls in the safe management of medicines. During this inspection, we reviewed weekly and monthly audits and found they had detected a small number of gaps in administration records. Managers recorded clear actions to drive forward improvements where there were identified shortfalls.
- We looked at staff training records and found that there was an annual requirement for medication training; all eligible staff had completed this training.

Track record on safety

- Incident reporting by the provider was good and shared learning from incidents happened across the hospital. We analysed data regarding safety incidents from three different sources, incidents reported by the organisation to the Care Quality Commission, incidents reported by staff on their electronic system, the organisations own reporting system and we reviewed the minutes from the providers' monthly incident review meeting. The hospital has notified the Care Quality Commission of three serious incidents at Garrow House over the last six months. Garrow House rated these incidents as high in severity, the incidents were all available on the electronic system and we could see clear actions taken against each incident. We could see discussions relating to the incidents documented in the incident review meeting minutes.
- A comprehensive inspection of Garrow House took place In January 2016. At that inspection a requirement notice was issued under regulation 12 of the Health and Social Care Act, safe care and treatment. This was because staff did not ensure that all equipment used for providing care and treatment was safe for use and because staff did not follow policies and procedures for the safe management of medicine.
- In November 2016, a focused, unannounced inspection took place to look at improvements since the January 2016 inspection. Following that inspection a warning notice was issued under regulation 17 of the Health and Social Care Act, good governance. This was because the hospital did not have effective systems or processes to ensure that all staff complied with the hospital's

medicine management policies and procedures. The hospital did not monitor and improve the quality and safety of the service sufficiently to ensure that medicines practices were safe for patients. The hospital did not adequately assess, monitor and mitigate the risks relating to patients health, safety and welfare. This included patients who received medication for rapid tranquilisation, anti-psychotic medication and patients who administered their own medication and the hospital did not maintain accurate, complete and contemporaneous records for patients prescribed medication.

- At this most recent inspection in June 2017 we found that although significant improvements had been made to documentation and systems to monitor staff compliance there were still shortfalls in the hospitals documentation when recording medicine management practices. We found that the Provider had put measures in place to identify shortfalls in documentation of medicine administration and we could see that identified shortfalls were picked up through the audit process.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to report incidents and were able to describe which types of incidents they would report. Staff felt confident using the electronic system and they were able to discuss how they shared learning from incidents when things go wrong.
- The provider used the governance structure to ensure staff received feedback. We reviewed the regional governance meeting minutes and could see evidence of shared and disseminated information. Managers shared information from the regional governance meeting at the hospital weekly clinical team meeting where discussion and learning from incidents took place. Staff told us they also received group emails highlighting learning from incidents and that they accessed minutes from the governance and clinical team meeting through the service shared drive.
- Staff told us they had weekly group supervision where they shared learning and attended formal de-brief sessions following serious incidents. The psychologist facilitated the debrief sessions which provided further opportunity for staff support and learning. If staff were not on shift when supervision or de-brief occurred they were still able to attend and were paid for their time. Staff were able to give a recent example of an incident which had resulted in a staff de-brief.

Duty of candour

- All staff were able to describe the duty of candour, they recognised they needed to be open and honest with patients when things go wrong. The provider had a duty of candour policy in place, which was up to date, and staff knew where they could find the policy.
- The hospital safeguarding adults at risk training contained a section on 'duty of candour', 94% of staff had completed this face-to-face training.
- We reviewed the hospital complaints register which provided a written record of each individual complaint, the accompanying investigation and outcome. We reviewed all records documented over the last 12 months. We could see evidence of meetings offered to complainants where discussions of the issues took place; we saw written apologies to patients and an open, honest approach within the response. Responses were provided in a timely manner.
- The hospital provided a debrief to staff when an incident occurred. The debrief was facilitated by the hospital psychologist and provided an opportunity to provide support for staff directly and indirectly involved with the incident. It was also an opportunity to learn and time to think about what could be done differently.

Are tier 4 personality disorder services well-led?

Vision and values

- The organisational vision was "to constantly find new ways to support people to discover new possibilities in their lives".
- The Values were;
  - We believe that everyone has the potential to grow, learn, and make choices.
  - We all communicate in an authentic and confident way that blends support challenge.
  - We are here to embrace change even when it is complex and uncomfortable.
  - We treat each other and those we support as individuals however difficult and challenging.

  - We deliver better outcomes by encouraging ideas and new thinking.

- We saw how job descriptions such as the nurse and clinical lead roles linked to the organisations visions and values. Although staff we spoke with found it difficult to recite the values in full, they were all able to say how the values applied to their practice and made them meaningful in their own words.
- All staff we spoke with were able to name the management team within the hospital, they were all able to tell us the names of those in leadership positions and described them as being highly visible and approachable. This was supported by patients we spoke with, who said managers were 'hands on' and approachable. Staff were aware who the regional manager of the organisation was and were able to tell us their name. Staff told us the regional manager attended the hospital governance meetings and had sent emails that informed staff of the visit and invited them to meet him.

Good Governance

- Staff we spoke with were clear about their roles within the hospital and were able to tell us what they were accountable for. Registered nurses spoke about patient risk and individual risk assessments. They were able to talk about medicine management issues identified through the management team and the work they had been doing to improve medicine management documentation. Support workers talked about the importance of building relationships with the patients and how they were able to understand the women better due to the specialist personality disorder training they had completed. Support workers described a key role in relationship management and were able to described how they supported the registered nurses.
- All employees received specialist training for working with the specific group of patients. Specialist training included an introduction to cognitive analytical therapy, personality disorder awareness training, risk assessment training, and recovery star care planning. Managers had access to an electronic monitoring system, which identified staff training performance and a training action plan identified any gaps in training. We were able to look at the hospital training matrix and see high compliance with both mandatory and non-mandatory training.
- All staff received an annual appraisal with reviews. We were able to see that appraisals were linked to the organisations vision and values.
- Senior managers ensured good supervision arrangements were in place for all staff. We looked at 13 staff files and saw all had identified supervisors and evidence of monthly supervision meetings from January 2017 to May 2017. Senior managers also provided 'flash' supervision which individuals could request as required. We saw evidence of 17 staff members who had accessed 'flash' supervision at least once over the three-month period from April 2017 to June 2017.
- There was sufficient numbers of staff on duty at all times. There was a minimum of one registered nurse on each shift; however, it was normal for two registered staff to be on duty throughout the day. We observed a registered nurse in communal areas at all times, and there was available staff to carry out the required observations of patients. The service had experienced a high number of vacancies that had resulted in the need of high agency staff usage. The service had recently recruited three registered nurses and provided a three-month contact to three agency nurses, which had improved staffing. The hospital undertook a recruitment drive which included targeted advertisement on social media and staff nurse post were reviewed and enhanced with senior staff nurse posts and salaries to reflect this. The service has recently recruited two new senior nurses one preceptorship nurses and was in the process of following up on references for a further preceptorship nurse; managers planned to continue with this recruitment drive until they filled all 12 nursing posts.
- At our last focused inspection in November 2016, we issued the registered manager with a warning notice under regulation 17, of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was because we found continued issues with staff compliance with hospital policies and procedures related to medicine management and ineffective systems to ensure that all staff complied with these policies and procedures. At this focused inspection in June 2017, we found that the manager had put in place a number of audits relating to medicine management that supported staff compliance. The registered manager met weekly with the clinical lead to check audit actions and carried out six monthly audits to

maintain oversight of staff compliance. We reviewed weekly and monthly audits and found they had detected a small number of gaps in administration records and there were clear actions recorded to make necessary improvements. However, we found staff did not always maintain accurate and complete records when recording decisions taken in multidisciplinary team meetings in respect of patients who were administering their own medication. There was also no record of the level of consciousness post rapid tranquilisation, in particular when a patient had refused to have their observations taken. This meant staff were not always compliant with hospital policy for recording observations following the administration of rapid tranquilisation.

- All staff we spoke with knew how to report incidents and were able to describe which types of incidents they would report. The provider used the governance structure to ensure staff received feedback from incident reviews. Senior managers shared information from the regional governance meeting at the weekly clinical team meeting were the team discussed any learning from incidents. Staff told us they also received group emails highlighting learning from incidents and that they could access the minutes from the governance and clinical team meeting through the service shared drive if they were unable to attend the meeting itself.
- All staff and patients we spoke with felt they could raise concerns if required and senior managers would take action. Garrow House had a complaints register where the registered manager documented details of all complaints including the type of complaint, the date of complaint, and the outcome. We reviewed this record as part of the inspection and saw evidence that complaints were reviewed, investigated and apologies provided in a timely way. One example was where a patient had complained about the cleanliness of the house. In response to this, managers employed an additional housekeeper and sent a written apology to the patient.
- All staff received training in the Mental Health Act 1983 and the Mental Capacity Act. Staff we spoke with had a good understanding of both Act's and were able to describe how they applied to their role. Garrow House had a service level agreement with the neighbouring hospital, which meant that they had support, and face-to-face training provided by a Mental Health Act officer.
- The hospital had good advocacy arrangements in place. The registered manager had meetings with the advocacy representative and was due to meet with them the week following our inspection. We could see full involvement of advocacy in a number of complaint letters and saw evidence of advocacy information displayed in communal areas of the building. Advocacy involvement was part of the multidisciplinary team meeting and seen as a positive addition to the hospital.
- Staff were able to describe how governance worked within the service and who attended the governance meetings. We looked at minutes of the governance meeting and saw evidence that staff discussed issues at their clinical team meeting. We looked at Garrow House clinical governance plan 2016 to 2017. It included actions taken on clinical and quality measures, development of the therapeutic framework, review of the therapeutic programme, care pathways development, and risk management.
- Staff were able to tell us what was on the risk register and their concerns reflected what we saw when we reviewed the risk register. Staff identified that the building had a number of blind spots but they were able to tell us how they mitigated the risks. They described the use of mirrors, which help them see hard to observe areas, sensors on doors in the downstairs bedrooms, which higher risk patients used and the use of individual observations and risk assessment, which allowed patients' access to different parts of the ward dependent on their individual risks.
- We reviewed 11 staff personnel files they were all well organised and contained a photograph of the individual for identification. Documents included enhanced disclosure and barring service forms (DBS), medical fitness, contracts of employment and qualified nurses' registration identification and renewal date. Files also contained two references and a signed confidentiality agreement from the employee.
- We saw systems in place concerning patient involvement. Garrow House employed an involvement co-ordinator who facilitated a weekly patient involvement meeting which all the women could attend. Two patient representatives also attended a regional involvement group. The same representatives will be attending an involvement lead workshop towards the end of June 2017. The patients were involved in choosing the fabrics and furnishings at Garrow House; they made recommendations for the

daily activities and were involved in staff recruitment. Patients were invited to attend the regional governance meeting and have input into the therapeutic meeting. There was a 'you said we did' notice displayed in the communal area that showed how staff responded to patients' concerns. All the patients attended their multidisciplinary team meeting and were fully involved in their care using the recovery star model. We observed some patient bedrooms whilst on inspection; all rooms we saw were spacious and highly personalised.

Leadership, morale and staff engagement

- All staff we spoke with spoke positively regarding the senior management team, their accessibility, support and a feeling of being valued.
- All staff spoke about a strong, supportive team culture and one staff member described the team as 'unique'. Staff told us how they supported each other when dealing with difficult incidents and how there was always someone to talk to if they were feeling under pressure. Staff understood their roles and the roles of others.
- Staff spoke about the difficulties they experienced working with a complex patient group and the concerns this can cause them, however they told us the positive team relationships and supportive culture helped them to manage the stress.
- Staff told us they had opportunity to develop their skills and knowledge through the internal training programmes and could request external training when required.
- Garrow House completed a staff survey in April 2017. There was an 83% staff response rate to this survey. Positive indicators included:
  - All staff felt they were treated with dignity and respect at work
  - All staff felt Garrow House was a well led service
  - 96% felt their colleagues were helpful and supportive
  - 88% of staff felt they were given everything they needed at work to make their work meaningful, encouragement and learning opportunities
  - 88% understood how the line management structure works and that that things are changed when they need to be
  - 84% of staff said they would recommend the service as a good place to work
- The biggest concern for staff from the staff survey identified that 80% of staff found their job stressful. The senior management team at Garrow House had tried to help staff manage this stress by the introduction of 'Flash' supervision and creating a strong culture of supervision within the service.
- The nominated individual and registered manager had completed a Workforce Race Equality Standard (WRES) report with action plan for 2017 to 2018. The report included actions identified through the report, the owner of each action and a completion date for each action. Presentation of this report is due at the next planned board meeting in June 2017. Areas for development identified through this action plan included identifying the ethnicity of staff survey respondents, identifying the likelihood of staff accessing additional or continuing professional development training, identifying how many staff feel they are subject to harassment either by service users, staff or management and identifying how many staff believe they are supported in career progression and promotion.

Commitment to quality improvement and innovation

- Garrow House had nominated one of their administrators for an award in recognition of their contribution to the service. The administrator was successful in winning and attending an event in London to receive the award.
- The psychiatrist and psychologist at Garrow House had completed a piece of research regarding tier four services and were hoping to get the research published.
- The leadership team completed a two-year review of the service and planned an away day to look at the work completed.
- The organisation was in the planning stage of setting up a nurse's forum to look at best practice guidelines such as The National Institute for Health and Care Excellence.
- There was evidence of local audits of both clinical files and medicine management. Staff we spoke with told us that the clinical file auditor sent them individual emails to remind them of any review dates which they needed to meet within the patient clinical files. Nurses told us about the work they were involved in with relation to medicine management and the audit checks they completed and we saw these were regularly completed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff document initial risk assessments for the self-administration of medicines.
- The provider must ensure that staff fully record physical health observations on administration of rapid tranquilisation.

Action the provider SHOULD take to improve

- The provider should review the environmental ligature assessment to include all areas of the ward.
- The provider should have one environmental ligature assessment completed by Garrow House to include all identified ligature points.
- The provider should review the emergency 'grab bag' contents and ensure all contents are easily accessible.
- The provider should ensure that all staff including agency staff respect patients privacy at all times and do not use personal phones in patient areas.
- The provider should ensure they monitor the use of the 'chill out' room for seclusion purposes and continue their discussions regarding the appropriateness of an identified seclusion room for the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not maintain accurate, complete and contemporaneous records in respect of each service user and of decisions taken in relation to the care and treatment provided. The provider had not kept a record of the initial risk assessment carried out at the multidisciplinary meeting regarding self -administration of medicines. Following the administration of rapid tranquilisation staff had not recorded the level of consciousness for patients, in particular when the patient had refused to have their observations taken.