Brierley Court Independent Hospital

Quality Report

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

Ratings

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

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

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

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

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 Brierley Court as requires improvement because

We had concerns about safety in this service. Ligature audits did not reflect the risks throughout the service. Actions identified in the fire safety risk assessment had not been actioned. Staffing establishment figures for registered nurses were too low. Risk assessments were not completed in line with the provider policy and not regularly reviewed. There were restrictive practices in relation to searching patients, locking of rooms and the garden area. Safeguarding notifications were not always made to CQC.

In care records, we noted no patient had a completed discharge plan. Accessible care plans were not in place for those who needed them.

Patients gave mixed feedback about the service. None of the patients we spoke to or who participated in the patient survey had been offered care plans and one did not know if they had any. None of the patients we spoke to or who participated in the patient survey were aware of a discharge plan.

The hospital had limited facilities in terms of rooms for therapy and activity. Patients were not engaged in sufficient meaningful activity to meet the target set by the provider. Patients were not having weekly individual sessions with named nurses in line with the provider's policy.

We did not feel that the service had a clear direction in terms of the model of care. Both the setting and some individual care plans were restrictive and did not reflect a rehabilitation setting, for example, the escort baseline risk assessments, the locked garden and laundry and the policy for random searching of rooms. Actions were not completed in a timely fashion, for example from provider compliance visits and risk assessments. We noted a reliance on dashboards which presented a different picture when the data relied upon for these was checked. We were concerned about oversight and monitoring in terms of admissions and whether patients' needs could be met by the service.

Summary of findings

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Brierley Court Independent Hospital

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

Summary of this inspection

Background to Brierley Court Independent Hospital

Brierley Court is an independent hospital in north Manchester. It was registered with CQC in October 2016 having changed provider.

Brierley Court provides care for men and women over 18 with a primary diagnosis of mental illness and/or personality disorder. The hospital is a locked rehabilitation service providing care for up to 21 patients. At the time of our inspection, the hospital had 10 patients, who were all detained under the Mental Health Act 1983. The hospital staff were also providing treatment to an informal patient living in the community.

Brierley Court provides the following regulated activities:

• assessment or medical treatment for people detained under the Mental Health Act 1983

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

There was a manager registered with the Care Quality Commission. The registered manager was also the accountable officer for the supervision, management and use of controlled drugs. However the manager was on long term leave and there had been no replacement accountable officer identified.

We have not inspected Brierley Court since Elysium Healthcare took over its management.

Our inspection team

The team that inspected the service comprised two CQC inspectors, a specialist advisor with a background in mental health nursing and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

Why we carried out this inspection

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

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.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with the interim hospital manager and regional manager;
- spoke with seven other staff members including a doctor, nurses, occupational therapist, psychologist and social worker;
- spoke with an independent mental health advocate;
- attended and observed one patients' daily planning meeting;
- looked at eight care and treatment records of patients;

Summary of this inspection

- carried out a specific check of the medication management including reviewing all medication charts; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received mixed feedback from patients during this inspection. Staff were generally described as friendly, respectful and polite, with one patient feeling some weren't. One patient said staff did not knock before entering their bedroom. Patients felt happy with the food, reporting that meal times were flexible and drinks and snacks were always available. There was positive feedback about the level of activities and sessions offered.

Patients were aware of the advocacy service and spoke positively of the service.

Patients had been unhappy with the provider ban on smoking with one noting they had suffered withdrawal symptoms and would go back to smoking and another noting the need for escorted leave to be granted before they could smoke. Patients complained about the ongoing problems with the heating and feeling cold.

One patient told us that whilst they were aware of how to complain they hadn't made any complaints as they felt nothing would get done. Another said they were aware of how to complain, but hadn't needed to and didn't think there would be negative repercussions if they did.

None of the patients we spoke to had been offered care plans and one did not know if they had any. None of the patients were aware of a discharge plan.

A patient survey reported similar mixed feedback. Three patients had participated, overall all three patients felt positive about their care, two rating this as very good and one excellent. All patients felt they were treated with respect and dignity. In terms of treatment, all patients felt they wanted more information about medication and side effects. None of the patients said they had been offered care plans or care programme approach minutes. None of the patients said their rights were read in a way they could understand. None of the patients said they knew how to make a complaint.

A carers survey had been completed in July 2017 but only two responses were received, both giving positive feedback about the service, although one carer expressed reservations about aspects of personal care not being addressed.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The ligature audits we saw had not been altered to show which risks were present in areas.
- The boiler and heating repairs were not completed in a timely fashion.
- Actions identified in the fire safety risk assessment had not been actioned.
- There were not sufficient registered nurses employed.
- Risk assessments were not completed to the provider policy and not regularly reviewed.
- There were restrictive practices in relation to searching patients and locked rooms and gardens.
- Safeguarding notifications were not always made to CQC as required.
- There were unexplained missed doses of medication.
- The controlled drugs accountable officer was on long term leave and no replacement was identified.

However:

- All areas of the building were clean and tidy.
- Medical cover was available through the day and at night.
- Staff we spoke to showed a good understanding of the duty of candour.

Are services effective?

Requires improvement

We rated effective as requires improvement because

- We did not see care plans in an accessible format for patients with a learning disability.
- There were communication assessments and health passports for patients, but these were poorly completed.
- There was no rehabilitative or recovery model in place at this service.
- Staff were not receiving regular supervision.

However:

- A practice nurse from another of the provider's hospitals carried out physical health assessments on admission and reviewed them every six months.
- There was a multidisciplinary team consisting of doctors, nurses, occupational therapist, a psychotherapist and a social worker.

Summary of this inspection

- Staff received an annual appraisal.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- None of the patients we spoke to or who participated in the patient survey had been offered care plans and one did not know if they had any.
- None of the patients we spoke to or who participated in the patient survey were aware of a discharge plan.
- Two patients felt staff were not visible or available, with one feeling the service was short staffed.
- One patient told us that whilst they were aware of how to complain they hadn't made any complaints as they felt nothing would get done.

However:

- We observed positive interactions between staff and patients during this inspection.
- Staff were generally described as friendly, respectful and polite.
- Patients were aware of the advocacy service and spoke positively of the service.
- One patient was currently involved in a real work opportunity having completed an application and interview process. They were receiving regular supervision and were well supported.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- In the eight records we reviewed, there were no discharge plans within these.
- The hospital had limited facilities in terms of rooms for therapy and activity.
- Some rooms, such as the laundry and rehabilitation kitchen, were locked and staff needed to open these for patients which meant patients could not complete their laundry or cook when they wished.
- There were garden areas, including a female only garden, but access to these was locked with staff needed to let patients use them.
- Patients were not engaged in sufficient meaningful activity to the target set by the provider.
- Patients were not having weekly individual sessions with named nurses as per the provider policy.

However:

Summary of this inspection

- The food was prepared on site and staff and patients ate together.
- The service could make adjustments if patients had mobility needs.
- All patients had a spiritual and cultural needs care plan. Food could be ordered which met religious or cultural needs.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We did not feel that the service had a clear direction in terms of the model of care. Both the setting and some individual care plans were restrictive and did not reflect a rehabilitation setting, for example, the escort baseline risk assessments which were from a secure setting, the locked garden and laundry and the policy for random searching of rooms.
- We found that actions were not completed in a timely fashion, for example from provider compliance visits, care and treatment reviews and risk assessments.
- We noted a reliance on information from clinical dashboards, these were not always correct when the data was checked and the data was not being acted on.
- We were concerned about oversight and monitoring in terms of admissions and whether patients' needs could be met by the service.
- Staff survey results suggested issues with the staff team in terms of respect, reliability, how unacceptable behaviour was tackled and positive culture.

However:

- Staff told us they felt well supported by the interim hospital manager.
- Staff were aware of how to raise concerns.
- Staff described good communication. They described feeling informed of developments in the company through staff meetings and newsletters.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff had a good understanding of the Mental Health Act and the associated code of practice. Mental Health Act training was part of the mandatory training calendar and 86% of staff were up-to-date.

Patients records showed that they had regular discussions with staff about their rights under the Mental Health Act. Reading of patients' rights was monitored in patient records. The provider target was for these to be read monthly but in the records we reviewed this had happened every two or three months.

We saw evidence that seven patients had exercised their right to appeal against their detention and the outcomes were recorded. However, for three patients, there was no record of their last tribunal date. One of these three had a future date scheduled. One patient had last appealed their detention over three years ago and the provider had not automatically referred this case to the tribunal as per the Mental Health Act Code of Practice section 37.39.

There was an independent mental health advocate who provided support to patients on request. The advocate visited every two weeks to ensure patients were aware of the support they could provide. Information about the advocacy service was displayed on notice boards.

The regional Mental Health Act administrator carried out audits of Mental Health Act documentation.

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy six per cent of staff had undertaken Mental Capacity Act 2005 training at the time of this inspection. Staff understanding of the requirements of the Act was adequate and they knew where they could seek advice. There was a policy that staff could refer to and the social worker provided guidance.

Staff carried out mental capacity assessments when there were doubts about the patient's mental capacity, for example, we saw one capacity assessment relating to managing finances. This meant that patients received appropriate support to help them make specific decisions.

There were no patients subject to the Deprivation of Liberty Safeguards and there were no pending applications.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
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 a three storey building with communal areas on the ground floor and bedrooms on the upper floors. External doors were locked with fob, number pad and key access for staff.

The layout of the building with accommodation across floors meant there were blind spots and areas with limited observation. There was mitigation for some of this in the form of parabolic mirrors, for example, on the stairs. Staff also completed a check of all patients' whereabouts and safety every hour. Increased observation levels were used if needed.

A ligature risk assessment was completed annually, with monthly audits completed by staff. The ligature audits we saw had not been altered to show which risks were present in areas. The full tool described a comprehensive listing of potential ligature points and these were meant to be crossed out or changed when areas weren't inspected. On the most recent audit, the rooms with anti-ligature specification appeared to have the same specification as a standard bedroom. There were also only 20 bedrooms listed when the service has 21 rooms. This meant that staff would not have an accurate tool to work from when assessing environmental or clinical risk for patient.

A nurse call system was in operation across the building.

The hospital had 21 single bedrooms but only ten were occupied at the time of this inspection. The environment and décor was dated and accommodation was cramped. There were not enough rooms, for example the dining room was used to see patients by professionals or used for visiting. There were not enough rooms available for multidisciplinary team members when they visited, for example to see patients for assessments or to complete reports. There were plans for an extensive programme of refurbishment to improve the premises, although this was only at the planning stage with no agreed start date. It was not clear whether this would provide enough space, but there were plans to reduce the number of bedrooms with most becoming en-suite. There were also plans to convert the top floor into two or three self- contained flats.

At the time of this inspection, there was major maintenance work being undertaken in the basement, with the heating system being replaced. There were portable heaters placed around the building. Following inspection, we learnt that this work had started in July 2017 and was completed in November 2017. The provider told us that during the period they maintained a heating supply and hot water supply, although at limited pressure. In September they purchased 11 portable heaters to increase room temperatures in addition to the heat provided by the boilers and then a further four portable heaters were brought in. Room temperatures were monitored daily and a record kept to ensure they did not fall below the recommended temperatures. However, patients had complained of no hot water for the two weeks prior to inspection and feeling so cold at night that they had gone to bed in clothing.

The hospital had male and female patients. There were arrangements for single sex accommodation that ensured

the safety, privacy and dignity of female patients. Bedrooms for males and females were located along separate corridors on different floors. The female corridor was accessible only by fob access and all female patients had their own fob. However, we did note feedback from a carer that following a patient losing their key and fob the door was left open. A fob entry system was due to be installed on the male corridor the week after this inspection. The manager confirmed that this was completed. Each corridor had additional bathrooms for use only by the patients on that corridor. There was a female only lounge adjacent to the female bedrooms. A female only garden space was available along with a mixed garden area.

A clinic room was clean and tidy. There was no examination couch available to examine patients. Patients could be seen in their own rooms. Equipment was available for routine physical healthcare checks. Medicines were stored appropriately including refrigerated medicines. Resuscitation equipment was stored in the nursing office with a defibrillator and grab bag available if needed.

All areas of the building were clean and tidy. Cleaning schedules showed all areas were regularly cleaned.

Environmental audits were completed annually and these were up to date. An external audit was completed by the provider every six months and included environmental audits. The last available report from April 2017 showed appropriate clinical and general waste contracts in place. The lift had been serviced and a contract was in place for an annual service. Servicing for gas and electrical installations was up to date.

A fire safety risk assessment was completed in August 2017. Regular fire drills were not being undertaken, general waste was not securely stored to prevent opportune fire setting and there was a large volume of paperwork archived in a store room on the first floor. There had been no servicing of extraction fans and ventilation and there was no fire compartmentation in the roof area. In terms of fire doors, intumescent strips around some fire doors were missing or painted over, some fire doors had closers missing or needing replacement and the rehabilitation kitchen had a door which was not a fire door and required replacing. There were not sufficient keys for the electric door override system.

Some of these issues had been rectified. However, the building still had false ceilings throughout the ground and first floor which could aid the spread of fire and the kitchen door had not been replaced. The plan for these was to be altered as part of a larger building wide refurbishment plan, however there was no scheduled start date for this. We shared our concerns with the fire service who visited and took action under their own powers issuing instructions to complete a new fire safety risk assessment and actions to be taken relating to fire detection systems, fire doors, emergency exit routes, fire resistant glazing and compartmentation of the building.

Safe staffing

The staffing establishment was for eight registered nurses and 16 healthcare support workers.

At this inspection, there were five registered nurses and 14 healthcare workers employed.

We reviewed the rota for the six weeks prior to inspection. The expected staffing for day shifts was for two registered nurses and three or four healthcare workers and at night for one registered nurse and two healthcare workers. On the day shifts there was generally one registered nurse in the weeks prior to inspection, with eleven day shifts out of a possible 42 shifts covered with two nurses. The manager was a registered nurse and told us they would cover breaks and assist with medication times if needed. However, their name was printed on each week's duty rota so it was not clear when they had been available to assist, for example on one week they were listed on the rota but at the foot of the page they were noted to be on annual leave.

At nights, we noted that registered cover was often from staff working overtime or an agency registered nurse. For the most part, substantive staff were not booked for regular night shifts. From 42 night shifts, 16 were covered by a bank or agency nurse and a further eight from regular registered staff working overtime. On some weeks, registered nurses worked a combination of day and night shifts to make up their weekly hours.

If additional staff were needed, we were told that this would generally be covered by the provider bank system. However, in data supplied by the provider, we noted that over a three month period, there had been 22 shifts filled by bank staff and 55 by agency staff. The provider explained that this was to cover nursing vacancies and nurse sickness and that there had been a freeze on recruitment due to the

patient to staff ratio. In the six weeks before inspection, there had been 31 shifts filled by bank staff and 16 by agency staff. All of these shifts apart from six were to cover night duties. For 13 of these night shifts, there was only one substantive staff member on duty.Staff and patients told us leave or activities were rarely cancelled due to staffing, although leave or activities may be moved times within the day. We did see that individual one to one nurse sessions were not taking place weekly as per the policy.

Medical cover was provided during the day by two psychiatrists, who attended Brierley Court. At night, there was a medical on call system with a doctor covering several provider hospitals, with a second on call back up. Staff could also contact the GP on call service if there were physical health concerns out of hours.

Mandatory training was in date for most staff with percentages of staff up to date above 75% for all but prevent training, which 73% staff had attended and basic life support. At the time of inspection, 72% of staff overall were up to date with basic life support. One registered nurse was out of date for both basic and immediate life support training but this was due to sickness. All other registered nurses were up to date for immediate life support.

Assessing and managing risk to patients and staff

There was no use of seclusion or long term segregation at this hospital.

Between February and August 2017 there had been eight episodes of restraint involving three patients reported by the provider. None of these incidents had involved prone restraint. During the same time period, there had been no use of rapid tranquillisation.

We reviewed four care records in relation to risk assessments. All patients had an escort baseline risk assessment completed shortly after admission. These were short risk assessments related primarily to leave and absconsion risk with headings for risk to public, risk to staff, risk of non co-operation, consideration for handcuffs, history of escape/abscond, outside assistance for escape and specific ministry of justice instructions. These did not reflect a rehabilitation setting.

The provider standard was that a more comprehensive risk assessment should be in place at three months following admission and the provider used the short term assessment of risk and treatability tool. In three files, we found these risk assessments were completed but were not up to date. One had no formulation documented. In the fourth file, this had not been completed, despite the patient having been admitted over three months previously. The provider also used the historical clinical risk 20 tool for risk assessments, these were not up to date and the psychologist was working through these to update them.

Positive behavioural support plans had been completed for some patients, but these showed little evidence of patient involvement, despite a patient centred format. There was not enough detail to guide staff in dealing with challenging behaviour and how this presented for individuals.

We were concerned about some of the restrictive practices in place at Brierley Court. Staff routinely searched patients returning from unescorted leave and searched bedrooms on a regular random basis. This was not in keeping with a rehabilitation environment nor based on individual risks. Items which patients were searched for included tobacco, as the provider organisation had introduced a company-wide smoking ban within its hospitals. There had been three reactive searches in the month before this inspection, all to search for tobacco related items and sources of ignition. Patients who had escorted leave were allowed to use e-cigarettes but these were kept by staff and could not be used in the hospital or the grounds. The laundry room was locked with patients given their own timeslot to use the room.

Staff were trained in de-escalation techniques as part of their managing violence and aggression training. We saw that when restraint had been used, this had been for short periods and the least restrictive necessary to support patients who were distressed.

Staff were trained in safeguarding adults and children, and staff showed a good understanding of what needed to be reported and what actions they would take. The occupational therapist was the safeguarding lead and maintained good links with the local authority.

Independent hospitals are required to notify the Care Quality Commission about safeguarding incidents. The service had notified five safeguarding alerts in the six

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

months prior to this inspection. The service had taken appropriate action to safeguard these vulnerable patients. However, we found that three recent safeguarding incidents had not been notified to us.

We were concerned about medicines management practices. Staff received training in medicines management with all five registered nurses having completed this at the time of inspection. There was a policy that provided guidance for staff. However, on reviewing prescription charts, for four patients there had been occasions when medication had not been administered. On these occasions the appropriate section on the medication card had not been completed and staff could not explain this. One patient had unsigned administration boxes for 17 doses of a medicine out of 62 possible doses that month. There was no evidence this had been noted or reviewed by nursing or medical staff.

Staff completed a stock check and clinic audit every week. However, there had been medicines errors that had been missed by this check. One patient had not been given a prescribed medication for 18 days as there was no stock available. This covered two weekends where audits should have identified the error. This was compounded by the fact that the out of stock medicine is dependence forming and should not be abruptly withdrawn.

The hospital had a controlled drugs accountable officer; however, the accountable officer was on a long term absence. The controlled drugs accountable officer is responsible and accountable for the supervision, management and use of controlled drugs and all hospitals are required to have an officer appointed.

There was a policy that included how the provider's adult services should make arrangements for child visitors; however, we did not see evidence of such arrangements having been made at Brierley Court.

Track record on safety

Since the provider took over this location, there had been no recorded serious untoward incidents.

All senior managers had access to dashboards that covered a range of data, such as patient information, risk assessments, evidence of physical health checks, observation levels, incidents and Section 17 leave.

Reporting incidents and learning from when things go wrong

All staff knew what to report and could use the electronic incident reporting system.

We looked at 10 records relating to incidents recorded in the six months prior to this inspection. These included four medication errors, three physical altercations between patients and three incidences of restraint on patients. Managers had put plans in place to reduce the risk of recurrence.

The provider disseminated a newsletter to all staff members explaining the lessons learned and what changes services needed to make as a result of incidents, to promote learning across all sites.

Duty of Candour

There was a policy outlining the duty of candour that provided guidance for staff. The policy set out the provider's approach to the duty of candour and what action it would take if an incident occurred that prompted the duty.

Staff we spoke to showed a good understanding of the duty of candour. Duty of candour was included in safeguarding training, which was delivered annually to all staff.

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

We reviewed eight sets of care records. Patients had multiple care plans and there was considerable overlap, for example, one patient had a management of violence and aggression care plan, a positive behavioural support plan and a risk management plan. Some patients had up to 16 care plans in their record. We saw six standard wording care plans used for spiritual and cultural care plans. There were also standard care plan formats for physical health conditions. Whilst patients may have the same condition, for example, asthma, this may present differently between patients and require different management.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We saw a lack of patient involvement in all care records. Some plans were written in the first person but then it was noted that the patient had refused to be involved. Plans were not recovery orientated.

We became aware of two patients who had specific learning disabilities. We did not see any care plans in an easy read format. There were communication assessments and health passports for patients, but these were poorly completed without sufficient detail and with little evidence of patient involvement.

Both patients had had care and treatment reviews in the last 12 months. Care and Treatment Reviews are part of NHS England's commitment to transforming services for people with learning disabilities, autism or both. CTRs are for people whose behaviour is seen as challenging and/or for people with a mental health condition. We saw that actions from these, in terms of improving positive behaviour support plans or developing health passports, had not been completed.

There had been no learning disability training for staff and none of the staff were experienced in learning disability care.

All care records were stored electronically. Access was protected to ensure the records remained secure. Paper records, such as Mental Health Act documentation, were stored securely.

Best practice in treatment and care

A practice nurse from another of the provider's hospitals carried out physical health assessments on admission and reviewed them every six months. They undertook blood tests and electrocardiogram readings as required. They completed long term conditions care plans. All patients were registered with a local GP surgery. Alerts were used on the electronic system to advise of physical health conditions and allergies. Doctors were aware of the importance of metabolic screening for patients prescribed antipsychotic medication and ensured this was completed.

The provider had recently introduced a no smoking policy across all their hospitals. All patients were offered support to reduce their smoking in groups and individually. All patients were able to access smoking cessation devises and advice.

Occupational therapy staff used the Model of Human Occupation Screening Tool to assess patients.

We saw one completed recovery star which despite having patient's views noted had been predominantly completed by staff. There was no rehabilitative or recovery model in place at this service which would then dictate what assessments and tools should be used.

Skilled staff to deliver care

A multidisciplinary team delivered care to patients at the service. Two psychiatrists were present one day per week, with multidisciplinary team meetings every fortnight. An occupational therapist and occupational therapy assistant were based at the service. A psychologist was based at the service one day per week. A social worker was available one day per week. Most of the multidisciplinary team were substantively employed in one of the providers other hospitals which provided care in a secure setting. The team members did not have a background in rehabilitation, for example, neither of the doctors was on the medical register as a rehabilitation psychiatrist and the psychologist specialised in psychotherapy and trauma work.

Staff received a comprehensive induction on joining the service, including bank staff. Agency staff received an induction and handover before they started work. Support workers were supported to complete the care certificate. Health care workers had opportunities to progress their careers, for example by training as nurse associates. This is a support role that sits alongside existing healthcare support workers and registered nurses to deliver hands-on care for patients.

We were given figures showing that most staff were receiving supervision every four to six weeks. However, staff we interviewed were not as clear that this was occurring with some reporting their last supervision to have been months previously. Figures supplied to CQC appeared to indicate that attendance at a staff meeting was counted as attending supervision. When clarification was sought, we were told that the supervision register submitted only showed the most current supervision session and staff meetings were included as an opportunity for operational supervision. Previous supervision records could not be viewed. Post inspection, the provider was using a new electronic supervision recording system which pulled data through into dashboards and would allow them to view previous supervision dates and to differentiate between operational supervision and clinical supervision. Multidisciplinary staff told us they received regular supervision as part of their substantive roles.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We found that in the period since the provider had taken over this location, 91% of staff had had an appraisal and all medical staff had been revalidated.

Staff told us there was support for further training and development, and we were told two staff were awaiting start dates for further training in substance use awareness and treatment.

Multi-disciplinary and inter-agency team work

Multidisciplinary team meetings took place fortnightly. Patients could attend these.

Handovers took place at each shift change. Multidisciplinary staff did not receive a handover as their work did not start at the same time, but would check with the nurse in charge or the manager if there had been incidents or changes they needed to be aware of.

We reviewed minutes of monthly staff meetings. Discussions included team performance, training, safeguarding, safety alerts and communications, outcomes measurement and the duty of candour.

Staff told us they had communication and contact with commissioners and other agencies involved in patients' care.

We asked for feedback from commissioners for the service and received feedback that the service did not have the facilities expected of a rehabilitation placement and that there had been delays in receiving reports from care programme approach meetings.

Adherence to the Mental Health Act and the Code of Practice

Staff had a good understanding of the Mental Health Act and the associated code of practice. Mental Health Act training was part of the mandatory training calendar and 86% of staff were up-to-date.

Patients records showed that they had regular discussions with staff about their rights under the Mental Health Act. Discussion of patients' rights was monitored via the dashboards. The provider target was for these to be discussed monthly but in the records we reviewed this had happened every two or three months.

We saw evidence that seven patients had exercised their right to appeal against their detention and the outcomes were recorded. However, for three patients, there was no record of their last tribunal date. One of these three had a future date scheduled. One patient had last appealed their detention over three years ago and the provider had not automatically referred this case to the tribunal as per the Mental Health Act Code of Practice section 37.39.

There was an independent mental health advocate who provided support to patients on request. The advocate visited every two weeks to ensure patients were aware of the support they could provide. Information about the advocacy service was displayed on notice boards.

The regional Mental Health Act administrator carried out audits of Mental Health Act documentation.

Good practice in applying the Mental Capacity Act

Seventy six per cent of staff had undertaken Mental Capacity Act 2005 training at the time of this inspection. Staff understanding of the requirements of the Act was adequate and they knew where they could seek advice. There was a policy that staff could refer to and the social worker provided guidance.

Staff carried out mental capacity assessments when there were doubts about the patient's mental capacity, for example, we saw one capacity assessment relating to managing finances. This meant that patients received appropriate support to help them make specific decisions.

There were no patients subject to the Deprivation of Liberty Safeguards and there were no pending applications.

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

Requires improvement

Kindness, dignity, respect and support

We observed positive interactions between staff and patients during this inspection. We attended a morning planning meeting where we saw staff listen to patient concerns and attempt to resolve these. Staff offered options and suggestions around daily planning. Interactions were warm and friendly.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We spoke to three patients about their care along with feedback from patients at the planning meeting. One patient felt the service was generally clean whilst two did not, with one commenting it was cleaned for this inspection.

One patient felt safe whilst one other did not but did not elaborate. Two patients felt staff were not visible or available, with one feeling the service was short staffed.

One patient complained about medication not always being ordered when needed and running out of stock.

Staff were generally described as friendly, respectful and polite, with one patient feeling some weren't. One patient said staff did not knock before entering their bedroom.

Three patients spoke to us about the situation with the boiler and access to hot water. One patient said they had been told this would be for two or three days and it had been two weeks. One patient said they were cold and were sleeping in their clothes at night to stay warm and that there had been no heating for over a week. One patient was preoccupied during interview with how cold they felt.

One patient complained about mice in the building. We were told that a pest control company was visiting regularly and setting traps to try to address this.

One patient felt that access to fresh air was sometimes an issue as staff had to unlock the door to access the garden.

Patients felt happy with the food, reporting that meal times were flexible and drinks and snacks were always available.

Two patients felt happy with their level of activities and sessions offered.

Patients had been unhappy with the provider ban on smoking with one noting they had suffered withdrawal symptoms and would go back to smoking and another noting the need for escorted leave to be granted before they could smoke.

One patient told us that whilst they were aware of how to complain they hadn't made any complaints as they felt nothing would get done. Another said they were aware of how to complain, but hadn't needed to and didn't think there would be negative repercussions if they did.

The involvement of people in the care they receive

Patients told us they had been able to visit the service before admission. Staff told us information was given to patients when they were admitted and they were assigned a nurse for the first 24 hours who checked on a frequent basis to see that they were settling in.

None of the patients we spoke to had been offered care plans and one did not know if they had any. None of the patients were aware of a discharge plan.

Patients were aware of the advocacy service and spoke positively of the service. The advocate visited the service for half a day each fortnight.

Community meetings were held every week where patients had an opportunity to discuss wider issues. The advocate would attend these. We saw minutes of some of these meetings that documented discussion about issues patients raised and feedback about issues raised in previous meetings. Staff had actioned "you said we did" points, such as a trip out and beverages to be available through the night for patients to make drinks.

A patient survey had been carried out by the corporate provider for 2016-17 and a report completed for Brierley Court. Three patients had participated in this. One patient reported receiving information before admission, with the other two responses that patients couldn't remember. All three patients felt welcomed when they were admitted. Two patients said they had been allocated a peer as a "buddy" when first admitted. One patient reported being aware of their care co-ordinator and one patient felt they knew what they needed to do to move on. Two patients felt involved in goal planning, with one feeling somewhat involved. All patients felt there was access to meaningful activity. No patients said they were aware of real work opportunities. In terms of time spent with the multidisciplinary team, two patients felt they had enough time to discuss their treatment. All patients felt they were treated with respect and dignity. Food was rated as very good by one participant, fair by another and poor by the third. In terms of treatment, all patients felt they wanted more information about medication and side effects. Two patients said they had requested and then received a talking therapy. One patient reported not enough care for physical health problems.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

None of the patients said they had been offered care plans or care programme approach minutes. None of the three said their rights were read in a way they could understand. None of the patients said they knew how to make a complaint.

Overall, all three patients felt positive about their care, two rating this as very good and one excellent.

Actions for improvements were developed from the findings and all had either been completed, such as implementing daily activity planning meetings, or were ongoing, such as ensuring that community care co-ordinators were invited to all care programme approach meetings and discussing blanket restrictions at community meetings.

A carers survey had been completed in July 2017 but only two responses were received, both giving positive feedback about the service, although one carer expressed reservations about aspects of personal care not being addressed.

The provider had developed real work opportunities in some of their other services and had introduced this to Brierley Court. Patients had the opportunity to attend interviews for these posts and were paid for the work they carried out. They also received weekly supervision. One patient was currently involved in this having completed an application and interview process. They were receiving regular supervision and were well supported.

Two patients had completed mandatory food hygiene training alongside staff and there were plans for further training to be offered in future.

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

Bed occupancy in the six months prior to this inspection was 52%. Current patients were admitted from north west England and Wales although the service had a national catchment. We were told bed occupancy levels were in part due to patients from out of the area having been repatriated, and in part to the hospital not admitting new patients due to the planned refurbishment.

Patients were referred to the service and a pre-admission assessment undertaken by members of the clinical team. Pre-admission assessments were available electronically for staff to read prior to admission. We saw that some patients had originally been admitted under section 17 leave to allow a transition period and this had worked well.

We were concerned at the lack of discharge planning or pathways for patients. All patient electronic records contained a discharge plan template. For one patient, it was noted this had not been discussed. For one patient, it was noted there were "no plans to discharge". For two patients, it was recorded that the service "doesn't meet needs". In one person's plan it notes noted a refusal to engage. Three plans were empty. The plans did not identify clear goals for the patients of what they needed to achieve to complete treatment. None of the patients we spoke to were aware of their discharge plans. There was a service level dashboard which included forecast discharges with a timescale and predicted date of discharge for all patients and a planned discharge location for one patient.

There had been one delayed discharge in the six months before this inspection which was due to difficulties accessing a suitable placement. The service had continued to support the patient in the community placement when discharged.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had limited facilities in terms of rooms for therapy and activity. A room on the second floor was used for some sessions, such as arts and crafts. The dining room was often used for individual sessions or activities. Office space was limited with members of the multidisciplinary team having no allocated space.

A patient's lounge was available, along with a female only lounge. These were furnished with sofas and a television. Patients were directed to their bedrooms as low stimulus areas as there were no quiet areas or rooms available.

Visits took place in the dining room. We were told that the female lounge had also been used for visits.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Some rooms, such as the laundry and rehabilitation kitchen, were locked and staff needed to open these for patients. The laundry had set times for each patient to use. The rehabilitation kitchen was situated on the first floor on the female only corridor. The kitchen was supervised by staff when male/female patients were cooking. When not in use the door was locked as the room contained cooking equipment and implements for which not all patients had access without supervision. The provider told us that daily cooking sessions were timetabled and there were ad hoc opportunities for patients to cook over weekends and at other times.

There were garden areas, including a female only garden, but access to these was locked with staff needed to let patients use them.

The food was prepared on site and staff and patients ate together. The kitchen staff had received a food hygiene rating of five stars. Patients gave positive feedback about the food and the availability of drinks and snacks throughout the day and at night.

A communal payphone with a privacy hood was available for patients to use. Some patients had access to their own mobile phones which was decided on an individual basis.

Some patients had keys to their bedrooms and patients were able to personalise these. Bedrooms were a good size to store possessions. There were no en-suite rooms and bathrooms were shared. Some bedrooms had storage lockers for medication but there were no patients who were self medicating at this inspection.

There was access to activities within the hospital, including nurse and occupational therapy led activities. Occupational therapy staff worked on weekdays and nursing staff organised ward based activities at the weekends. Sessions and leave were planned at the morning meeting with patients. Set sessions delivered during this inspection included baking, a breakfast group and arts and crafts. Occupational therapy staff had made links with local colleges, vocational placements and volunteer opportunities. One patient was attending courses at a placement. The provider was introducing work based opportunities and one patient was involved in this currently. There were group community trips including social events like ten pin bowling and visiting the Blackpool illuminations.

Managers used a number of dashboards to monitor leave and activity. These showed that in the six months prior to inspection, there had been no planned leave cancelled. A dashboard monitored patients' progress in completing meaningful activity. All patients had a planner of activity with between 26-33 hours of activity planned. This included planned sessions, escorted and unescorted leave, independent living skills, health promotion group, social events, exercise and psychology sessions. Each patient had a percentage of their planned activity recorded, with one patient who had 100% completion and no others above 50%. One patient had completed just 12% of their planned activity.

This dashboard also monitored whether 1:1 nursing sessions were happening on a weekly basis. Over the four weeks before inspection, according to the provider dashboard, four patients had no individual session, one patient had one session, three patients had two sessions and two patients had three sessions. We were told that the dashboard was not picking up information correctly from activity templates and that these had been altered to ensure that data was captured.

Meeting the needs of all people who use the service

The service could make adjustments if patients had mobility needs. There were wet rooms available on the ground floor. The service had a ramp and a lift and was wheelchair accessible.

There were two patients at the time of this inspection who had a diagnosed learning disability. We did not see communication assessments or plans for these patients. It was not clear what the plans were for their admissions. There had been no learning disability training for staff and none of the staff were experienced in learning disability care.

We were told leaflets for reading patient's rights were available in easy read format. We did not see any medication or treatment leaflets in an accessible format.

All patients had a spiritual and cultural needs care plan. Food could be ordered which met religious or cultural needs.Staff told us they would help patients to find community based places of worship. One patient had asked about chaplaincy support but said she had been offered leave to the local place of worship instead, but did not feel comfortable there.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Listening to and learning from concerns and complaints

Staff recorded all complaints in a complaints book. There were six complaints in the book, five of these had been resolved quickly at a ward level. One complaint had been escalated to the complaints officer for further investigation. This reflected the complaints policy. Staff and patients were aware of how to complain.

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

Requires improvement

Vision and values

The service values were:

Innovation - so we drive forward the standards and outcomes of care

Empowerment - to encourage all to lead a meaningful life

Collaboration - because in partnership we can deliver transformational care

Integrity - because we are ethical, open, honest and transparent

Compassion - show respect, consideration and afford dignity to all

Staff described wanting to deliver good care and to help patients to move on. Our impression was that the provider values had recently been developed and not yet embedded, we saw for example that supervision records reflected the previous provider's values.

The description of the service from the provider website was

There is an intensive, individualised programme to enable patient to gain the skills to transition from group living in restricted environments to wherever possible, managing their own tenancy in the community.

We have work placements available for patients within the local community and the programme focuses on independent living skills, as well as social inclusion, education and employment engagement. There are also close links with the local community for residents to access local college, work placements and amenities.

These statements described a community rehabilitation model but we did not feel that the service had a clear direction in terms of the model of care. There had been work to introduce opportunities for employment and vocational work, but only one patient was attending a community based placement and one patient was undertaking a real work opportunity within the hospital. Both the setting and some individual care plans were restrictive and did not reflect a rehabilitation setting, for example, the escort baseline risk assessments, the locked garden and laundry and the policy for random searching of rooms. No patient was self medicating and not all had a key to their own room.

No staff were experienced in rehabilitation, with many of the multidisciplinary team substantively employed at one of the provider's secure hospitals.

Good governance

There were problems in the overall governance at this service. It was acknowledged that there had been changes in the last twelve months in terms of a new company provider and a change in manager to cover long term leave.

We found that actions were not completed in a timely fashion. For example, we requested the fire safety risk assessment following inspection. This was completed in August 2017, which was two months overdue. Some actions had been completed from this. There were some actions that had been identified and these had originally been noted with a three months completion date. However, the provider had then noted that these would be completed as part of the refurbishment plans. We discussed concerns in relation to this with the local fire service who visited Brierley Court. They found significant issues which had not been identified as part of the fire safety risk assessment and issued instructions for a new fire risk assessment to be completed and actions taken in relation to the issues they identified.

The provider undertook its own compliance visits. The most recent visit took place in April 2017. At this visit, actions were raised in terms of care plans (person centeredness and evidence base), individual sessions, overdue reading of rights and overdue risk assessments.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Whilst some issues had been addressed, these issues have all been noted at this inspection visit, suggesting that when concerns are identified, these are not addressed in a timely fashion.

The service risk register had been completed generically and without reference to specific risks for this service, including the fire safety risks or issues identified on the providers compliance visit, for example, building work needed. The low numbers of registered nurses and freeze on recruitment was not included in the risk register.

We noted a reliance on dashboards which presented a different picture when the data relied upon for these was checked. For example, the discharge dashboard had a date for each patient within the next two years for when discharge was planned. However, in clinical records, the discharge plans were blank or poorly completed. Patients reported to us, and in the provider patient survey, that they were not aware of discharge plans or what they needed to do to move on. The supervision dashboard suggested that most staff were up to date with supervision, but closer examination suggested that this included attendance at meetings as managerial supervision and figures for previous supervision could not be supplied.

We were concerned about oversight and monitoring in terms of admissions and whether patients' needs could be met by the service. There were two patients with a learning disability and it was not clear what the purpose of admission or future planning was for these patients. Despite care and treatment reviews having been completed, actions from these were not complete or poorly undertaken, for example, positive behaviour support plans. There were no staff with training in learning disability working within the service.

Qualified nurse numbers were concerning, given that staff were working combinations of days and nights or high levels of overtime to ensure that shifts were covered.

Leadership, morale and staff engagement

Staff told us they felt well supported by the interim hospital manager. They described good access to training and opportunities to develop. Registered nurses had felt supported during preceptorship. Support workers spoke about opportunities to progress by completing the care certificate and progression into nurse associate roles.

Staff were aware of how to raise concerns. Staff were also aware of the provider whistleblowing policy and a confidential phone line that they could use.

Staff spoke positively to us about some of the incentives that the company promotes, for example, regular raffles and vouchers.

Staff described good communication. They described feeling informed of developments in the company via staff meetings and newsletters.

A staff survey was undertaken annually. The most recent results were reviewed. There were positive responses from staff about their work. Nearly three quarters of staff felt they had the resources needed to do a good job and nearly two thirds of staff felt they had sufficient time to do their job well. Sixty percent of staff felt there was a visible positive culture and felt well informed about what was going on in their team.

In terms of line management, apart from one person, staff felt their line manager treated them with respect and felt supported by their manager. Nearly three quarters of staff, 73%, felt able to influence the way things were done in their team, with 66% feeling part of a well managed team.

In terms of corporate leadership and management, most staff felt they were proud to work for Elysium, with only one person disagreeing. Seventy-eight percent of staff felt the provider valued the services they provided. Just over 60% rated the provider company as having a positive culture.

There were responses which suggested issues within the team. Over half of staff surveyed felt they were respected by co-workers, however 33% of staff did not feel respected by their co-workers, nearly half of staff felt unacceptable behaviour was not consistently tackled and 40% of staff were undecided or could not rely on their colleagues. One fifth of staff reported harassment, bullying or abuse from staff. Only 42% of staff endorsed the statement that the company managers knew how things really were.

Commitment to quality improvement and innovation

The provider company were developing systems to enable monitoring, for example, the use of clinical dashboards. However there were issues with these at Brierley Court in terms of the quality and reliability of the data produced and actions taken.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The provider has introduced real time work opportunities and community programmes in other services and has started to implement this at Brierley Court.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ligature risk assessments include the specific risks evident in individual areas, for example, patient bedrooms.
- The provider must ensure there are sufficient registered nurses employed.
- The provider must ensure risk assessments are completed and reviewed as per the policy.
- The provider must review the policy and procedures regarding random searches.
- The provider must ensure all safeguarding alerts are notified to CQC.
- The provider must ensure medicines are managed safely.
- The provider must ensure that there is a controlled drugs accountable officer who is able to perform the necessary duties.
- The provider must ensure staff are trained in basic life support.
- The provider must ensure that each patient has a clear discharge plan.
- The provider must ensure that patients with learning disabilities have their care plans available to them in an accessible format.
- The provider must ensure that health passports are completed with sufficient detail.
- The provider must ensure that staff receive training in supporting patients with a learning disability.
- The provider must ensure that all staff are receiving adequate supervision.
- The provider must ensure that all patients are aware of their care plans, involved in these and offered copies of these.
- The provider must review restrictive practices and their compatibility with a rehabilitation setting.
- The provider must develop an appropriate model of care for the service which includes an assessment which ensures that only patients whose needs can be met are admitted.
- The provider must review the reliability of the dashboards in use.
- The provider must ensure that environmental assessments are completed and actions met in a timely fashion.

Action the provider SHOULD take to improve

- The provider should review the activities available to patients
- The provider should ensure patients have weekly sessions with their named nurse.
- The provider should ensure that staff discuss patient's rights with them on a monthly basis as per their policy.

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: Assessments did not always contain evidence of the patient's views. Care plans did not clearly set out patients' involvement or their views. Discharge plans had not been completed adequately and there were no clear discharge pathways in place for patients. Six records contained plans that were the same as those written for other patients and these appeared to be standardised plans. Care plans were not in an accessible format for those patients who required these. Health passports lacked specific details about medical conditions and their management. This was a breach of regulation 9 (3) (b)

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: Ligature risk assessments had not been reviewed to include specific ligature points within the service.

This section is primarily information for the provider

Requirement notices

Risk assessments were not completed and reviewed as per the provider policy.

Medicines were not managed safely in terms of stock availability and medicines administration charts not completed.

This was a breach of regulation 12 (2) (a)(b) and (f).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Environmental assessments, for example, the fire safety risk assessment, were not acted on in a timely fashion to address safety issues. This was a breach of regulation 15 (1) (d) and (e).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not registered a controlled drugs accountable officer when the previous officer went on long term leave. There was no model of care in place for the service. There was a reliance on dashboards to monitor service provision, but these were not always populated with accurate information. There was no oversight of staff supervision. There were restrictive practices in place which had not been reviewed in light of the setting.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of registered nurses employed. Staff were not receiving regular supervision. Staff did not receive training or guidance in the care of patients with a learning disability. This was a breach of regulation 18(1) and (2) (a).
	Environmental assessments, for example, the fire safety risk assessment, were not acted on in a timely fashion to address safety issues. Safeguarding notifications were not made to CQC for every safeguarding alert. This was a breach of regulation 17 (1)(2) (a) and (b).