Broomhill

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

Overall summary

Broomhill offers mental health care, support and treatment to men and women. The hospital has acute wards, and long stay / rehabilitation wards. During our inspection we found some concerns relating to medicines management; infection prevention and control; observation documentation and recording, and the privacy and dignity of some patients. We also saw two isolated incidents whereby staff had spoken to patients in an unacceptable way. We found that:

- Staff did not always adhere to the provider's policy when undertaking patient observations. We examined records for eight patients who were on enhanced observations. We found gaps in seven of the eight records. We also found that there were inconsistencies in some records. This meant that we could not be assured that patient observations had been carried out in accordance with their identified risks and care plans.
- The registered nurses on both wards we spoke with, who were agency and had administered medications, did not know the process for the recording of medicines disposal. Registered nurses did not always adhere to the provider's policy in relation to the administration of controlled medicines. This meant that medicines could be unaccounted for, or disposed of incorrectly.
- Managers had not ensured that beds and bedding were clean and well maintained. We saw bed bases and mattresses which were not clean. We found sheets, pillowcases, pillows and a duvet which were either dirty, or not fit for purpose and required replacing. We found several mattresses which were too long for the divan bases.
- Staff were not always kind and respectful towards patients. During an incident of restraint, we saw one staff member shouting at a patient. During a separate incident, we heard a nurse say to a patient that if they did not stop being destructive, they would be taken to their room and be given an injection. The provider took action to investigate the poor behaviour of staff in the two incidents seen on CCTV.
- Staff did not always maintain the privacy and dignity of some patients. We observed the privacy and dignity of some patients who were having their medicines administered had been compromised. Some staff continued to speak to one another in languages that patients did not understand, despite this being highlighted as a concern during inspections in February and July 2020.
- Managers did not have robust processes in place to ensure they had clear oversight of the quality of care being delivered to patients day to day. On all the

Summary of findings

inspections we have carried out since February 2020 we found aspects of poor care that the provider had not identified. Whilst the provider made the required improvements when we told them to they had failed to identify these themselves and therefore had not acted to ensure care was always safe and of a high standard.

- The culture between staff and managers was not open. Some staff and patients felt unable to raise complaints directly to senior managers. Complaints about poor staff behaviour and practice were made directly to CQC and not via the managers of the service. We raised issues about culture at our inspections in February and July and the provider took steps to address them. Staff and patients continued to share their experiences with the CQC directly, despite the provider having internal processes in place.

However,

- Registered nurses undertook regular checks of the stock of controlled medicines, and medicines liable for misuse.
- Staff planned observation allocations at the commencement of each shift and rotated staff regularly.
- We observed some caring and respectful interactions between staff and patients. During two incidents seen on CCTV, other staff involved in the incidents, were observed to use de-escalation skills and positive interactions when patients were distressed.
- Some patients spoke positively about their care and treatment.

Summary of findings

Contents

Summary of this inspection

Background to Broomhill

Broomhill provides care, treatment, and support to individuals with mental health concerns. It provides 99 beds across seven wards:

- Holdenby ward is an acute mental health services for women with 14 beds. This is an open ward.
- Cottesbrooke ward is an acute mental health services for men with 14 beds.
- Althorp ward is a specialist dual diagnosis rehabilitation service for men with 14 beds. This is an open ward.
- Kelmarsh ward is a complex mental health high dependency service for men with 14 beds.
- Lamport ward is a specialist Neuro-behavioural rehabilitation service for men with 14 beds.
- Spencer ward is a long term complex care service for men with 14 beds.
- Manor ward is a long term complex care service for women with 15 beds.

The Care Quality Commission undertook a comprehensive inspection of the service in February 2020. The overall rating for the service was Inadequate. Four of the five key questions - safe, effective, caring and well led were rated as inadequate. The responsive key question was rated as requires improvement. The Care Quality Commission imposed urgent conditions upon the provider's registration at this time. The provider met the conditions imposed, which were subsequently removed. The service was placed into special measures.

The Care Quality Commission undertook a focused inspection in July 2020. This inspection was carried out in response to many concerns which had been raised via complaints and whistle blowing concerns from both patients and staff, raised directly to the CQC. At the time of our last inspection we found the following concerns:

- Managers had not ensured that personal protective equipment was always available to staff. Masks were not available upon entry to the main building. Hand sanitiser was not always available.
- Staff did not undertake temperature checks of visitors upon entry to the main building on the day of our visit as per providers' visitors' policy.
- Staff did not social distance during handover meetings on three wards.
- Staff had not always cleaned equipment used to carry out physical observations between patients.
- Managers had not undertaken risk assessments for staff from black and ethnic minority backgrounds, in respect of Covid-19.
- Staff had not deep cleaned two communal toilet areas regularly.
- Staff did not fully adhere to infection prevention and control principles as outlined in the Health and Social Care Act 2008.

The service was issued with a Section 31 letter of intent following the inspection in July 2020. A Section 31 letter sets out where urgent action is required, to prevent the Care Quality Commission from imposing conditions to a provider's registration. The provider was required to provide a written response to the Care Quality Commission, along with an action plan to address urgent infection control issues identified. The provider had completed all actions identified in July, by the time we re-inspected in September 2020.

During this inspection, we identified a breach of The Health and Social Care Act (Regulated activities) Regulations 2014 under Regulation 12 (safe care and treatment) and Regulation 17 (good governance). The provider was issued with a warning notice, and are expected to send the CQC a plan to tell us how they will ensure they meet requirements under these Regulations. The service remains in special measures.

Our inspection team

Our inspection team consisted of an inspection manager, inspector and a Mental Health Act reviewer.

Summary of this inspection

Why we carried out this inspection

We undertook this inspection after the Care Quality Commission received further concerns raised by a patient. The patient made concerns directly to the CQC and not via the provider. Concerns raised included poor care; attitude of staff; staff members speaking in languages other than English, staff not conducting patient observations safely; a lack of privacy and dignity; concerns around medication management; and poor standards of cleanliness.

How we carried out this inspection

An inspection manager and inspector arrived at the hospital on the 02 September 2020. This visit was unannounced. An inspection manager, inspector and Mental Health Act reviewer returned to the service, unannounced on the 10 September 2020, where the inspection was concluded.

We have not re-rated this service or examined every key line of enquiry in all key questions. The inspection focused on specific issues. The ratings from the last comprehensive inspection conducted in February 2020 stay the same.

Prior to the inspection we reviewed all notifications including complaints and whistleblowing concerns that we had received about the service.

During the inspection visit, the inspection team:

- Undertook a tour of the ward on Holdenby ward and Manor ward
- Spoke with 14 patients who were using the service. We asked the provider to display posters around the service to encourage staff, patients and carers to share their experience. We also received anonymous feedback via a "tell us about your experience" form, from one patient and one staff member.
- Reviewed 287 hours of observation records
- Observed how staff cared for patients during three separate incidents, via CCTV
- Observed some administration of medicines via CCTV
- Reviewed medicine management on Holdenby and Manor wards
- Spoke with two qualified staff and two healthcare support workers
- Reviewed a range of meeting minutes, policies and procedures, and audit schedules for the service.

What people who use the service say

We spoke with 14 patients who were receiving care across the hospital and received one anonymous feedback from a "tells us about your experience" form. Patients gave mixed feedback.

- Eight patients told us that they had heard staff speaking to one another in languages which they did not understand. Some of the patients told us that when staff spoke in a language they did not understand they, thought staff had been talking about them.
- Three patients we spoke with told us that they felt cared for and looked after. Two patients spoke positively about their care and treatment and felt that staff did their jobs well.
- Two patients told us that staff generally treated them with dignity and respect, although described some staff on occasions as "abrupt and rude". This was made in reference to staff interrupting when patients were having conversations at night time and were told to go to bed.
- Three patients told us that staff did not always treat them with dignity and respect. One patient told us that they did not like the way in which some staff had spoken to them. Another patient described some staff as being "arrogant". One patient described permanent staff as "responsive" to requests, in contrast to some agency staff who were often "slow to respond" to them. One patient told us that staff had been rude to them about their weight.

Summary of this inspection

- One patient told us that in their experience, staff had always treated them with dignity and respect.
- One patient told us “staff were supportive and made sure they gave the best possible care”.
- One staff member we spoke with, told us that patients were encouraged to change their own bedding, with a focus upon rehabilitation.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect against all key lines of enquiry in the safe question. This inspection focused on specific areas of safety, including medicine management, observations of patients and infection prevention and control.

We found:

- The registered nurses on both wards we spoke with, who were agency and had administered medications, did not know the process for the recording of medicines disposal. Registered nurses were not always following policy in relation to the administration of controlled medicines. We were concerned that medications could be unaccounted for or disposed of incorrectly.
- Staff did not always adhere to the provider's policy when undertaking patient observations. It was not always clear in the observation record, who the observing staff had been, and how many staff had been observing the patient. We found numerous gaps where no recording had taken place. This meant that we could not be assured that patient observations had been carried out in accordance with their identified risks and care plans.
- Managers had not ensured that beds and bedding were clean and well maintained. We found dirty bedding, mattresses and bed bases. Some mattresses did not fit the divan. They were too long, which resulted in an overhang.

However;

- Registered nurses undertook regular checks of controlled medicines and medicines liable for misuse.
- Staff planned the observation allocations at the beginning of every shift, to ensure that staff rotated regularly.
- Following inspection, the provider submitted data from their patient satisfaction survey conducted in August 2020. There was a return rate of 59%. 44 out of 55 (80%) patients said they had been treated with dignity and respect. 45 out of 55 (82%) patients said they knew how to raise a complaint. 40 out of 55 (74%) said they were happy with the response to their complaint.

Are services effective?

We did not inspect against this key question.

Summary of this inspection

Are services caring?

We did not inspect against all key lines of enquiry in the caring question. This inspection focused on specific areas including how staff treated patients and how staff maintained the privacy and dignity of patients.

We found;

- Staff were not always kind to patient's. We saw on two separate occasions, a staff member speak to patients in an unacceptable way. The provider took action to investigate the poor behaviour of staff in the two incidents seen on CCTV.
- Eight patients told us that they had heard staff speaking to one another in languages which they did not understand. Some patients thought that staff had been talking to each other about them.
- Staff compromised the privacy and dignity of some patients during medicines administration.

However;

- We observed some caring and respectful interactions between staff and patients. During the same incidents seen on CCTV, other staff involved demonstrated use of de-escalation skills and showed positive interactions when patients were distressed.
- Some patients spoke positively about their care and treatment.
- Following inspection, the provider submitted data from their patient satisfaction survey conducted in August 2020. There was a return rate of 59%. 44 out of 55 (80%) patients said they had been treated with dignity and respect. 45 out of 55 (82%) patients said they knew how to raise a complaint. 40 out of 55 (74%) said they were happy with the response to their complaint.

Are services responsive?

We did not inspect against this key question.

Are services well-led?

We did not inspect against all key lines of enquiry in the well led question. This inspection focused on specific areas of Governance to include how senior staff managed and maintained the oversight of patient safety and wellbeing.

We found;

- Managers did not have robust processes in place to ensure they had clear oversight of the quality of care being delivered to patients day to day. On all the inspections we have carried out

Summary of this inspection

since February 2020 we found aspects of poor care that the provider had not identified. Whilst the provider made the required improvements when we told them to they had failed to identify these themselves and therefore had not acted to ensure care was always safe and of a high standard.

- The culture between staff and managers was not open. Some staff and patients felt unable to raise complaints directly to senior managers. Complaints about poor staff behaviour and practice were made directly to CQC and not via the managers of the service. We raised issues about culture at our inspections in February and July and the provider took steps to address them. Staff and patients continued to share their experiences with the CQC directly, despite the provider having internal processes in place.
- Managers had not ensured that beds and bedding were clean and well maintained. We found that the mattress audit was overdue. It was due for completion in May 2018. This had not been undertaken by the provider. This had resulted in a poor standard of cleanliness of some patient's beds, bedding and mattresses.
- Managers did not undertake any audits of observation documentation or practice. Therefore, senior staff were unaware that staff did not always adhere to the provider's policy when undertaking observations. The provider could not be assured that patient observations had been undertaken in accordance with their identified risks and care plans.
- Managers had not communicated audit outcomes effectively. We found that team meeting minutes, board meeting minutes, and quality forum meeting minutes did not record specific outcomes of audits. Therefore, no actions had been identified to address shortfalls.
- Management interventions had been ineffective in addressing staff speaking to one another in languages that patients did not understand.
- Following inspection, the provider submitted data from their staff survey conducted in August 2020. There was a return rate of 35%. 70 out of 88 staff (80%) said if they raised a concern or complaint it would be acted on. 68 of 88 staff (77%) felt Broomhill was well led.

Acute wards for adults of working age and psychiatric intensive care units

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Maintenance, cleanliness and infection control

Managers had not ensured that beds and bedding were clean and well maintained. In response to concerns raised by a patient, we carried out inspections of beds, mattresses and bedding on Holdenby ward. We examined four bedrooms in total. Three of four mattresses examined were stained, one was slightly sticky, and all were dusty. All mattresses viewed needed cleaning. Three out of four sets of bedding were all stained and needed changing. One sheet was ripped. Two of the four beds had either dirty pillows, or pillows that were of poor quality and were out of shape and needed replacing. One staff member we spoke with, told us that patients were encouraged to change their own bedding. Staff assisted them if asked.

When we returned to the hospital on our second visit, the provider told us they had completed a bed audit and had taken appropriate action, which had included ordering new bed divans.

Medicines management

Managers had not ensured that staff (including agency staff) were safely disposing of medicines in line with the provider's policy. We completed a medicines check on Holdenby ward. A nurse we spoke with was unaware of any system for recording the disposal of medicines. However, the nurse did know where discarded medicine was stored.

Staff were not fully adhering to the provider's policy when administering controlled medicines. We found on the morning of our visit, on Holdenby ward, that a nurse had signed three controlled medicines as administered to patients. However, there was no second registered nurse signature to witness the administration as required.

Managers had ensured that nurses undertook regular stock checks of controlled medicines and medicines liable for misuse. We checked a sample of medicines against the balance recorded. All of these were correct. The nurse did not use the controlled medicines / medicines liable for misuse index at the beginning of the books to locate the medicines sampled. The index had not been updated. Therefore, it took the nurse some time to locate the correct corresponding pages during the checks.

The provider did not have adequate oversight of medicines management. We found numerous issues relating to medicines on Holdenby ward. These included finding one liquid medicine with no opening date; no opening date on some emollient cream and one patient inhaler which was not in a labelled box. Therefore, it was not clear who this belonged to. In addition, we found some analgesia gel which had expired in June 2020. We found that in a box of 25mg tablets, was a loose strip of the same medicine, but of a higher dose (100mg). This was brought to the attention of the nurse in charge. We also found that one medicine stock cupboard was broken and therefore unlockable. This still held medicines.

Management of Patient Risk

Staff had not always completed patient observations in line with the provider's policy. We viewed observation records of three patients who were prescribed enhanced observations. That is, patients who were either on one to one observation, or two to one observation. We found gaps in recordings in all three records. In total we viewed 114

hours of documentation. We found that there were gaps in recordings adding up to to nine hours. The expectation of the provider is that a recording is made every hour for those patients on enhanced observations.

One record reviewed of a patient on two to one observation, had ten entries recorded by one staff member and not two. Therefore, we could not be assured that two staff had undertaken all observations as expected.

However, we saw that whenever possible, staff rotated between observations regularly. Staff planned observation allocations at the commencement of each shift to ensure that staff received adequate time between undertaking observations. This was in line with the providers policy, and national guidance. We also saw that observing staff had written something during periods of observations undertaken. Although entries were not always very detailed, there was some narrative around the patient's mood and presentation.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

We did not inspect against this key question.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Kindness, privacy, dignity, respect, compassion and support.

Staff had not always treated patients with kindness and respect. We interviewed 14 patients in total across the hospital and received anonymous feedback from one patient via a "tell us about your experience" form. Eight patients told us that they had heard staff speaking to one another in languages which they did not understand. Some patients told us that when they heard staff speaking in languages they did not understand, they felt staff had been talking about them.

Three patients told us that staff did not always treat them with dignity and respect. One patient told us that they did not like the way in which some staff had spoken to them.

Another patient described some staff as being "arrogant". One patient described permanent staff as "responsive" to requests, in contrast to some agency staff who were often "slow to respond" to them. One patient told us that staff had been rude to them about their weight.

Two patients told us that staff generally treated them with dignity and respect, although described some staff on occasions as "abrupt and rude". This was made in reference to staff interrupting when patients were having conversations at night time and were told to go to bed.

Three patients we spoke with told us that they felt cared for and looked after. Two patients spoke positively about their care and treatment and felt that staff did their jobs well.

One patient told us "staff were supportive and made sure they gave the best possible care".

Nursing staff did not always ensure that patient's privacy and dignity was respected. One nurse on Holdenby ward told us they would administer insulin to patients on a chair directly outside the clinic room. We sampled CCTV footage of some administrations of medicines on Holdenby ward. We observed two separate occasions where patients received medicines where their privacy and dignity was compromised. One patient sat on a chair outside the clinic, had a finger prick blood tests taken, and then entered the clinic to have their insulin administered. The clinic door remained open. Staff and patients walked past the clinic while the nurse continued with the procedure.

A nurse took a second patient, in a wheelchair into the clinic. On several occasions, the clinic door was open. Staff and other patients walked past. Staff swapped the escort mid task. We saw other staff stood at the door of the clinic, in conversation with the nurse who was delivering the task to the patient.

Staff had not always responded positively to patients during incidents. We observed two episodes of CCTV which were of incidents that had been recorded on the providers' incident log. However, during the same incident seen on CCTV, other staff involved demonstrated use of de-escalation skills and showed positive interactions.

However, on Holdenby ward, we saw one example of a staff member using a 'threat' of a consequence to a patient's behaviour. During this incident, the patient was agitated, shouting, banging furniture and hitting walls. Staff told the patient that shouting was appropriate if it helped them

ventilate, but added abusing and destroying property was not. A staff member was heard saying "if you do that, you will have to go to your room and I will give you an injection".

We did not observe any episodes of staff speaking to one another, in languages which patient's did not understand, in the CCTV footage viewed.

Following inspection, the provider submitted data from their patient satisfaction survey conducted in August 2020. There was a return rate of 59%. 44 out of 55 (80%) patients said they had been treated with dignity and respect. 45 out of 55 (82%) patients said they knew how to raise a complaint. 40 out of 55 (74%) said they were happy with the response to their complaint.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

We did not inspect against this key question.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Culture

The culture amongst staff and managers was not open and transparent when raising and dealing with concerns from patients and staff about poor staff attitude. Staff and patients shared their experiences with the CQC directly rather than with the provider in the first instance. We raised issues about culture at our inspections in February and July and the provider took steps to address them. Staff and patients continued to share their experiences with the CQC directly, despite the provider having internal processes in place.This inspection also took place as a result of a further whistle-blowing account directly to CQC.

Previous inspections found that staff frequently spoke to one another in languages that patient's did not understand. Patients voiced that this made them feel uncomfortable, and that they felt that staff were talking about them. Eight out of the 14 patients we spoke with at this inspection, told us that staff still spoke in languages they did not understand.

Management interventions to address this had been ineffective. Managers had reminded staff that English must be the language spoken on the wards, as it was essential that staff were able to communicate effectively with patients and understand their risks. We viewed ward staff meeting minutes from the last three months. We saw that staff had discussed staff speaking in languages other than English in a meeting on Holdenby ward. A staff member confirmed that this was still happening occasionally. A second staff member commented that some staff spoke very little English. The chair of the meeting confirmed that the provider had implemented a language and literacy test at interview stage for all staff.

We received one anonymous compliment from a member of staff that gave a positive account of working at Broomhill.

Following inspection, the provider submitted data from their staff survey conducted in August 2020. There was a return rate of 35%. 70 out of 88 staff (80%) said if they raised a concern or complaint it would be acted on. 68 of 88 staff (77%) felt Broomhill was well led.

Governance

The provider did not have robust, ongoing monitoring of the quality of the service. The provider had been responsive to concerns raised by the Care Quality Commission. However, inspections undertaken in February and July identified different issues that the provider had failed to recognise independently.

Staff completed some clinical audits. Staff undertook monthly audits of infection control, care records and clinic rooms monthly. Staff also undertook a quarterly health and safety audit. The visiting pharmacist undertook monthly audits of medicines. The provider did not show any evidence of audits undertaken in relation to observation documentation or practice. The provider was unaware that staff had not always adhered to policy. We found many discrepancies and omissions in observation records. The provider could not be assured that patients observations had been carried out in line with individual risk and care plans.

Acute wards for adults of working age and psychiatric intensive care units

Managers showed us a scheduled task list for the hospital, which showed that staff should conduct a mattress audit monthly. However, the first record of staff undertaking this was on 11 September 2020. This was the day after our first unannounced site visit. We saw that a mattress audit was due to be completed by staff in May 2018. It was not clear if staff had completed this. We could not be sure when staff last carried out a visual check of mattresses.

Managers had not maintained full oversight of medicines management, despite regular audits of medicines and of clinics. The process of disposing of medicines was not consistent across the hospital and had not been identified by the provider through any audit processes.

We found that staff had to re-set the fridge temperature for 25 days in July 2020; 18 dates in August 2020 and two dates in September 2020 on Holdenby ward, to ensure that the temperature was safe to store medicines. The nurse confirmed that staff had reported this but was unclear as to what actions managers had taken.

Managers had not taken robust steps to ensure that staff stored medicines securely. Staff had recorded in the July, August and September 2020 audits on Holdenby ward, that within the clinic room a medicine cupboard did not lock. This cupboard remained unlockable and held medicines during our inspection.

Managers had not communicated audit outcomes effectively. We found that team meeting minutes, board meeting minutes and the quality forum meeting minutes did not record specific outcomes of audits staff had undertaken. Therefore, no actions had been identified to address shortfalls or to make improvements.

Long stay or rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Maintenance, Cleanliness and Infection Control

Managers had not ensured that beds and bedding were clean and well maintained. In response to concerns raised by a patient, we carried out inspections of beds, mattresses and bedding on Manor ward. We examined five bedrooms in total. Three of the five mattresses viewed did not fit the divan. The mattresses themselves were too long, which resulted in an overhang. Three of the five bed bases were stained. Two out of the five mattresses needed cleaning. Three out of the five beds had bedding which was very stained (sheets and pillow cases) and required changing. One duvet was stained and discoloured. One mattress had no bottom sheet. One bed base had a panel missing at the head end of the base. Pillows in one room needed replacing. They were very dirty, stained and out of shape. Staff assisted them if asked. One staff member we spoke with, told us that patients were encouraged to change their own bedding, with a focus upon rehabilitation.

When we returned to the hospital on our second visit, the provider told us they had completed a bed audit and had taken appropriate action, which had included ordering new bed divans.

Medicines Management

Managers had not ensured that staff were safely disposing of medicines in line with the provider's policy. We completed a medicine check on Manor ward. The registered nurses on both wards we spoke with, who were agency and had administered medications, did not know the process for the recording of medicines disposal. However, the nurse did locate the current disposal record, following a search of the clinic.

Nursing staff were not always adhering to the provider's policy when administering controlled medicines. On the morning of our visit, a nurse had signed one controlled medicine as administered to a patient on Manor ward. However, there was no second registered nurse signature to witness the administration as required. This did not follow the provider's policy or best practice. We also found one liquid medicine which did not have the date of opening.

Staff undertook regular stock checks of controlled medicines and medicines liable for misuse. We checked a sample of these medicines against the balance recorded. All of these were correct. The nurse did not use the controlled medicines / medicines liable for misuse index at the beginning of the books to locate the medicines sampled. Staff had not updated this. Therefore, it took the nurse some time to locate the correct corresponding pages during the checks.

Staff had not ensured that there was a clinical waste bin within the clinic on Manor ward. However, when we highlighted this, a nurse located one and placed it in the clinic.

Management of Patient Risk

Staff had not ensured that patient observations had been undertaken in line with the provider's policy. We viewed observation records of five patients who were prescribed enhanced observations. These included patients who were either on one to one observation, or two to one observation. We found gaps in recordings in four records. In total we viewed 173 hours of documentation. We found that their were gaps in recordings adding up to to 22 hours. The expectation of the provider is that staff record an entry every hour for those patients on enhanced observations.

Long stay or rehabilitation mental health wards for working age adults

We found inconsistencies in records where staff names had been recorded on Manor ward. In four recordings, the names of staff who carried out the observations was different to the name of staff who had completed the entry. It was therefore unclear at times who the observing nurses had been.

One patient record who was on two to one observation, had three entries recorded by one staff member and not two.Therefore, we could not be assured that two staff had undertaken all observations as expected. We also found that the same nurse had made entries to several enhanced observation records, indicating they had been observing more than one patient at a time. The provider identified the issue as staff not logging out of the electronic system. Therefore there is not a true account within the patients records, of who provided that care for the patient or monitored the patients risk. The provider failed to complete accurate contemporaneous records of all patients care

However, we saw that whenever possible, staff rotated between observations regularly. Staff planned observation allocations at the commencement of each shift to ensure that staff received adequate time between undertaking observations. This was in line with the providers policy, and national guidance. We also saw that observing staff had written something during periods of observations undertaken. Although entries were not always very detailed, there was some narrative around the patient's mood and presentation.

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

(for example, treatment is effective)

We did not inspect against this key question.

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

Kindness, Privacy. Dignity, Respect, Compassion and support

Staff had not always treated patients with kindness and respect. We interviewed 14 patients in total across the hospital and received anonymous feedback from one patient via a "tell us about your experience" form. Eight patients told us that they had heard staff speaking to one another in languages which they did not understand. Some patients told us that when they heard staff speaking in languages they did not understand, they felt staff had been talking about them.

Three patients told us that staff did not always treat them with dignity and respect. One patient told us that they did not like the way in which some staff had spoken to them. Another patient described some staff as being "arrogant". One patient described permanent staff as "responsive" to requests, in contrast to some agency staff who were often "slow to respond" to them. One patient told us that staff had been rude to them about their weight.

Two patients told us that staff generally treated them with dignity and respect, although described some staff on occasions as "abrupt and rude". This was made in reference to staff interrupting when patients were having conversations at night time and were told to go to bed.

Three patients we spoke with told us that they felt cared for and looked after. Two patients spoke positively about their care and treatment and felt that staff did their jobs well.

One patient told us "staff were supportive and made sure they gave the best possible care".

Nursing staff had not always ensured that patient's privacy and dignity was respected. A nurse on Manor ward told us they would administer insulin to patients outside of the clinic room. The door of the clinic opened onto the dining room. We observed via CCTV a patient sit in a chair in the dining room, by the clinic and had their medicines administered via a spoon. Other staff and patients were present in the dining room at this time.

Staff had not always responded positively to patients during incidents. We observed one episode of CCTV which was of an incident that had been recorded on the providers' incident log. During this incident, we saw a member of staff shout repeated times, close to the face of the patient (“calm down”). However, within the same incident, we saw a different staff member who showed positive and supportive body language. This resulted in the patient walking with staff towards the clinic for medicine. The provider told us during feedback, that they had not yet

had a chance to look at this incident but would do so based on the information provided to them. We were told retrospectively that managers had taken appropriate action and an investigation was pending.

We did not observe any episodes of staff speaking to one another, in languages which patient's did not understand, in the CCTV footage viewed.

Following inspection, the provider submitted data from their patient satisfaction survey conducted in August 2020. There was a return rate of 59%. 44 out of 55 (80%) patients said they had been treated with dignity and respect. 45 out of 55 (82%) patients said they knew how to raise a complaint. 40 out of 55 (74%) said they were happy with the response to their complaint.

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

We did not inspect against this key question.

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

Culture

The culture amongst staff and managers was not open and transparent when raising and dealing with concerns from patients and staff about poor staff attitude. Staff and patients shared their experiences with the CQC directly rather than with the provider in the first instance. This was an issue of concern at our inspections in February and July. This inspection also took place as a result of a further whistle-blowing account directly to CQC.

Previous inspections found that staff frequently spoke to one another in languages that patient's did not understand. Patients voiced that this made them feel uncomfortable, and that they felt that staff were talking about them. Eight out of the 14 patients we spoke with at this inspection, told us that staff still spoke in languages they did not understand.

Management interventions to address this had been ineffective. Managers had reminded staff that English must be the language spoken on the wards, as it was essential that staff were able to communicate effectively with patients and understand their risks. We viewed ward staff meeting minutes from the last three months. Managers had not recorded anything in relation to staff speaking to one another in languages patient's did not understand. The provider had introduced language and literacy tests at the interview stage for all staff.

We received one anonymous compliment from a member of staff that gave a positive account of working at Broomhill.

Following inspection, the provider submitted data from their staff survey conducted in August 2020. There was a return rate of 35%. 70 out of 88 staff (80%) said if they raised a concern or complaint it would be acted on. 68 of 88 staff (77%) felt Broomhill was well led.

Governance

The provider did not have robust, ongoing monitoring of the quality of the service. The provider had been responsive to concerns raised by the Care Quality Commission. However, inspections in February and July identified different issues that the provider had independently failed to recognise.

Staff completed some clinical audits. Staff undertook monthly audits in infection control, care records and clinic rooms. Staff also undertook a quarterly health and safety audit. The visiting pharmacist completed monthly audits of medicines. The provider did not show any evidence of audits undertaken in relation to observation documentation or practice.The provider was unaware that staff had not always adhered to policy. We found many discrepancies and omissions in observation records. The provider could not be assured that patients observations had been carried out in line with individual risk and care plans.

Managers showed us a scheduled task list for the hospital. This showed that staff conducted a mattress audit monthly. However, the first record of staff undertaking this was on 11 September 2020. This was the day after our first

unannounced site visit. We saw that staff were due to complete a mattress audit in May 2018. It was not clear if staff had completed this. We could not be sure when staff last completed a last visual check of mattresses.

Managers had not maintained full oversight of medicines management, despite regular audits of medicines and clinics. The process of disposing of medicines was not consistent and had not been identified by the provider through any audit processes.

Managers had not communicated audit outcomes effectively. We found that team meeting minutes, board meeting minutes and the quality forum meeting minutes did not record specific outcomes of audits. Therefore, no actions had been identified to address shortfalls or to make improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that staff always communicate with and in front of patient's in a language that they can understand. (Regulation 10).

The provider must ensure that patient's privacy and dignity is maintained at all times when undertaking all aspects of care and treatment. (Regulation 10).

The provider must ensure that staff treat patient's with kindness and respect at all times. (Regulation 10).

The provider must ensure they have robust information and monitor this in order to assure themselves of the quality of the service provided, and takes action to make improvements accordingly. (Regulation 17)

The provider must ensure records of enhanced observations are completed in full and follow the provider's policy (Regulation 12).

The provider must ensure that dispensing of medication for controlled drugs, is completed in line with best practice and the provider's policy (Regulation 12).

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 10 HSCA (RA) Regulations 2014 Dignity and respect

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

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

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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