Brook House

Quality Report

Brook House
Shrewsbury Court
Clifton Close
Old Trafford
Manchester
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Website: www.deepdenecare.org.uk

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

We rated Brook House as requires improvement because:

- The hospital was not compliant with the Mental Health Act Code of Practice, published 2015. The required policies within the Code of Practice were not written and available. One prescription card had medication prescribed for a patient as required (PRN) which was not authorised on their T3 form. Staff had not received training in the revised Code of Practice. The responsible clinician frequently changed the days of the ward rounds at very short notice, meaning patients were not prepared for their meeting, the advocate was not present and if family or external professionals were due to attend they would not have been aware of the change.
- Staff did not consider the Mental Capacity Act in their everyday practice. Capacity assessments were not taking place in accordance with the Mental Capacity Act and there was no consideration of best interest processes.
- The hospital could compromise the safety of patients. The environmental risk assessment was not fit for purpose and did not identify the ligature points within the building or advise staff of how to mitigate the risks. The hospital manager was not following the ligature and self-harm policy. There was a sign on the clinic room door to inform staff that oxygen was stored there, however the oxygen was stored in the staff office. There was no emergency medication available for the overdose of benzodiazepines. The prescription cards were illegible. This posed a risk of staff administering the wrong medication to patients. There were no care plans in place for patients prescribed antipsychotic medication above the British National Formulary limits.
- Staff did not receive the training relevant to their role. Mandatory training attendance levels were below 75% for the majority of courses, including emergency first aid and safeguarding adults. Staff did not receive training on the Human Rights Act. Specific training for the needs of the patients were low, including diabetes awareness at 21% and drug and alcohol awareness at 53%
- The provider was not complying with the Duty of Candour Regulation. The policy did not specify that people should receive a written apology. Staff we spoke with were not aware of the duty of candour.
- Care was not patient centred. Restrictive practices were in place including locking the cutlery away and not allowing detained patients to hold their own lighters. A patient had been deskilled, who was previously cooking independently and living in the annex. They had to move back into Brook House due to building works, had all meals cooked for them, and were in a hospital with locked doors. Care plans were nurse led and it was not clear what actions patients needed to take to progress from the service. Staff had not referred a patient identified as requiring psychology. There was no written information provided to patients upon admission to assist with orientation within the environment. Community meetings had a disproportionate amount of staff present compared to patients and actions from previous meetings were not always completed.
- The hospital was not well led. There was no evidence of learning from incidents at a hospital or provider level. Policies at the hospital were all out of date, mainly from 2013. However, the provider had more recent versions in place, which the hospital had not made available to staff. Staff felt unable to progress within the organisation with limited opportunity for development including no opportunity to complete National Vocational Qualifications. There were no examples of staff surveys or any other methods or forums for staff to give feedback about the service.

However:

- The hospital was homely and welcoming and provided the facilities to promote patients' recovery including access to drinks and snacks at all times and areas to

spend in quiet. Patients had keys to their bedrooms and had their own mobile phones. The majority of patients had progressed within their time at Brook House and were pursuing activities in their local community independently. The occupational therapy assistant had created a plan to show times of activities available in the local community.

- We observed warm, positive and nurturing interactions between staff and patients. All patients reported staff were friendly, caring and respectful. Patients had access to advocacy. Families were involved in ward rounds and care programme approach meetings if patients wished. Patients gave feedback about the service via service user questionnaires and community meetings.
- The hospital manager was following the complaints policy and investigations were completed in a timely manner. Information was on display to inform patients how to complain.
- Staff had appraisals and supervisions. Regular team meetings took place. Debriefs were taking place following incidents.
- The provider's recruitment and selection policy, dated July 2015, complied with the Health and Social Care Act 2008(Regulated activities) Regulations 2014 in relation to recruiting staff that are fit and proper.

Summary of findings

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Requires improvement

Brook House

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Brook House

Brook House is an independent hospital providing care and rehabilitative support for up to 12 adult men experiencing complex mental health needs in a locked rehabilitation unit. The hospital also had use of three flats in the service next door, from the same provider, to offer a move on service for patients to develop their independence prior to discharge. However, the additional flats were closed at the time of the inspection, as building work was underway. The provider is Deepdene Care Limited. Deepdene Care provides services at seven other locations across England, mainly residential care homes for adults with mental health needs. Brook House is the only independent hospital operated by Deepdene Care.

Brook House has been registered with CQC since February 2013.It is registered to provide the following regulated activities:

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

The hospital is located in a residential area of Old Trafford.

The hospital has a registered manager who is also the controlled drugs accountable officer.

CQC last inspected Brook House in December 2014 as part of the pilot to trial new inspection methodology; the hospital was not rated as part of the process. CQC made recommendations for the hospital to consider including Mental Health Act documentation requirements, medicines storage and discharge planning with patients.

Prior to the inspection the provider contacted CQC to inform of their plans to close Brook House as a hospital. Within the presentation from the registered manager and compliance manager, they informed us that due to a reduction in occupancy and changes in commissioning arrangements they propose redesigning the service to be a nurse led mental health service attached to Clifton House, the residential service next door. The registered manager of Clifton House would be responsible for the expanded service. At the time of inspection, staff were aware of the proposed changes and consultation was underway, particularly with staff whose roles were at risk. Patients were not aware of the proposed changes, the registered manager advised that the provider had informed commissioners first and then following this, patients would be informed following guidance from commissioners. The compliance manager hoped that the redesigned service would be open by September 2016.

Our inspection team

Team leader: Sarah Heaton, Inspector.

The team that inspected the service comprised two CQC inspectors, a Mental Health Act reviewer and a nurse with experience of working in services for men with mental health needs in a rehabilitation setting.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- received a presentation from the hospital in relation to the history of the service and future plans;
- looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with the registered manager and compliance manager for the hospital;
- spoke with nine other staff members; including a doctor, Mental Health Act administrator, nurses, occupational therapy assistant, social worker and support workers;
- spoke with an independent advocate;
- attended and observed a ward round;
- looked at six care and treatment records of patients, case tracking in detail three of these;
- reviewed all prescription cards;
- carried out a specific check of the medication management; and
- looked at a range of minutes of meetings, policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five patients.

All patients reported the hospital was clean.

All patients reported staff were caring and respectful, they knocked on their doors prior to entering their room.

Patients felt safe in the hospital the majority of the time, however when patients' behaviour became hostile, some patients found this intimidating.

Two patients reported their progress and felt they did not need nursing care anymore as they went out independently and one was managing their finances independently.

A patient, who had been in the hospital for several years, reported that there were more activities available than there used to be. Activities on offer include pool, walking, cinema and day trips out. However, patients reported the community meetings were not that effective and suggestions they had made, staff had not acted upon including certain day trips out and activities within the hospital.

An area for improvement would be for the bedrooms to be ensuite, as patients had to share communal toilets and bathrooms.

A patient, who was informal, reported it would be beneficial to have an open door or the possibility of being able to come and go from the hospital without asking staff to let them in and out.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- The hospital manager was not following the ligature and self-harm policy and the daily environmental risk register did not identify ligature points and risks within the building or advise staff of how to mitigate the risks.
- There was no flumazenil stocked which is used for the reversal of the central sedative effects of benzodiazepines. Patients were prescribed benzodiazepines and would not have emergency medication available to them if they reacted to the medicine or were given an incorrect dose.
- Medicines for the patients in the service next door were stored in Brook House fridge including opened eye drops from Jan 2016, insulin pens from March 2015. Staff were not following the provider's medicine policy, by not discarding eye drops 28 days after opening.
- The doctor who had completed the prescription cards had poor handwriting and it was difficult to decipher. This posed a risk of staff administering the wrong medication to patients.
- Oxygen was marked as being in the clinic however; it was stored in the office.
- Staff mandatory training attendance levels were below 75% for a number of courses, including emergency first aid and safeguarding adults.
- The provider's policy on duty of candour was not compliant with the regulation and staff were not aware of the duty of candour.
- Restrictive practices were in place including locking the cutlery away and not allowing detained patients to hold their own lighters.
- The observation policy in place only focused on enhanced observations and did not provide guidance to staff on how to complete and record observations of patients on general observations.
- The medicine management policy did not reflect current practice including Controlled Drugs (Supervision of Management and Use) Regulations 2013.
- The flooring in the laundry room had missing sections and the seating in the dining room was torn on some seat pads, which increased the infection control risk.
- Risk assessments did not include risk mitigation plans for patients.

Summary of this inspection

- There was not a formal process within the organisation by which important lessons to be learnt from incidents could be disseminated to staff.

However:

- Debriefs took place following incidents.
- Staff understood how to safeguard vulnerable adults and how to escalate safeguarding concerns.
- The hospital was very clean.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The hospital did not have the specified policies in place as required under the Mental Health Act Code of Practice, published 2015.
- Patients were not always offered a copy of their section 17 leave form.
- The responsible clinician frequently changed the days of the ward rounds at very short notice, meaning patients were not prepared for their meeting, the advocate was not present and if family or external professionals were due to attend they would not have been aware of the change.
- Capacity assessments were not taking place in accordance with the Mental Capacity Act, there was no consideration of best interest processes.
- Staff had variable knowledge of the Mental Capacity Act. The hospital manager could not explain the five statutory principles of the Act or that you assume capacity until proven otherwise. However, five of the nine other staff we spoke with were able to explain the principles and that capacity is decision specific.
- The provider had a Mental Capacity Act policy, dated March 2016. There were a few typographical errors within the policy, which could cause confusion. The policy stated that health and social care staff could conduct capacity assessments however; the hospital manager advised that they would refer capacity assessments to the patient's home team. The updated policies were not present at the hospital and available to staff.
- Care plans were nurse led and it was not clear what actions patients needed to take to progress from the service.
- There were no care plans in place for patients prescribed antipsychotic medication above the British National Formulary limits.
- Daily records for patients did not include information about support provided by staff or the activities that patients had pursued.

Summary of this inspection

- There was little evidence of physical health promotion, especially in relation to patients reducing or stopping smoking and the impact this may have on their medicines.
- There were low levels of staff completion of training courses in a number of areas including diabetes awareness and drug and alcohol awareness. Staff reported a lack of development opportunities.
- Staff had not referred a patient identified as requiring psychology.

However:

- Patients were actively involved in the planning of their section 17 leave including completing part of the form prior to the responsible clinician's authorisation.
- The independent mental health advocate was visible in the hospital, details were on display of how to make contact with them and we observed patients had a positive relationship with them and would approach them for support.
- Detention paperwork was accessible to all clinical staff.
- We saw evidence of the regular attempts to explain to patients what their rights were whilst detained.
- Staff we spoke with understood their role in relation to the Mental Health Act.
- Detailed care plans were in place for patients with diabetes.
- There was a good range of multidisciplinary professionals within the hospital including a Mental Health Act administrator, occupational therapist and occupational therapy assistant and social worker.
- The provider had a policy on the Deprivation of Liberty safeguards, dated May 2016. The policy explained how to apply for a Deprivation of Liberty safeguard.

Are services caring?

Good

We rated caring as good because:

- We observed warm, positive and nurturing interactions between staff and patients.
- Staff knew patients well including their future plans.
- All patients reported staff were friendly, caring and respectful.
- Patients had access to advocacy.
- Families were involved in ward rounds and care programme approach meetings if patients wished.
- Patients gave feedback about the service via service user questionnaires and community meetings.

However:

Summary of this inspection

- There was no written information provided to patients upon admission to assist with orientation within the environment.
- Care plans were nursing focused. Patients' perspectives were included in some of the care plans however they did not include unique support needs of patients, including how best to support them and what their coping strategies were.
- One patient had a care plan in place for shadowed local leave, he was not aware that he was being shadowed whilst on unescorted community leave.
- Community meetings had a disproportionate amount of staff present compared to patients and actions from previous meetings were not always completed.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The service was not moving patients on in a timely manner. The aim of the hospital was to move patients on within twelve to eighteen months. Several patients had been at the hospital for more than eighteen months, one patient over two years and another over five years.
- In five of the six files examined, a discharge care plan was in place; such plans were non-specific in their approach and did not specify the potential timing or location of eventual discharge.
- Staff had not updated or reviewed discharge plans. The registered manager told us this was because patients were not ready for discharge.
- Care plans were also unclear as to what patients needed to do to achieve step down or discharge from the unit.
- The provider had made the decision to close the service as a hospital and reconfigure the service to join the service next door and offer nursing care. Staff were going through the consultation process and commissioners had been contacted regarding the future of the six remaining patients. However, the provider had not discussed this with patients or the advocate.
- A patient had been de skilled; they were previously living in the annex and had to move back into Brook House due to building work. They were previously cooking independently, however, at Brook house they had all meals cooked for them, and were in a hospital with locked doors.
- Information on display regarding activities within the hospital was out of date and did not reflect activities available.
- There were limited activities available in the hospital, especially at weekends. Patient surveys identified the need to improve activities on offer.

Summary of this inspection

- There was no computer available for patients to use.

However:

- The hospital was homely and welcoming and provided the facilities to promote patients' recovery including access to drinks and snacks at all times and areas to spend in quiet.
- Patients had keys to their bedrooms and had their own mobile phones.
- The majority of patients had progressed within their time at Brook House and were pursuing activities in their local community independently. The occupational therapy assistant had created a plan to show times of activities available in the local community.
- Patients reported the food was good and that the chef had made changes to the menu from feedback from patients via the feedback questionnaire and community meetings.
- The service had supported patients to explore their faith. The quiet lounge was available for use to pray. There was a multi faith calendar on display in the hospital to assist with planning.
- A variety of information was on display for patients including how to complain, how to contact the CQC and the role of the advocate and how to contact them.
- The hospital was following the complaints and compliments policy and resolving investigations in a timely manner.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff attendance at mandatory training was low, with the majority of the courses completed attendance at below 75%.
- There were a variety of clinical audits in place, however they were not always meaningful and did not feed into any meetings or follow best practice.
- There was no dedicated administration support for the hospital; the hospital manager seemed to delegate administration tasks to support workers.
- Policies at the hospital were all out of date, mainly from 2013. However, the provider had more recent versions in place, which the hospital had not made available to staff.
- The policies required by the Mental Health Act Code of Practice, published in 2015 were not available. There was no written information available for patients upon admission to the hospital to orientate them to the hospital and provide important information.
- Staff turnover rates were 20% from January to July 2016.

Summary of this inspection

- The culture of the hospital was not inclusive. Interactions observed and minutes reviewed showed a culture of informing and telling staff what to do, not acknowledging the contribution staff could give.
- Staff felt unable to progress within the organisation with limited opportunity for development including no opportunity to complete National Vocational Qualifications.
- There was very limited understanding of the duty of candour within the service and the policy did not comply with the regulations.

However:

- Staff were knowledgeable in relation to safeguarding vulnerable adults and understood the process for escalating concerns.
- Sickness rates were low at one per cent.
- Staff meetings, appraisals and supervisions took place.

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.

The Mental Health Act reviewer, as part of the inspection team completed a review of the service in relation to its adherence to the Mental Health Act.

Positive findings were that patients had lots of unescorted leave and there were good links with a range of external organisations, including local facilities where patients could participate in creative activities and use the information technology facilities.

The legal folders were well organised and statutory detention documentation was readily available. Staff ensured that patients understood their rights under section 132 on a monthly basis, where patients declined this, staff reattempted this on a further three occasions.

Patients were actively involved in the planning of section 17 leave. Leave was discussed within the ward round and patients were encouraged to complete part of the form stating where they would be going within their leave and then the responsible clinician signed and authorised the leave.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts where required. The T3 forms reflected the prescribed medication in four out of five records. One prescription card had medication prescribed for a patient as required (PRN) which was not authorised on their T3 form, although the medicine had never been given. The inspection team escalated this to the hospital manager and compliance manager who were going to ensure the responsible clinician returned to the hospital to resolve the situation.

We spoke with the independent mental health advocate who visited the hospital at least once a week and was available to support patients at their ward round or care programme approach review. Patients had a positive relationship with the advocate and they reported they would talk to them if they were unhappy or wanted to complain.

Staff we spoke with were aware of their role in relation to the Mental Health Act including explaining section 132 rights to patients and providing copies of section 17 leave forms to patients. Staff reported receiving training in the Mental Health Act. Training compliance of mental health awareness was 63%.

Areas for the hospital to improve on included the recording of a discussion about capacity to consent at appropriate times. There was little evidence in the files we reviewed.

The hospital did not have any of the necessary policies and procedures updated, reviewed or written following the revised Code of Practice, published in 2015. CQC expected hospitals to be compliant with the revised policies by October 2015. Staff had not received training in the revised code of practice.

Care plans were nurse led. Staff recorded patients' views within care plans but these did not appear to inform the interventions required. There was no clear sense of what patients needed to do to achieve step down or move on. There was little evidence of any formal physical health promotion within care plans or more broadly. Discharge care plans were in place for four out of five detained patients' records but were non-specific in terms of the timing and location of eventual discharge. Staff told us they had not reviewed the discharge plans as the patients were not ready for discharge.

Records reviewed showed in two out of five records for detained patients, staff had not completed the section 17 leave form to indicate if patients were offered a copy of the form.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act, with 95% staff completion.

Although the provider had a Mental Capacity Act policy, dated March 2016 this was not available at the hospital for staff to follow. The policy included the key principles, assessment of capacity being decision specific, advanced decisions, the role of the Independent Mental Capacity Advocate and how and when to assess capacity. There were a few typographical errors within the policy, particularly in the section called "when should capacity be assessed" which could cause confusion. The policy stated that health and social care staff could conduct capacity assessments however, the hospital manager advised that they would refer capacity assessments to the patient's home team. This could cause a delay and would not always be necessary.

The provider had a policy on the Deprivation of Liberty safeguards, dated May 2016. The policy explained how to apply for a Deprivation of Liberty safeguard, including the difference between an urgent and standard authorisation.

Staffs' understanding of the Mental Capacity Act was variable; the registered manager was unable to explain the principles of the Mental Capacity Act and only referred to a Deprivation of Liberty safeguards if patients were at risk to self and others and that the safeguards restricted people from leaving the building. When asked about capacity assessments, the registered manager advised they would involve the patient's care coordinator from their home team, they did not acknowledge that staff would be making assessments of patients' capacity on a daily basis. However, five other staff including members of the multidisciplinary team were able to explain that capacity is decision specific and you assume capacity unless proven otherwise

The mother of a patient was managing his finances for him. There was no evidence that staff had completed a capacity assessment regarding managing his finances or a best interests meeting regarding the decision.

The hospital did not have anyone under a Deprivation of Liberty safeguards and the responsible clinician reported there had been a patient under the safeguards approximately two years ago.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

The hospital was clean, there was a full time domestic member of staff who followed cleaning schedules.

The hospital was over two floors with one staircase in the middle of the building. There was a living area, quiet lounge and dining room incorporating a conservatory. The environment was very homely with a variety of soft furnishings. Bedrooms were quite spacious with double beds in some rooms. There were hand basins in the bedrooms; patients had to use one of three communal bathrooms and toilets.

There were several ligature points (places to which patients intent on self-harm might tie something to strangle themselves) throughout the building. Within any rehabilitation setting, patients are being prepared to move on to their own accommodation or community living. Therefore, we would expect patients to have exposure to more risks within the environment. It is still important for hospitals to have plans in place to mitigate ligature risks. At the last inspection in December 2014, there was no ligature or environmental audit or action plan in place. At this inspection there was a "daily environmental risk register identifying ligature points throughout the building and how they are managed" document which provided examples of what a ligature point may be including handles, light fittings and curtain rails and then a list of rooms that they may be in. Staff were expected on each day and night shift to date, tick and sign to say that had checked all ligature points. However, it was not clear of the purpose of the request, there were no specific points listed for the hospital, it did not identify the ligature points in each room and did not specify how staff should mitigate the risk. Therefore, staff were not provided with the information required about the environment to ensure they were keeping the patients safe.

There were several concerns with the clinic room and medicines management. The clinic room was small. There was a sign on the clinic room door to advise that the oxygen was stored in the clinic. However, the oxygen and defibrillator were actually stored in the staff office. This meant if there were bank, agency or new staff working who needed to locate the oxygen in an emergency, it would be delayed due to the inaccurate signage. In addition, if emergency services were called, especially the fire service they should be made aware of the location of oxygen due to its flammability. The medicines trolley was dirty with spillages on the trolley. There was no flumazenil stocked which is used for the reversal of the central sedative effects of benzodiazepines. National Institute for Health and Care Excellence guidelines [CG16] Published date: July 2004 Self-harm in over 8s: short-term management and prevention of recurrence advises, "If poisoning with benzodiazepines is suspected, flumazenil, given cautiously, can help reduce the need for admission to intensive care." We raised the above issues with the managers on the inspection who were going to address the concerns raised.

There were completed audits in place for the monitoring of the oxygen, resuscitation bag, medicine fridge and defibrillator.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

There was antibacterial gel and lotion available at the entrance to the hospital, which we observed staff using. Staff completed cleaning rosters. The hospital manager discussed any areas requiring attention or maintenance in meetings with the domestic and maintenance staff. We observed sections of the flooring in the laundry missing and torn seat pads on some chairs in the dining room, which would increase the risk of infection. We reviewed infection control and environmental audits, which did not identify the flooring and seat pads as a risk and requiring attention. The hospital had had an external review in preparation of the inspection, the report highlighted the flooring as a risk due to wear and tear, however, staff had not identified actions or put an action plan in place.

Nurse call systems were in bedrooms and bathrooms: once activated the alarm sounded in the staff office to alert staff assistance was required.

Safe staffing

Establishment levels within the hospital were four qualified nurses, two senior support workers and six support workers in the team. Due to the reduction in patient numbers and the hospital being at half of its capacity the staffing levels were one qualified staff and two support workers on each shift. If the hospital was full then there would be one qualified staff and three support workers on each shift.

Within the last six months, from February to July 2016 there had been 29 shifts covered by qualified bank nurses and 11 shifts covered by qualified agency nurses. This was primarily to cover annual leave. There were 29 shifts covered by bank support workers and five shifts covered by agency support workers. A qualified bank nurse covered a large number of the shifts and had access to the organisational training.

Staff sickness rate within the last six months was 1% and staff turnover rate for the same period was 20%.

The registered manager determined the staff structure and advocated for the new roles of senior support worker and senior nurse, which the provider accepted. The senior nurse left in January 2016 and the provider decided not to recruit to the post. The role of the senior support worker was to mentor support workers, provide one to one sessions with patients and assist with record keeping alongside the qualified nurses. The registered manager was able to adjust the skill mix and staffing levels for the service, as they deemed necessary, for example during the inspection, there was one qualified nurse and three support workers on shift.

Patients told us and records confirmed that one to one sessions took place with their named nurse. Patients could tell us who their named nurse was.

All patients had unescorted leave within the local community. Staff also facilitated activities including walking groups, the cinema and to play pool.

The responsible clinician attended the hospital once or twice a week to facilitate the ward rounds and care programme approach reviews. They were on call out of these hours and staff could contact them by phone or pager. In a medical emergency, staff would contact emergency services.

Qualified nurses received training in immediate life support however, the compliance manager told us that it had expired due to a change in training provider and that qualified nurses were due to attend the training in September 2016.

Mandatory staff training levels that were below 75% were:

- Food hygiene 68%
- Care plans and risk assessment 47%
- Communication and record keeping 58%
- Emergency first aid 63%
- Epilepsy awareness 53%
- Fire awareness 53%
- Health and Safety 47%
- Infection control 68%
- Moving and Handling 35%
- Mental health awareness 63%
- Oxygen and defibrillator 58%
- Physical health monitoring 53%
- Safe handling of medicines for qualified staff 60%
- Safeguarding vulnerable adults 58%

Recently the provider had introduced eLearning for mandatory courses. Staff raised concerns about the moving and handling training in an eLearning method rather than practical.

Assessing and managing risk to patients and staff

Brook House did not have a seclusion room. There were no reported incidents of seclusion, segregation or restraint. If

patients' mental state deteriorated and they became aggressive or agitated and the hospital could not meet their needs, the hospital would seek support from the local acute wards and arrange an admission. This had happened with a recent patient.

We reviewed six care records. All records had a current risk assessment in place including a risk screen. However, there were no risk management plans in place. This meant there were no recorded strategies as to how to manage individual patient risks.

We identified two blanket restrictions in use in the hospital. Staff locked cutlery away and counted it in after use. Staff were unable to explain why this was in operation, they felt it may have linked to the risk posed by a past patient. The hospital had not reviewed this practice. The hospital did not allow patients detained under the Mental Health Act to hold their own lighters, which was not individually risk assessed. We felt the blanket restrictions were not proportionate to the hospital setting and patient mix at the hospital and did not promote a rehabilitative approach. CQC raised concerns at the last inspection, in December 2014 regarding local rules and restrictions that managers could not explain the rationale for and the hospital manager had not addressed or reviewed this.

There was one informal patient, he understood his rights and knew he could leave at will, however as the building was locked and he did not have a fob to enter or exit the building he was dependent on staff letting him in and out of the building.

All policies were beyond their review date. The majority were due for review in March 2015. The hospital had a "ligature and self-harm policy" which was undated. The policy had an appendix to it called "self-harm and ligature risk assessment" which included areas of the hospital, self-harm and ligature risks identified, level of risk, control measures and review date. The expectation of the policy was that the unit manager, clinical lead and health and safety advisor would complete the risk assessment every six months. The hospital manager was not following this policy and had not completed the risk assessment; instead, they had created their own document, which was not fit for purpose.

The enhanced observations policy, dated March 2013 due for review March 2015 referred to levels of observation of level one; being with the patient at all times, level two; close proximity to patients, noting observations every 15 minutes and level three observation; observing every 15 minutes. The policy did not include a definition of general observations. All patients detained under the Mental Health Act were on general observations, which staff recorded every hour. We reviewed the observation records and staff were completing the observations and records appropriately, however they did not have any guidance to follow.

Staff attended safeguarding vulnerable adults training, with only 58% staff completion. However, staff we spoke with could explain what constituted a safeguarding concern and how they would escalate their concern for the manager to report to the safeguarding team.

We reviewed the clinic room and all the prescription cards. At the last inspection in December 2014, we found medicines supplied by different manufacturers with different batch numbers and use by dates stored within the same package; we reviewed all medicines and found this had been fully resolved. However, we found medicines for the patients in the service next door were stored in Brook House fridge including opened eye drops from Jan 2016 and insulin pens from March 2015. This contravenes the provider's "medication policy and procedure" dated March 2013, which states eye drops, should be discarded after 28 days. There were also medicines in the controlled drugs cupboard for a patient who was discharged at the beginning of July 2016; the hospital manager reported that they were waiting for the pharmacist to collect them. There was also patient information leaflets stored within the boxes of different medication, which could pose a risk if staff or patients read this believing it was for the medication in the box.

The doctor who had completed the prescription cards had poor handwriting and it was difficult to decipher. This posed a risk of staff giving the wrong medicines to patients. There was also one example of a medicine on a patient's prescription card, which was not included in their T3. (A T3 is a Certificate of second opinion. It is a form completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs, or has not consented to treatment, but that the treatment is necessary and can be provided without the patient's consent.) We escalated this as a priority and the doctor visited the hospital to rewrite the prescription cards and print the name of the medication to make it legible.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The General Medical Councils "good medical practice" 2013 states that "documents you make (including clinical records) to formally record your work must be clear, accurate and legible." The prescription cards did include allergies of patients. The medicine cards had been completed correctly by the qualified nurses with no missed doses or blank entries.

Controlled Drugs (Supervision of Management and Use) Regulations 2013 advises that the controlled drugs accountable officer "should ensure: up to date standard operating procedures in relation to the management and use of controlled drugs, which cover (amongst other matters) best practice relating to (i) the prescribing, supply and administration of controlled drugs, and (ii) clinical monitoring of patients who have been prescribed controlled drugs." The medication policy and procedure dated March 2013 referred to the Misuse of Drugs (Safe Custody) Regulations 1973 for the storage of controlled drugs however did not refer to other more recent legislation including Controlled Drugs (Supervision of Management and Use) Regulations 2013 and The Misuse of Drugs Regulations 2001. The provider could not be assured staff were using current guidance.

Track record on safety

The hospital had not had any serious incidents in the last 12 months. Therefore, staff could not share any examples of learning from serious incidents or changes in practice as a result. There had not been any learning shared from other parts of the organisation.

Reporting incidents and learning from when things go wrong

Staff were aware of what constituted an incident or an accident and how to report it. We reviewed the incident and accident forms. The hospital manager completed a monthly incident and accident summary report and submitted this to the directors. The report highlighted the number and nature of incidents and accidents, summary of the incident, strategies put in place, any additional training for staff and any policy and procedural change. The hospital had three incidents in January 2016, one in February 2016, two in March 2016, one in April 2016, none in May 2016 and one in June 2016.

Debriefs took place following incidents. The hospital manager completed a post incident/accident debrief checklist. Questions on the checklist included: had a debrief taken place, precedents to the incident, good practice, areas to improve, had the patient had a debrief, had the care plan and risk assessment been updated. Staff involved in the incident or accident completed a debrief form, capturing what happened, good practice, areas to improve and a one to one with the patient. Dependant on the nature of the incident determined who was involved in the debrief, sometimes it was a support worker and qualified nurse and where the incident was more serious the hospital manager was involved. We reviewed the incidents and accidents from 2016 and found that they all had debrief forms completed and the hospital manager had reviewed each incident and completed the checklist.

Staff told us and records confirmed that there was not a formal process within the organisation by which important lessons to be learnt from incidents could be disseminated to staff.

Duty of Candour

The provider had a duty of candour policy, dated November 2015. However, the policy was not compliant with Regulation 20 of the Health and Social Care Act. It did not include that the apology must be in writing to the individual and did not explain the definition of moderate and severe harm. The policy did not give staff guidance on how to complete the investigation or any timescales they had to adhere to.

Staff we spoke to had not heard of the duty of candour.

The hospital manager was aware of what the duty of candour was, however, advised they had not had any incidents or accidents that met the requirements for duty of candour.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We reviewed six care records. All contained pre admission reports; assessments completed by the hospital manager and another member of the clinical team prior to admission.

Records also contained a patients' rights charter which was:

- I have the right to be treated with respect as an equal human being
- I have the right to acknowledge my needs as being and equal to those of others
- I have the right to express my opinions, thoughts and feelings
- I have the right to make a mistake
- I have the right to choose not to take responsibility for other people
- I have the right to be me without being dependant on the approval of others

There was no evidence of staff completing physical health examinations on admission.

All records contained up to date care plans however, they were nurse led and contained language that was not accessible or meaningful to patients. Staff did not write individually tailored interventions in the care plans and would use words as encourage and engage with the patient but not advise staff of how to do so. Patients had completed recovery stars in three of the records reviewed however, one patient declined to complete this on a second occasion. The recovery stars were stored within recovery folders, separate to the clinical records and the information recorded by the occupational therapy team conflicted with the clinical records, for example, advising a patient should attend fortnightly community meetings when they were monthly.

There was one patient prescribed antipsychotic medication above the British National Formulary limits. This patient did not have a care plan in place in relation to high dose antipsychotics and what staff need to consider and be observant for in relation to side effects and additional monitoring required.

Patients had pre discharge plans in place, however staff did not review them and feedback from the registered manager was that patients were not ready for discharge so the plans did not need reviewing. The plans did not include what steps patients had to achieve to reach their goal. Staff reviewed other care plans however, they did not change and usually had no change recorded. The hospital stored all patient records securely, locked in the staff office.

The daily records for patients did not include information about support provided by staff or the activities that patients had pursued. They referred to care plans in place which were numbered and advised whether there were any issues in relation to these, for example; "CP5 no issues with medication" .The notes advised patients had not attended to their personal care but did not show any staff intervention to support patients and encourage this. This meant it was difficult to monitor progress of patients and interventions provided.

Best practice in treatment and care

National Institute for Health and Care Excellence guidelines [CG185] Bipolar disorder: assessment and management Published date: September 2014 advises, "people with bipolar disorder, especially those taking antipsychotics and long-term medication, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider and routinely monitor weight and cardiovascular and metabolic indicators of morbidity in people with bipolar disorder." The hospital offered a variety of meals, which were balanced and nutritious. Staff took the weight, waist measurements, blood pressure and pulse of patients on a monthly basis and recorded where patients refused.

There was little evidence of physical health promotion. The 2016, Department of Health publication: Improving the physical health of people with mental health problems: Actions for mental health nurses, advises that staff should support patients with stopping smoking, tackling obesity, improving physical health levels, reducing alcohol and substance use, sexual and reproductive health, medicine optimisation and dental and oral health. We could only find evidence of staff offering walking groups to patients to increase their physical activity and support to visit their GP regarding smoking cessation and no other evidence in relation to the above recommendations.

We found detailed care plans in place for people with diabetes, including early warning signs for staff to indicate if a patient was becoming hypoglycaemic or hyperglycaemic. Support included diabetic eye screening,

referrals for podiatry and the nutrition and diabetic service. As recommended in the National Institute for Health and Care Excellence guidelines [NG28] Type 2 diabetes in adults: management published date: December 2015.

The occupational therapy team completed an initial assessment of patients and an interest checklist to identify potential activities patients may be interested in pursuing. The model of human occupation screening tool was in use and the occupational therapy team made recommendations including patients attending community meetings and participating in cooking sessions. Two of the three recovery files we reviewed had two weekly activity planners in place for patients, which included activities that they pursued independently.

The hospital had a variety of internal audits in place including reviews of patient's files. Staff had completed resuscitation and oxygen weekly checks, which had not identified incorrect signage of the location of oxygen. Staff completed daily fridge checks and records showed that the temperatures were all within limits. Staff completed defibrillator checks daily with details of when to order new pads.

Skilled staff to deliver care

The hospital had nurses, support workers, a social worker, occupational therapist and occupational therapy assistant providing input into the service. A local pharmacist provided the pharmacy service and the provider would soon be changing.

Staff received the organisational induction including eLearning courses and mentorship from a more experienced staff member to orientate them to the hospital. We reviewed 14 supervision files and found staff were receiving supervision every two to five months. The provider had an "employee guidance performance appraisal and development" policy and procedure, dated March 2013 which stated, "your line manager will meet with you regularly for supervision." The policy did not specify the expected frequency of supervision. The provider sent an updated version of the policy dated December 2015, which included more information about the appraisal cycle, however still stated, "your line manager will meet with you regularly for supervision." The hospital manager thought the frequency of supervision was every three months. Staff had varied understanding of the frequency of supervision, with some reporting every month, others every three months and others every six months. In 12 of the 14 files we reviewed staff had had an appraisal.

Clinical team meetings took place with the hospital manager, qualified nurses and members of the multidisciplinary team every one to three months. The agenda included nurse's files, patient care, Mental Health Act documentation requirements, training, new referrals and staffing. Monthly staff meetings took place with support workers, qualified nurses, and the hospital manager. Agenda items included the upcoming inspection, proposed changes to the service, training, audits and a recent whistle blowing.

Additional training offered to staff included alcohol and drugs awareness, with 53% staff completion and diabetes awareness with 21% completion. Staff identified there was no specific training in relation to rehabilitation and recovery. Staff reported there were no development opportunities within the organisation including accredited courses to support their progression including National Vocational Qualifications and Regulated Qualifications Framework which are accredited work based training courses.

The hospital did not provide training on the Human Rights Act as recommended in National Institute for Health and Care Excellence guidelines [NG10] Published date: May 2015 Violence and aggression: short-term management in mental health, health and community settings.

There were no examples of staff being performance managed however; there was an example of a complaint from one member of staff about another being resolved via mediation.

Multi-disciplinary and inter-agency team work

Ward rounds for patients took place weekly however; the responsible clinician discussed the patients on a fortnightly basis, with half the patients discussed each week. There were concerns about the frequency of the ward round days being changed at very short notice by the responsible clinician, often on the day which resulted in patients not being prepared, the independent mental health advocate not being present and family or external professionals not being able to attend. The social worker, occupational therapist, nurse and Mental Health Act administrator attended the meetings in addition to the patient and

responsible clinician. We observed a ward round which had been changed on the day, therefore the advocate was not present. Staff did not discuss risk assessments and care plans within the ward round. Feedback from a patient was that staff were doing things for him rather than enabling him to do things for himself. The multidisciplinary team had identified one patient as needing psychology input however; staff had not made a referral. Support workers were not involved in the ward rounds when they provided the majority of the care for patients. The responsible clinician wrote a summary of the ward round in the daily notes however, this was difficult to read due to their handwriting.

Staff and patients reported that their home team care coordinator attended their care programme approach reviews. We were told there were variable relationships with care coordinators in relation to future plans for patients. The hospital advocated that some identified future placements were not appropriate for patients. A number of patients had moved on from the hospital in the last six months.

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

Staff we spoke with understood their role in relation to the Mental Health Act including the section status of patients, support to complete section 17 forms, provide copies of forms to patients and sign patients in and out of the building. Staff had access to copies of the Mental Health Act Code of Practice, published 2015. None of the required policies and procedures required to be in place following the publication of the Code of Practice in April 2015 were available.

Staff reported receiving training in relation to the Mental Health Act but not the revised code. Staff training compliance in mental health awareness was 63%.

Records showed little evidence of discussions with patients regarding their capacity to consent to treatment, upon admission to the hospital, or when a new form T2 (a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it.) Or T3 (a certificate of second opinion completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent) was being completed. Most patients had medication authorised by a second opinion appointed doctor and the hospital had sought such authorisation in a timely manner. Consent to treatment forms were attached to the prescription cards. All T2 and T3 forms except one were completed appropriately. One patient's medication chart specified as required (PRN) medication that was not authorised by his associated form T3. This medication had, however, never been given to the patient. The responsible clinician rectified this two days after we raised the concern, when they returned to re write the prescriptions.

We saw evidence of the regular attempt to explain to patients what their rights were whilst detained and we saw evidence of staff supporting patients to prepare for tribunals or managers' hearings they were to attend.

Patients were routinely and positively involved in discussions about their section 17 leave and supported to determine where they could take their leave. Patients completed part of the section 17 leave form prior to the authorisation of the responsible clinician. This was positive progress as at the last inspection, in December 2014 we identified concerns, as conditions of patients' leave were not clearly recorded. However, in two of the five leave forms examined there was no evidence that staff had offered or given a copy of the section 17 form to patients. Patients had to complete a "self risk assessment and risk management plan" prior to going on unescorted leave, which included where they were going to and the purpose and the time of return and their risks and how they would reduce the risk and the clothes that they were wearing which the patient signed and also a staff member.

The hospital had their own Mental Health Act administrator who organised the legal files to a high standard and attended the weekly ward rounds to take minutes. However, they worked in isolation, as their role was unique in the organisation. They were in the process of seeking peer support externally from the organisation, which the hospital supported.

At the last inspection in December 2014, there was a concern that detention paperwork was not available to all staff. The provider had fully resolved this and all staff knew where the paperwork was, and had access to it.

The Mental Health Act administrator scrutinised all documentation relating to newly admitted patients. They

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

were in the process of developing a checklist to record this. We also saw evidence that reports for tribunals and managers' hearings were thorough and prepared in a timely manner. However, staff told us that the responsible clinicians' reports were often late in their production.

The independent mental health advocate was very pro-active in terms of her involvement with patients and met with all new patients to explain her role. The advocate visited the hospital weekly, usually on the day of the ward round and on additional days if required by patients, for example to support patients in their care programme approach meetings. The advocate was regularly involved in supporting four of the six patients. We met with the advocate and it was evident how well they knew the patients. One patient also asked the advocate to be present in our meeting with the patient and the advocate was able to ensure the patient understood the meeting and shared their views. The hospital had posters displayed on walls explaining to patients how they could make direct contact with the independent mental health advocate. Staff had participated in training sessions facilitated by the independent mental health advocate to clarify the role and function of the independent mental health advocate.

Good practice in applying the Mental Capacity Act

Staff attended training in the Mental Capacity Act with 95% completion.

There were no patients subject to Deprivation of Liberty safeguards and the responsible clinician advised the last patient subject to Deprivation of Liberty safeguards was over two years ago.

Staff had variable knowledge of the Mental Capacity Act. The hospital manager could not explain the five statutory principles of the Act or that you assume capacity until proven otherwise. However, five of the nine other staff we spoke with were able to explain the principles and that capacity is decision specific.

The provider had a Mental Capacity Act policy, dated March 2016. The policy included the key principles, assessment of capacity being decision specific, advanced decisions, the role of the Independent Mental Capacity Advocate and how and when to assess capacity. There were a few typographical errors within the policy, particularly in the section called "when should capacity be assessed" which could cause confusion. The policy stated that health and social care staff could conduct capacity assessments however; the hospital manager advised that they would refer capacity assessments to the patient's home team. This could cause a delay and would not always be necessary. The updated policies were not present at the hospital and available to staff.

The provider had a policy on the Deprivation of Liberty Safeguards, dated May 2016. The policy explained how to apply for a Deprivation of Liberty Safeguard, including the difference between an urgent and standard authorisation.

We reviewed six care records and found little evidence of the utilisation of the Mental Capacity Act within case files, even where a patient's capacity to consent to a particular decision was relevant. One patient's mother was managing their finances. We could not find any evidence within their records that an assessment of capacity to manage their own finances had been completed or that a best interests meeting had taken place to determine if it was in their best interests for the mother to manage their finances. This meant staff were not following the recommendations of the Mental Capacity Act.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

We observed warm, positive and nurturing interactions between staff and patients. Staff knew patients well including the independent mental health advocate. They were able to give an overview of the patients' needs and their future plans.

We spoke with five patients. All patients reported staff were friendly, caring and respectful, they knocked on their doors prior to entering their room. Patients reported staff would make time to listen to them.

The involvement of people in the care they receive

There was no written information provided to patients upon admission, there was a historic service user guide, which was not in use as it contained information regarding the previous manager and other out of date information. The hospital manager advised they were waiting for staff at

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Requires improvement

the head office to update the document. However, the compliance manager confirmed it was the role of the hospital manager to ensure the information was available for patients. On admission, patients received a tour of the ward and staff verbally gave patients information about the hospital.

We reviewed six care records and found that care plans were nursing focused. Patients' perspectives were included in some of the care plans however they did not include unique support needs of patients, including how best to support them and what their coping strategies were. Care plans were quite general and included phrases such as encourage and offer support without specifying how staff should do that. Two of the patients we spoke with could explain the content of their care plans and discharge plan. Three patients told us they were involved in writing their care plans or staff had shown them their care plans.

One patient had a care plan in place for shadowed local leave. He was not aware that he was being shadow whilst on unescorted community leave. Records reported he refused to discuss the care plan. The evaluation sheet captured no concerns however; staff had not reviewed or discussed this with the patient.

Patients had access to advocacy. Details of how to contact the advocate were on display within the hospital. The advocate visited the hospital weekly, usually on the day of the ward round and on additional days if required by patients, for example to support patients in their care programme approach meetings. The advocate was regularly involved in supporting four of the six patients.

If it was the patients' wish, they invited family and carers to their ward rounds and care programme approach meetings. One patient's mother was heavily involved and managed his finances for him. Another patient had overnight leave to stay with his family.

The hospital manager had sent a service user questionnaire to patients on 25 April 2016 with the focus on food and activities. Six out of nine questionnaires had been returned. Patients gave feedback in relation to food they liked and did not like and other food they would like to have on the menu. The outcome in relation to activities was that the hospital identified they needed to inform patients of how they can get involved and what activities were available.

The hospital manager sent another service user questionnaire to patients on 9 May 2016. Eight out of nine questionnaires had been returned. Questions included how happy patients were at the hospital, three patients reported they were happy, four reported they were ok and one patient was not happy. All eight patients felt staff treated them with dignity and respect. Six patients said they knew how to complain and two did not. Six patients were aware of their care plans and two patients reported not being aware of their care plans. The hospital manager completed a summary regarding the feedback of the questionnaires and advised patients of how to complain about the service if they needed to.

Community meetings took place on a monthly basis. We reviewed the minutes from the last six months. We noted significantly more staff attended than patients, on one occasion there were seven staff present and two patients. This may have had an impact on patients feeling it was their meeting and their ability to voice their opinions. There was a standard agenda including points raised at the last meeting, actions, food, maintenance, activities, complaints, advocacy and any other business. There were occasions where staff did not identify actions from previous meetings, did not review them or note them at the following meeting. Staff were not completing some actions. Some of the patients we spoke to told us the meetings were boring. The social worker was about to take over chairing the meetings.

There were no examples of patients being involved at a senior level within the service, for example by recruiting staff.

There were no advance decisions in place for patients. CQC highlighted this at the last inspection in December 2014, along with the need for patients to be involved in the development of their care plan and care pathway.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Patients were from Trafford, Salford and Manchester. The hospital was at 50% occupancy. There had been a number of patients moving on from the service within the last six months with no new referrals to the service. Due to the reduction in referrals and changes in demands from commissioners, the provider had made the decision to close the service as a hospital and reconfigure the service to join the service next door and offer nursing care. Staff were going through the consultation process and commissioners had been contacted regarding the future of the six remaining patients. However, the provider had not discussed this with patients or the advocate. We highlighted this with the managers to ensure this happened as a priority.

Commissioner's views of the service were that historically they were not proactive at moving patients on. At the last inspection in December 2014 CQC identified the need to improve the written plans and pathways to promote recovery, rehabilitation and discharge. Including patients knowing what steps they had to achieve to progress from the hospital. The hospital manager had created "Brook House flowchart for rehabilitation patient pathway" in 2015. The pathway included referrals to the service, 28 day trial period of assessment, ongoing evaluation including which assessment tools would be used, full admission to Brook House with the guideline length of admission between 12 and 18 months, input from the social worker and occupational therapy department, recovery model and identifying outcomes, transitional period to the annex ideally within nine to 12 months, then progress to a Community Treatment Order with the aim of being in the annex for six months to develop skills for independent living then discharge from the service.

We spoke with one patient who had been living in the annex. However, due to the building work taking place he had to move back into Brook House and had not been able to practice his skills, he did not do his own cooking whilst at Brook House and could not come and go freely without asking staff to let him out of the hospital. He had been at the hospital for over five years. Of the three records we case tracked, one patient had been at the hospital over five years, another for 22 months and another for just over a year.

Although we saw evidence that in five of the six files examined a discharge care plan was in place, such plans were non-specific in their approach and did not specify the potential timing or location of eventual discharge. Care plans were also unclear as to what patients needed to do to achieve step down or discharge from the unit. When asked about the review of these plans, the hospital manager advised that staff had not reviewed the discharge plans, as patients were not ready for discharge. The data provided by the hospital prior to inspection advised they had had two delayed discharges from November 2015 to April 2016 due to finding appropriate future placements.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital was homely and welcoming, with a large sized lounge, large dining area which incorporated a conservatory and an area for patients to access hot and cold drinks, snacks and fruit. There was a quiet lounge available for use and good use had been made of the large landing with chairs and tables to provide other quiet areas for patients to use. There was a pleasant large garden, which patients primarily used for smoking. Access to this was open throughout the day from eight in the morning to midnight, and the hospital provided a shelter for patients who smoked. Patients and staff told us there had recently been a barbeque in the garden to celebrate a patient's birthday. There was a small clinic room; however, there was enough space to administer medicines to patients. In addition, there was a portacabin building where members of the multidisciplinary team had offices and there was a large meeting room, which the hospital used for ward rounds and care programme approach meetings.

Patients had keys to their bedrooms and where they declined this, they signed to say they had refused. Patients were able to personalise their bedrooms. Patients were able to keep and use their mobile phone, but access to the internet was not routinely available to patients. There was no computer within the hospital for patients to use.

In the entrance hall there was a planner of weekly activities available, however this did not indicate when the activities occurred. We explored this with the occupational therapy assistant who advised it was out of date and needed removing. Trips out had taken place to Blackpool and the park. The majority of patients had progressed within their time at Brook House and were pursuing activities in their local community independently. The occupational therapy assistant had created a plan to show times of activities available in the local community. These included leisure centres, exercise and a local social enterprise specialising

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

in offering support to people with mental health needs including psychological support and access to a variety of other activities including computers, a community café, music and gardening.

Activities based within the hospital had declined; staff and patients told us this was partly due to the reduction in patients, lack of interest from patients and patients being more independent. Support staff did facilitate walking groups, pool groups and trips to the cinema. The occupational therapy staff offered cooking and baking sessions and regular one to one sessions were taking place with a patient to develop their maths and budgeting skills. Staff told us one to one sessions were more productive than group activities where there was less interest from patients. There were no regular activities taking place in the hospital at weekends however, a number of patients utilised their unescorted community leave and one patient had overnight leave to stay with his family.

Patients reported the food was good and that the chef had made changes to the menu from feedback from patients via the feedback questionnaire and community meetings. This included specific dishes from certain cultural and ethnic backgrounds.

Meeting the needs of all people who use the service

The hospital building had low-level access and there were downstairs bedrooms available for people with mobility difficulties.

Leaflets were all in English, which was appropriate for the patient mix however; staff could access interpreters and translation services if required.

The service had supported patients to explore their faith and had provided support to enable a patient to visit a mosque. The quiet lounge was available for use to pray and staff used this for prayer. There was a multi faith calendar on display in the hospital to assist with planning for cultural and faith events.

The notice boards had a variety of information on for patients including staying safe in the sun, how to complain and a suggestions box, ward round days, how to contact the CQC, MIND Leaflet on street drugs, clozaril leaflet, solicitor's advert regarding appealing to the Mental Health Review Tribunal and an advocacy service board including contact details for the advocate.

Listening to and learning from concerns and complaints

The provider had a complaints policy, last reviewed in September 2013. The policy explained the complaints process and included timescales for investigations and acknowledgements to complainants. The hospital manager completed a complaints and compliments log, which included the name and contact details, date received, reference number, person dealing with the complaint or compliment, summary including actions taken and date resolved. The hospital had not had any complaints in 2016; they had received one in 2015 and four in 2014. We reviewed the complaints file and found that timely investigations took place, meetings with appropriate people and complaints reviewed and an outcome communicated within timescales. The hospital had received one compliment in 2016 from a parent about the care provided by the hospital to her son.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Vision and values

At the presentation to the inspection team, the hospital manager described the providers core principles as:

- Treat all our service users with respect and dignity.
- Deliver recovery through activity, inclusion and lifestyle.
- Be adaptable and flexible to service user needs.
- Be dedicated, professional and proactive.
- Maintain a clean, safe and homely environment.

The service aims were described as:

- To promote independence within a safe and therapeutic environment.
- To rehabilitate within a caring, supporting and homely environment.
- To reintegrate back into community living.

Staff reported directors and senior staff visiting the hospital however, they did not interact with staff.

Good governance

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff attendance at mandatory training was low, with the majority of the courses completed attendance at below 75%. The provider had recently introduced eLearning courses to increase compliance; however, staff felt that face-to-face training was more beneficial as you could explore areas and ensure your understanding.

Staff received annual appraisals and six monthly reviews. Supervision took place at variable frequencies from every two to five months; the policy stated supervisions should be regular with no specified frequency. This meant staff could have long gaps between supervisions.

There were a variety of clinical audits in place, however they were not always meaningful and did not feed into any meetings or follow best practice. For example there were clinical record audits completed which were also discussed at the clinical team meetings and no concerns were identified however, we found care plans were not patient centred and did not provide steps that patients had to achieve to progress from the hospital. At the last inspection, in December 2014 CQC raised a concern that the hospital should improve clinical governance and audit system to ensure there was a more focused and streamlined system in place. We reviewed minutes from clinical governance meetings, found these to be brief with updates and summaries on maintenance, training, appraisals, forums in development, information management, records, revalidation, duty of candour and controlled drugs. The only reference in relation to audits was for occupational therapy audits, which were in development.

There was no evidence of learning from incidents from across the organisation at the clinical governance meetings. Staff were not aware of any learning from incidents at the hospital and meeting minutes did not show any lessons learnt.

Staff were knowledgeable in relation to safeguarding vulnerable adults and understood the process for escalating concerns.

The provider did not use any key performance indicators to monitor performance. The only data submitted to senior managers was the number of incidents, accidents, complaints and compliments on a monthly basis. Recently the provider had introduced a human resources electronic dashboard, which showed managers the sickness levels, vacancies and turnover rate of the service.

There was no dedicated administration support for the hospital; we observed the hospital manager delegating administration tasks to support workers.

Policies at the hospital were all out of date, mainly from 2013. However, when we requested additional policies from the provider, the version they sent were reviewed and updated in 2015 or 2016. The hospital did not have the most recent version of policies and procedures available for staff to refer to. The policies required by the Mental Health Act code of practice, published in 2015 were not available. There was no written information available for patients upon admission to the hospital to orientate them to the hospital and provide important information including contact details. When explored with the hospital manager they advised that it was the role of the senior managers and directors to complete. However when discussed with the compliance manager they felt it was the role of the hospital manager to complete.

The hospital manager was on call out of working hours, if staff needed assistance or guidance they would ring the hospital manager's works phone. When the hospital manager was on leave the registered manager from the service next door would provide the on call cover. However, the neighbouring service was a residential care home and not a hospital. Therefore, the registered manager may not have had the skills and knowledge to perform this function.

Leadership, morale and staff engagement

In the last six months from January to July 2016, sickness rates within the hospital were one percent. Staff turnover rates were 20%. Due to the reduction in staff on shift and the hospital being at half capacity, the provider had decided not to recruit to the posts.

Staff reported they would raise concerns to their immediate manager first, for support workers this would be the nurse in charge and for qualified nurses this would be the hospital manager. CQC had received one whistleblowing in February 2016; the hospital manager provided a prompt detailed response. However, in the review of team meeting minutes we noted references to the whistleblowing advising staff to contact their manager first and then the head office prior to going to CQC. The minutes clearly said contacting CQC should be as a last resort. The culture in

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

the hospital did not promote a learning and developmental culture. We observed staff being given instructions and spoken to sharply in our presence when discussions should have taken place in private.

Staff felt unable to progress within the organisation with limited opportunity for development including no opportunity to complete National Vocational Qualifications or Regulated Qualifications Framework.

The clinical team worked well together and were knowledgeable and responsive to patient's needs.

There was very limited understanding of the duty of candour within the service and the policy did not comply with the regulations.

Team meetings minutes showed a culture of information giving not two-way communication and consultation with the staff team.

Commitment to quality improvement and innovation

The hospital was not involved in any research or quality accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must create an environmental risk assessment, which identifies the ligature points within the hospital and how staff should mitigate the risks. This should comply with the hospital's "ligature and self-harm policy"
- The provider must ensure they have a sign to show the accurate location of the oxygen.
- The provider must ensure that the appropriate emergency medicine is available for patients including flumazenil.
- The provider must review the risk assessment tool used to consider the incorporation of a risk management plan to provide guidance to staff should a risk present.
- The provider must ensure that staff receive training so that they have the knowledge and skills to undertake their roles, including Mental Health Act Code of Practice, 2015.
- The provider must review the blanket restrictions of locking cutlery away and not allowing patients to hold their own lighters and should individually risk assess any restrictions.
- The provider must review their observation policies to ensure that it includes patients on general observations, and the expectations on staff.
- The provider must review their medicines management policy to ensure it reflects current practice including controlled drugs.
- The provider must ensure that the policy on the duty of candour complies with the regulation and ensure staff are aware of duty of candour and their role in relation to this.
- The provider must ensure the most recent version of policies are available to staff at the hospital.
- The provider must ensure they assess patient's capacity to consent to proposed treatment, at admission and a review of treatment including the creation of a new form T2 or T3. The assessment must be recorded within the patient records.
- The provider must ensure that all patients are offered a copy of their section 17 leave forms.
- The provider must ensure they advise the advocate, patients, family and other professionals to changes in ward rounds and keep changes to a minimal to reduce the impact on patients and those advocating on their behalf.
- The provider must ensure that all required policies and procedures identified in the Mental Health Act Code of Practice, published April 2015 are written and available.
- The provider must ensure they follow the Mental Capacity Act in relation to assessing patients' capacity to make specific decisions and follow the principles of best interests including meetings where appropriate.
- The provider must ensure that care plans are in place for patients prescribed high dose antipsychotics and what staff need to consider and be observant for in relation to side effects and additional monitoring required.
- The provider must ensure that care plans including discharge plans are reviewed to reflect current needs of patients and identify steps patients need to achieve to reach their goal.
- The provider must ensure there is written information available to patients at the point of admission to assist them to orientate themselves to the hospital and their expectations.
- The provider must review the appropriateness of the clinical audits in place and how they feed into the clinical governance structure.
- The provider must ensure there is a system in place to share lessons learnt with staff, including learning from other parts of the organisation.

Action the provider SHOULD take to improve

- The provider should review the flooring in the laundry and seating in the dining room and consider the upgrading of these to improve infection control.
- The provider should ensure they promote physical health promotion for patients including recommendations from Department of Health guidance.

Outstanding practice and areas for improvement

- The provider should review the Mental Capacity Act policy to remove the typographical errors and ensure the policy provides clear guidance of when staff should assess capacity.
- The provider should raise awareness with patients of advanced decision and offer support to patients to complete these if they wish.
- The provider should review their supervision policy to include the expected frequency of supervision.
- The provider should review the recording of daily records to capture interventions offered by staff and activities pursued by patients and progress made.
- The provider should review the training offered to staff to consider including rehabilitation, recovery, and Human Rights Act and review the appropriateness of eLearning training that may be better facilitated in a practical setting including moving and handling.
- The provider should ensure that their approach to supporting patients was one of enabling and skill development rather that completing tasks for patients.
- The provider should identify how they can access psychology for patients and refer as identified.
- The provider should ensure that they communicate and regularly review with patients their decision to shadow them whilst on leave and ensure the leave status reflects this.
- The provider should review their arrangements for community meetings to ensure the agenda is appealing to patients, the ratio of staff to patients present is not disproportionate, and actions reviewed at the following meeting.
- The provider should review the possibility of enabling patients access to a computer.
- The provider should update the information on display regarding activities available for patients to ensure it reflects activities available.
- The provider should review the development opportunities available to staff including vocational training courses.
- The provider should review how they consult with staff and involve them in the service design and delivery.
- The provider should review the arrangements for providing on call management advice out of office hours and communicate these arrangements to staff.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The responsible clinician changed the day of the ward round with very short notice, meaning patients could not prepare for the meeting, the advocate was not present and family and external professionals could not attend. Restrictive practices were in place including locking the cutlery away and not allowing detained patients to hold their own lighters. Care plans were nursing focused and the language used was not accessible to patients. A patient who had progressed to the annex facility had to move back to Brook House as there was building work in the adjoining service, whilst at Brook House he was not able to use his skills of cooking, all his meals were prepared for him and as an informal patient he had to ask the staff to let him out of the building as it was locked. Activities on display were out of date and did not reflect what was taking place. Discharge plans were in place for five of the six patients however, they did not include the steps patients had to achieve to progress from the service. Staff did not update or review the plans to reflect the progress with an individual. There was no written information provided to patients upon admission to assist them to orientate them to the service. This meant that patients were not receiving person centred care. This was a breach of Regulation 9 (1) (3) (b) (f) (g)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The daily environmental risk register was not fit for purpose and did not identifying ligature points throughout the building nor provide staff with guidance as to how they would mitigate the risks. There was no flumazenil stocked which is used for the reversal of the central sedative effects of benzodiazepines. Medicines for the patients in the service next door were stored in Brook House fridge including eye drops from Jan 2016, insulin pens from March 2015. This contravenes the medicine policy for how long it can be stored for before disposal. The doctor who completed the prescription cards had poor handwriting and it was difficult to decipher. Oxygen was marked as being in the clinic however; it was stored in the office. This meant that patients were not receiving safe care and treatment. This was a breach of Regulation12 (2) (a) (b) (d) (f) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Policies available to staff at the hospital were out of date. None of the policies required under the Mental Health Act Code of Practice were available. There was no evidence of learning from incidents at a hospital or provider level shared with staff.

This section is primarily information for the provider

Requirement notices

This meant patients were not receiving care from a hospital that was well led.

This was a breach of Regulation 17 (1) (2) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Training levels were low. The majority of mandatory training attendance was less than 75% completion including: 63% for emergency first aid, 35% for moving and handling 60% safe handling of medicines, 58% for oxygen and defibrillator training and 58% safeguarding vulnerable adults. Specialist training levels were low with training completion rates of 53% for alcohol and drugs awareness and 21% diabetes awareness. Staff did not receive training in the Human Rights Act, Mental Health Act Code of Practice 2015, recovery or rehabilitation. Qualified staff training in Immediate Life Support had lapsed. This meant staff did not have the necessary skills and knowledge to effectively support the group of patients. This was a breach of Regulation 18 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour How the regulation was not being met: Staff had limited understanding of the Duty of Candour. The Duty of Candour policy was not compliant with the regulation; it did not specify that people should receive a written apology.

This section is primarily information for the provider

Requirement notices

This meant there was a risk that patients would not know when the hospital had done something wrong that they should have apologised for and did not receive a written apology.

This was a breach of Regulation 20 (4)