

Coventry and Warwickshire Partnership NHS Trust

Brooklands

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, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Janet Shaw

Core service provided: Medium secure forensic

Male/female/mixed: male

Capacity: 15

Jade

Core service provided: Specialist assessment and treatment, 16–25 years

Male/female/mixed: male

Capacity: 15

Amber

Core service provided: Specialist assessment and treatment 18+

Male/female/mixed: male and female

Capacity: 12

Malvern

Core service provided: Low secure

Male/female/mixed: male

Capacity: 15

Snowden

Core service provided: Low secure

Male/female/mixed: male

Capacity: 11

Eden

Core service provided: Low secure

Male/female/mixed: female

Capacity: 15

1 Tuxford

Core service provided: Adolescent Specialist Assessment and Treatment 12–19 years

Male/female/mixed: mixed

Capacity: 6

3 Tuxford

Core service provided: Adolescent Specialist Assessment and Treatment 12–19 years

Male/female/mixed: mixed

Capacity: 6

We found at this inspection that Brooklands was not compliant with the safety and suitability of premises. This was because the security systems in place in Janet Shaw were not sufficient to protect the safety of people who used the service and staff. The gate lock had failed and whilst the perimeter was secure, the measures introduced limited people's access to outside space.

People were at risk in the seclusion rooms in Malvern and Eden units of being cold and of harming themselves.

People's privacy and dignity were not respected if they needed to use the seclusion room in Amber unit.

We saw that the medicine management systems were generally safe and ensured people had the medicines they were prescribed to promote their health and wellbeing. Staff did not have updated rapid tranquilisation training which could put people at risk of harm if they needed this.

Safeguarding processes were robust and all staff had received training to ensure they knew how to safeguard people from harm who used the service. However, for some staff this needed to be updated.

We saw that people received support from a team of professionals who worked together to ensure they had the care and treatment to meet all their needs effectively.

People's physical health needs were monitored and met.

We found that each unit worked in isolation and did not share best practice which could mean that people's care and treatment may not have been as effective as it could be.

People told us they did not like the food provided. We saw this was discussed at meetings held with people who used the service; however people were not aware of what they could do to make changes where possible.

Summary of findings

Staff in Tuxford units were qualified and competent so that the treatment that children received was effective in meeting their needs and enabled them to move on to more suitable placements.

Some staff in other units required further training in how to meet individual needs to ensure they supported people to be safe.

People told us, and we saw, that they were supported to be involved in their care plans and to attend their reviews.

We saw that staff interacted well with people who used the service to promote their wellbeing and self-esteem.

We saw that some people did not participate in regular meaningful activities to ensure their treatment was effective and met their needs.

Generally we found that staff respected people's privacy and dignity to promote their wellbeing.

We found that people knew why they had been detained under the Mental Health Act and what their rights to appeal to this were.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The security system in Janet Shaw and the seclusion rooms in Malvern and Eden units were not safe to ensure the safety and protection of people who used the service, staff and the public.

Safeguarding processes were robust and staff had received the training they needed to ensure people's safety.

Medicine management systems were generally safe to ensure that people received their medicines safely to meet their health needs.

In all units, apart from Jade, there were sufficient staff employed with the appropriate skills to ensure people's safety. Some staff in Jade unit did not have the appropriate skills to ensure people's safety at all times.

Staff in Tuxford units safely ensured that the children's behaviours were managed appropriately.

We found in Amber unit that restrictions were placed on all people who used the service to ensure their safety and not as an individual response to people's needs.

Are services effective?

We saw that people received support from a team of professionals who worked together to ensure that they had the care and treatment to meet all their needs effectively.

We found that each unit worked in isolation and did not share best practice, which could have meant that people's care and treatment may not have been effective as it could be.

People's physical health needs were monitored and met.

Staff in Tuxford units were qualified and competent so that the treatment that children received was effective in meeting their needs and enabled them to move on to more suitable placements.

Some additional training was needed for staff in Amber unit in caring for people with autism so that all people's needs could be met.

Are services caring?

We saw that advocacy services for young people were used. Regular meetings were held in each unit to ask for people's views about the service.

People told us, and we saw, that they were supported to be involved in their care plans and to attend their reviews.

We saw that staff interacted well with people who used the service to promote their wellbeing and self-esteem.

We saw that some people did not participate in regular meaningful activities to ensure their treatment was effective and met their needs.

Generally we found that staff respected people's privacy and dignity to promote their wellbeing.

Are services responsive to people's needs?

We saw that staff respected people's religious and cultural needs to ensure their wellbeing.

Some further input was needed to ensure that the needs of all people who used the service could be met.

Summary of findings

We saw that generally people were prepared for their discharge to ensure it was a smooth transition and their re-admission to hospital was prevented.

Are services well-led?

We found that it was unclear what the purpose and role of Jade unit was, which meant that some people's needs may not be met.

Staff generally felt they were safe at work; however we found a security issue in Janet Shaw and staffing issues in Jade unit which could have placed staff at risk of harm.

Staff told us that they were well managed and supported by their line manager, but they did not feel well managed by the director level of the Trust.

Staff did not feel involved in the Trust as a whole and the Trust vision and values were not embedded into the units.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

The Mental Health Act (1983) allows a person to be admitted to hospital for assessment and treatment of their mental health. This imposes restrictions upon their liberty, for example, they may not be able to leave hospital without permission and they may be given treatment against their consent. This means important safeguards must be in place to make sure they know their rights to appeal against detention and systems are in place to ensure correct procedures are being followed in detaining and treating the person. The Mental Health Code of Practice gives guidance to hospitals on how to do this. We monitor the Mental Health Act and Code of Practice to ensure it is being adhered to.

Detained people were given their rights so they knew how to appeal against their detention.

Medicine that was prescribed to be given as required was not always given in accordance with the legal authority.

People's capacity to consent to medicine was recorded. There was a lack of monitoring of rapid tranquilisation.

People had access to section 17 leave and on some wards this was very varied and provided people with interesting experiences. The conditions of the leave set out on the forms were not always clear.

We found that availability of activities was varied between wards and was dependent on the staffing levels provided.

We saw that access to seclusion facilities did not always facilitate the privacy and dignity of people who used the service.

The security measures on one ward led to undue restrictions on the movement of people who used the service. On another ward we saw that undue restrictions were placed on people rather than individually risk assessing people to meet their needs.

Long stay/forensic/secure services

We found that the security system in Janet Shaw was not safe and put people who used the service, staff at potential risk of harm.

The seclusion rooms in Malvern and Eden units were cold and unsafe which posed a risk to people who used the service.

We saw that the medicine management systems were generally safe and ensured people had the medicines they were prescribed to promote their health and wellbeing. Staff did not have updated rapid tranquilisation training which could put people at risk of harm if they needed this.

Safeguarding processes were robust and all staff had received training to ensure they knew how to safeguard people who used the service from harm. However, for some staff this needed to be updated.

We saw that people received support from a team of professionals who worked together to ensure that they had the care and treatment to meet all their needs effectively.

We found that each unit worked in isolation and did not share best practice which could have meant that people's care and treatment may not have been effective as it could be.

People told us they did not like the food provided. We saw that this was discussed at meetings held with people who used the service; however, people were not aware of what they could do to make changes where possible.

We saw that in some units people were provided with appropriate activities and treatment programmes to promote their recovery and wellbeing. However, we saw that this varied in the evenings and at weekends which meant some people were bored and under-stimulated.

People told us that they were involved in their care planning and had agreed to their treatment.

Summary of findings

We saw that the bathrooms in Janet Shaw needed to be refurbished to promote the privacy and dignity of people who used the service. One person told us that their privacy was not always respected by staff as they left their observation panels open in their bedroom door.

Two wards had been merged together into Malvern unit in October 2013. We saw that this had not been planned to meet people's individual needs but as a response to refurbishing a building that had not been commissioned to be used as such. This impacted on how staff could respond to meet people's individual needs.

We saw that people's religious and cultural needs were respected and met.

We found that staff were unaware of the role of the directors within the Trust and did not feel led by them.

In Eden unit we saw that the role of the clinical lead and ward manager were confused which made it unclear as to who was accountable for the leadership of the unit.

Child and adolescent mental health services

We saw that the units were well staffed so that the individual needs of the children could be safely met.

Parents spoken with told us they had no concerns about the safety of their children when they were at the unit.

We found that some children displayed extreme behaviours of self-harm and violence towards others. However, this was managed by staff safely so as to promote children's wellbeing.

Staff were qualified and competent so that the treatment that children received was effective in meeting their needs and enabled them to move on to more suitable placements.

We observed that staff engaged well with each child and ensured they received the care and support they needed.

The environment in Tuxford units should be improved to ensure that children benefit from a caring and supportive environment.

We saw that staff responded to children's individual needs so that their religious and cultural needs were respected.

Some children placed there were a long way from their home. Staff responded to this by ensuring that children had regular contact with their family.

Staff spoken with told us that they were valued by the leaders of the Trust and felt their views were listened to.

Staff told us and we saw that there were plans to refurbish the building; however there were no firm dates and timescales set for this.

Services for people with learning disabilities or autism

All staff had received training in safeguarding vulnerable adults from abuse and processes were in place so that staff knew how to ensure that people were safe.

Systems for seclusion needed to be improved to ensure safety and wellbeing for the person needing seclusion and others.

In Amber unit we found that staff responded to people's behaviours by placing restrictions on them and the response was not based on individual's risks which could impact on people's safety and wellbeing. All people who used the service could only access their mobile phones for one hour in the weekday evenings but could at all time at weekends. Staff could not explain to us the rationale for this.

Summary of findings

There were enough staff to ensure people's safety in Amber unit. However, in Jade unit there were sometimes insufficient staff with the appropriate skills to meet people's complex needs and ensure their safety.

We saw that professionals worked together to meet people's individual needs and ensure that their care and treatment were effective.

People did not participate in regular meaningful activities to ensure their treatment was effective and met their needs. Activities were not personalised to people's Individual interests and needs. Several activities were record as 'relaxing' and so were passive which did not help to promote some people's wellbeing.

We saw that people's physical health care needs were monitored and met.

We observed that staff interacted well with people who used the service and knew how to support them to meet their needs.

Department of Health guidance that requires the provision of separate spaces for men and women to ensure they are cared for separately. This standard was not always being met. This meant that people's privacy and dignity was not always respected.

We saw that staff respected people's religious and cultural needs to promote their wellbeing.

We found that some staff lacked awareness about the needs of people who have autism. The environment was not suitable in Amber unit for people who had autism which impacted on their wellbeing. However, plans were in place to improve this to benefit people who used the service.

It was unclear what the role of Jade unit was as it was for people from a wide age range and needs. Staff were not sure what the purpose of the unit as a whole was which meant that some people could be at risk of not having their needs met.

Staff told us they were well supported by their managers; however, they did not feel valued by senior managers in the Trust and told us they did not have contact with them. This could mean that they are not clear of their role within the Trust and how it impacts on the Trust as a whole to benefit people who use the service.

Summary of findings

What people who use the location say

As part of this inspection we looked at survey results, held groups with people using the services and their relatives, spoke with some individuals who requested to speak with us personally, and used comments cards before and during the inspection. We did not receive any comments about Brooklands on the comment cards received.

During our inspection we spoke with people who used the service on each of the units in the hospital. They told us:

"I feel safe here."

"The groups I attend are really helpful. I can manage my anger now."

"I'm allowed to use my mobile phone for one hour in the evening and all day on Saturday and Sunday, I would like to use it more often."

Another person told us they did not know why they could not use their mobile phones at certain times but this is what staff had told them

People told us they were well supported by staff. One person told us that staff were very supportive to them when one of their parents died. Another person said told us they could talk with staff and that staff are amazing.

Several people told us that they did not like the food that was provided at Brooklands. People said there was an offered choice of food but there was not much to choose from. People described the food as nasty and not good and that they did not like it.

People told us they were involved in their care plans and attended meetings that were about them. One person said they attended their review meetings and they were okay. Three people told us that they had input into their care plans and had signed to show they agreed with them.

All people spoken with told us that they could have contact with their family if they wanted this. One person told us their family visited regularly and there was a room where they could go and talk. People also told us they could have an advocate who helped them to express what they thought about being at the hospital.

Some people told us that the activities that were provided were not enough and they were bored. Several people told us that there was a gym on site that they could use. However, they told us there were not enough gym instructors and the gym was not open at weekends.

We also spoke with relatives of people who used the service. One relative told us that they took their hat off to the staff, who were really calm and brilliant with their relative. One relative told us that staff had treated them well and valued their opinion, they had been treated really nice and staff were respectful

Another relative told us they were really pleased as their relative used to be on a lot of medicine but this had been reduced since they had been at Brooklands.

Areas for improvement

Action the provider **MUST** take to improve

- We found at this inspection that Brooklands was not compliant with Regulation 15 – safety and suitability of premises. This was because the security systems in place in Janet Shaw were not sufficient to protect the safety of people who used the service and staff.
- People were at risk in the seclusion rooms in Malvern and Eden units of being cold and of harming themselves. People's privacy and dignity were not respected if they needed to use the seclusion room in Amber unit.

Action the provider **SHOULD** take to improve

- Staff need to have updated training in rapid tranquilisation.
- Some staff need updated training in safeguarding.
- Staff should be offered a de-brief following incidents.
- Firm plans with timescales should be in place as to when and how the environment in Tuxford will be improved.
- Risk assessments in Malvern unit should be reviewed and updated to reflect the new environment.

Summary of findings

- Meaningful activities should be offered at all times and not just during the day.
- All staff should be aware of the need to respect people's privacy and dignity.
- Clearer direction and leadership of staff, clearer role of Jade unit.
- People who use the service could be better supported to express their views about the meals provided. There are patient champions identified but more staff support could be given to ensure that ways to measure the quality of care that people who used the service experience is effective and that people can make changes where possible.

Action the provider COULD take to improve

- Staff could share ideas of best practice to make the service more effective for people who use it.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was a good system of reviewing incident forms so that lessons could be learnt to ensure people's safety and welfare.
- Input from people's families was encouraged and it was recognised of the positive impact this could have on people who used the service.
- Groups to assist people in their treatment were well led and all grades (not just qualified nurses and doctors) of staff were encouraged to be trained in leading these.
- There were discharge plans in place soon after a person was admitted so that their treatment and recovery were not delayed.
- People who used the service had regular health checks and an annual health check.
- Incidents where people were at risk of harm were reported appropriately to local safeguarding teams.
- People who used the service understood why they were detained under the Mental Health Act, what their treatment plan was and their rights to appeal.
- We observed good interactions between staff and people who used the service.
- Staff spoken with were positive about how well the multi disciplinary team worked together to benefit people who used the service.
- Information was provided to people who used the services about the medicines they were prescribed. This was in a format that was easier for people to understand.
- Protocols that stated what medicine should be given to a person when required, for example, to help them to calm down were centred on the person. They identified clear early warning signs of how the person behaved and what support staff could give the person before having to use the medicine.
- Amber Ward at Brooklands is AIMS accredited and rated excellent with the Royal College of Psychiatrists. AIMS is a standards-based accreditation service designed to improve the quality of care in psychiatric wards. Standards are drawn from authoritative sources and cover all aspects of the inpatient journey. Compliance is measured by self- and peer-review.

Brooklands

Detailed findings

Services we looked at:

Mental Health Act responsibilities; Long stay/forensic/secure services; Child and adolescent mental health services; Services for older people; Services for people with learning disabilities or autism

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included CQC inspectors, Mental Health Act Commissioners and a number of specialists: Expert by Experience, Consultant Psychiatrist in Forensic Services, Consultant Clinical Psychologist, and learning disability nurses.

Background to Brooklands

The Trust has a total of 21 active locations. There are three hospitals sites: Brooklands, St Michael's Hospital and Caludon Centre. Nine of these locations provide mental health services including Brooklands.

The Trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 10 inspections covering five locations which are registered for mental health conditions.

Brooklands has a forensic medium secure service for men called Janet Shaw, two specialist assessment and treatment services called Jade and Amber units, Malvern and Snowdon units for men who require a low secure environment and Eden unit for women who require a low secure environment. There are also two adolescent specialist assessment and treatment services in Brooklands called 1 and 3 Tuxford.

We inspected Amber Unit, Brooklands on 27 June 2013, following concerns raised by visitors to the unit. We found people's views were not always taken into account in the way their treatment was delivered. We also found that people's privacy and dignity was not always respected. We saw that people did not always experience care, treatment and support that met their needs and protected their rights.

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our wave 1 pilot inspection. The Trust was selected as one of a range of Trusts to be inspected under CQC's revised inspection approach to mental health and community services.

Detailed findings

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Mental Health Act responsibilities
- Long stay/forensic/secure services

- Child and adolescent mental health services
- Services for people with learning disabilities and autism

Before visiting, we reviewed a range of information we hold about the location and asked other organisations to share what they knew about the location. We carried out an announced visit on 21, 22 and 23 January 2014. During our visit we held drop in sessions with a range of staff at the location, such as nurses, care staff, psychologists, speech and language therapists and occupational therapists. We talked with people using services and staff from all areas of the location. We observed how people were being cared for and spoke with family members and reviewed care or treatment records. We met with people using services and family members, who shared their views and experiences of the location. We carried out an unannounced visit on the evening of 21 January 2014.

Mental Health Act responsibilities

Information about the service

The Mental Health Act (1983) allows a person to be admitted to hospital for assessment and treatment of their mental health. This imposes restrictions upon their liberty, for example, they may not be able to leave hospital without permission and they may be given treatment against their consent. This means important safeguards must be in place to make sure they know their rights to appeal against detention and systems are in place to ensure correct procedures are being followed in detaining and treating the person. The Mental Health Code of Practice gives guidance to hospitals on how to do this. We monitor the Mental Health Act and Code of Practice to ensure it is being adhered to.

Brooklands has a forensic medium secure service for men called Janet Shaw, two specialist assessment and treatment services called Jade and Amber units, two low secure units for men called Malvern and Snowdon and Eden unit for women who require a low secure environment. There are also two adolescent specialist assessment and treatment services in Brooklands called 1 and 3 Tuxford.

Summary of findings

Detained people were given their rights so they knew how to appeal against their detention.

Medicine that was prescribed to be given as required was not always given in accordance with the legal authority.

People's capacity to consent to medicine was recorded. There was a lack of monitoring of rapid tranquilisation.

People had access to section 17 leave and on some wards this was very varied and provided people with interesting experiences. The conditions of the leave set out on the forms were not always clear.

We found that availability of activities was varied between wards and was dependent on the staffing levels provided.

We saw that access to seclusion facilities did not always facilitate the privacy and dignity of people who used the service.

The security measures on one ward led to undue restrictions on the movement of people who used the service. On another ward we saw that undue restrictions were placed on people rather than individually risk assessing people to meet their needs.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We found there were robust processes in place to give people who used the service their section 132 rights. This meant that people could access hospital manager's hearings, Independent Mental Health Review Tribunals and understood their right to an Independent Mental Health Advocate to support them. However, it was not clear who provided information on the 'Nearest Relative' rights to people.

We saw that people's rights were provided to them in a format that used pictures on the Tuxford wards and the person's level of understanding was described in their records. The giving of rights to people who were detained was repeated so that staff could be sure that people continued to have an understanding of these.

In Janet Shaw Clinic we found that for two people who used the service their 'as required' medicines were not written on the appropriate T2 or T3 certificates and were not dated. This meant that the staff would not be clear under what legal authority they were giving treatment. A T2 certificate is issued for consenting to people's medicine and a T3 certificate is issued for non – consenting people to be given medicine without their consent.

We found in the Tuxford units that people had their capacity and consent to their treatment recorded and that people who were detained had T2 and T3 certificates in place.

In Malvern unit we found discrepancies between the ward leave sheet and Section 17 leave forms. The escorted ground leave said experienced staff to escort but it was not clear as to what experience these staff needed to have. It also stated that staff had to be PAMOVA trained but the Trust used MAPA physical intervention. The Trust's missing persons policy expired on 19 April 2013 and had not been reviewed.

We saw that staff had not received updated training in rapid tranquilisation which could put people who used the service at risk of harm if they needed this. We spoke with the Mental Health Legislative Committee who informed us that they did not know which of their governance

committees monitored the use of Rapid Tranquilisation. This could mean that the use of this was not being which could put the safety and welfare of people who used the service at risk.

We saw that the seclusion room in Malvern unit was at the end of the unit past the bedrooms of people who used the service. This meant that if a person needed to be secluded to ensure their safety and that of others, they would have to be moved to the other end of the unit by staff. Therefore, their dignity and safety and that of others was at risk of being compromised. We saw that a metal thermostat was placed in the seclusion room which would put the person at risk of harming themselves.

The ward manager told us that this had been reported to the estates department but was not clear when this would be removed to ensure people's safety. We saw that there was no communication system between the room and the staff observation area. This meant that the person would be isolated and unable to communicate with staff who were observing them, which could impact on their safety and wellbeing. Staff told us, and records we sampled, showed that the seclusion room had not been used however, if it was needed it would not be safe to use.

In Eden unit we saw that the seclusion room was cold and staff told us they had identified this and reported it to estates but the heating had not been repaired. Therefore there was no suitable room to seclude people should this be necessary. There was no risk assessment to show what action would be taken to reduce the risks of using an alternative room for seclusion. This could put people who used the service at risk of harm.

Staff spoken with told us that they would use the small lounge known as the quiet lounge for someone who required low stimulus or a quiet space if they were agitated.

Are Mental Health Act responsibilities effective? (for example, treatment is effective)

In Jade unit one person's records we looked at was not clear as to the level of their learning disability or their capacity to consent to treatment under section 58 of the Mental Health Act.

Mental Health Act responsibilities

In Janet Shaw we saw that one person was prescribed Lorazepam to be taken when required. There was no legal authorisation for this on the T2 or T3 certificates or an emergency S62. We were also concerned that an 'as required' prescription for another person had no legal authorisation (T2/T3 certificates) in place. Staff relied on what the person's doctor had stated verbally when giving this medicine to the person. This could mean that the person was not given their medicine as prescribed by their doctor. We saw that another person's T2's were old and had not been cancelled by the doctor. This could mean that the person was not receiving the current medicine prescribed by their doctor.

We found discrepancies between the ward leave sheet and Section 17 leave forms. In Malvern unit we saw that one person's Section 17 leave form was signed appropriately but said that the person could go on leave with experienced staff but it was not clear what this meant. The ward manager told us they had raised this with the person's team of professionals that worked with them but it had not been defined in the leave policy or written down. Another person's Section 17 leave form had a crib sheet about their leave at the front of their file but this did not match the Section 17 leave form. The ward manager said they had raised this with the doctor's secretary but had not checked that this had been amended.

We found that the expired Section 17 leave forms were crossed out to prevent misunderstandings as to what the person's current leave was.

We found that there were no Approved Mental Health Professionals reports in three of the five files we looked at in Tuxford 1 and 3. This should be available with the person's detention papers and should describe the reasons for detention, the consultation with the nearest relative and consideration of the least restrictive options to detention. We found that in one young person's file there was conflicting information about their status when they were assessed for detention under the Mental Health Act. It was unclear if they were subject to a full care order under Section 31 of the Children's Act 1989. This would have deemed the Local Authority to be the Nearest Relative, yet one of the young person's parents was noted to be the Nearest Relative under the Mental Health Act. Staff were

unable to confirm the status of the young person on the day of our inspection. The Trust acted responsively and obtained legal advice to confirm the lawfulness of the young person's detention.

The availability of Independent Mental Health Advocacy services to support people who were detained was evident on the Tuxford wards. They attended the ward meetings, reviews and supported the young person with Independent Mental Health Tribunals.

We found that people were at risk in the seclusion rooms in Malvern and Eden units of being cold and of harming themselves.

Are Mental Health Act responsibilities caring?

In Amber unit we found that people understood their treatment and the reasons for decisions made. We saw that people had the information about their Section 132 rights under the Mental Health Act that they needed, in a way they could understand. We saw that the Independent Mental Health Advocate was involved to ensure that people understood their rights but not all people who were detained could access this.

The advocate told us that the Independent Mental Health Advocate service was only partially funded they concentrated on Jade, Amber & Tuxford wards only. The Trust confirmed that advocacy services were commissioned by the Local Authority at Brooklands.

We found on the Tuxford units that section 17 leave was properly authorised and stated the conditions of the leave such as frequency, duration and whether the young person needed an escort. This meant that young people and their parents would know the parameters of leave and contingency arrangements. We saw that Section 17 leave was authorised so the young person could go to many interesting places as part of their treatment plan.

People's privacy and dignity were not respected if they needed to use the seclusion room in Amber unit. On Amber we saw that there was no de-escalation suite which would help the person to calm down to try to reduce the need for seclusion. We saw that the seclusion room was accessed through the corridor where the bedrooms were for women.

Mental Health Act responsibilities

This meant that men might have to go through this corridor if they needed to access the seclusion room, which could impact on the privacy and dignity of all people who used the service.

We found that the gate in Janet Shaw was not robust and failed when rain seeped into the gate closures. A manual system was introduced to make the perimeter safe. However, this resulted in undue restrictions to access to fresh air for people who were detained after 4pm during weekdays and at all times during weekends, where people had to smoke and access fresh air in a small ring-fenced area referred to as the 'Cage.'

There was variability between wards in relation to the availability of activities based on assessed needs. For example, there appeared to be fewer activities in Malvern unit due to staffing levels, whilst in Eden unit there were more. This meant that there was a lack of equity to therapeutic activities required as part of a person's recovery from mental illness.

Are Mental Health Act responsibilities responsive to people's needs? (for example, to feedback?)

We found in the Tuxford units that there was good involvement of young people in activities and that they were able to put forward expressions of their interests which meant that individual activities were provided.

In Janet Shaw people told us that they could access the fenced outside area between 10am and 4pm for fresh air. However, at weekends and evenings they had to go into a smaller compound where people also smoked. They told us this was too restrictive.

We found that in relation to section 117 that discharges from the hospital were planned and that the responsibility

and involvement of the person's home local authority took place. This meant that people were given an opportunity to be discharged to an area which they knew and they may have increased contact with their family and friends.

In Amber unit we found that staff responded to people's behaviours by placing restrictions on them and this was not based on individual's risks which could impact on people's safety and wellbeing.

Are Mental Health Act responsibilities well-led?

We saw in the Tuxford units that systems were in place by the Mental Health Act Administrators to undertake record audits to ensure that detention and treatment was being given under the appropriate legal authority. Mental Health Act Administrators also ensure detention renewals, hospital managers' hearings and Independent Mental Health reviews are organised and the person's nearest relative are invited to these. However, we saw numerous minor errors in the files, for example, the incorrect date of commencement of the young person's detention. In Tuxford units we did not see Approved Mental Health Professionals reports in young people's files. These show the reasons why a person is detained and if the person or their nearest relative had been consulted. We saw evidence of good clinical leadership and support in the Tuxford units.

There is a Mental Health Legislative committee which monitors that statutory requirements are carried out. There are hospital managers' hearings which are an important safeguard for people to appeal against their detention. However, it is unusual for people to be discharged from their section by the hospital managers. The Mental Health Legislative Committee reports to the Safety and Quality Committee, which in turn reports by exception to the Trust board.

Long stay/forensic/secure services

Information about the service

Janet Shaw Clinic is a medium secure forensic service for up to 15 men. Snowdon and Malvern units are low secure forensic services for up to 15 men in each unit. Eden unit is a low secure forensic service for up to 15 women.

Summary of findings

We found that the security system in Janet Shaw was not safe and put people who used the service, staff and the public at risk of harm. The Trust responded to this to ensure people's safety.

The seclusion rooms in Malvern and Eden units were cold and unsafe which posed a risk to people who used the service.

We saw that the medicine management systems were generally safe and ensured people had the medicines they were prescribed to promote their health and wellbeing. Staff did not have updated rapid tranquilisation training which could put people at risk of harm if they needed this.

Safeguarding processes were robust and all staff had received training to ensure they knew how to safeguard people from harm who used the service. However, for some staff this needed to be updated.

We saw that people received support from a team of professionals who worked together to ensure they had the care and treatment to meet all their needs effectively.

We found that each unit worked in isolation and did not share best practice which could mean that people's care and treatment may not have been as effective as it could be.

People told us they did not like the food provided. We saw this was discussed at meetings held with people who used the service, however people were not aware of what they could do to make changes where possible.

We saw that in some units people were provided with appropriate activities and treatment programmes to promote their recovery and wellbeing. However, we saw that this varied in the evenings and at weekends which meant some people were bored and under stimulated at these times.

People told us that they were involved in their care plan and had agreed to their treatment.

We saw that the bathrooms in Janet Shaw needed to be refurbished to promote the privacy and dignity of

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people who used the service. One person told us that their privacy was not always respected by staff as they left their observation panels open in their bedroom door.

Two wards had been merged together into Malvern unit in October 2013. We saw that this had not been planned to meet people's individual needs but as a response to refurbishing a building that had not been commissioned to be used as such. This impacted on how staff could respond to meet people's individual needs. For example, staff told us that some people were not compatible to live with each other which meant there were more incidents where people were agitated with other people who used the service. Some people were ready to be discharged so were being supported in developing their independence skills, allowing them to move back into the community. Other people had recently been admitted so were at an earlier stage of their treatment. This made it difficult for staff to ensure all people had the support they needed.

We saw that people's religious and cultural needs were respected and met.

We found that staff were unaware of the role of the directors within the trust and did not feel led by them.

In Eden unit we saw that the role of the clinical lead and ward manager were confused, which made it unclear as to who was accountable for the leadership of the unit.

Are long stay/forensic/secure services safe?

Learn from incidents and improve standards of safety for people who use services

Staff told us that incident reporting was done online which meant that the multi-disciplinary team (MDT) of professionals who worked with the person received incident forms within 24 to 48 hours of an incident occurring. The MDT then discussed if the incident was dealt with safely and what could have been done better. Managers spoken with told us that several staff were confused as to what a serious incident was and that this meant these may not be reported appropriately, and so allowing them to be reviewed and appropriate action taken to ensure people's safety.

Several people spoken with told us they felt safe at the hospital. One person told us that they felt safe and can talk to staff and that if they were not happy they would speak to their named nurse.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services

We found that the sgate in Janet Shaw was not robust and failed when rain seeped into the gate closures. This meant that the two gates at the front of the unit, that should have opened separately to ensure that people could not get out unescorted by staff, both opened together. Staff and people told us, and records we looked at showed, that this had been a fault first reported in June 2013. At that time action was taken to repair the fault to ensure the safety of people who used the service and the public. In September 2013 we were told and records sampled showed, that the system failed again. Action was again taken to repair the fault at the time however, we saw that the system had consistently failed since September 2013 and it failed again during our inspection. The response to this system failure by the Trust was to provide a manual system that was operated by a security guard. On Mondays to Fridays from 10am to 4pm people had free access to the gardens around the unit. However, outside of these times, which included all the weekend, people were escorted by staff five at a time to use a small fenced area which staff and people referred to as the 'Cage.'

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This meant that people could smoke cigarettes and have an opportunity to get outside for five minutes every hour. If people did not smoke they were in a confined space with those who did, so were at risk of inhaling cigarette smoke. We saw that staff accompanied people into the fenced area and it was then locked by the member of staff in the fenced area who had the keys. This could have meant that people could take the keys from the staff and get out unescorted, which posed a risk to the people and the public.

We asked to look at the fire evacuation plan and saw there was no evidence to show that this had been reviewed since December 2010. We were told that fire evacuation plan remained unchanged because people, could still be evacuated into the garden safely. We looked at the policy for the management of security within Janet Shaw unit and found at the last review the policy had not been amended to include the risks of the broken gate. However an additional procedure to instruct unit and security staff on the manual system was produced. Following our inspection a representative of the Trust informed us that action was taken to ensure the safety of people who used the service and staff.

We found in Janet Shaw that medicine management systems were well organised. When people required medicines to calm them down, if they became agitated, we saw that clear documents were in place that focused on what this meant for the person and how to ensure their safety and wellbeing. However, we found that staff had not received training in how to give a person rapid tranquilisation if needed, to ensure their immediate safety and wellbeing. Staff spoken with told us, and records we sampled, showed that this had rarely been used. We found that one person had been prescribed a medicine on 20 January 2014 but there was no dosage of this written on the chart. We saw that this had been given by a nurse the evening before, but it was unclear what dosage the nurse would have given. This could impact on the person's safety and wellbeing. We raised this issue immediately with the ward manager who assured us that this would be rectified.

Understand and manage risk to the person using services and others with whom they may live with

In Snowdon unit we saw that people's pre-admission assessments had been completed by nurses and specialists and on the person's admission, other

professionals were involved in the assessments. This meant that all the staff working with the person were aware of the risks to their safety and how to support them to reduce these.

In Malvern unit, in records we sampled, we saw that people's risk assessments had not been updated since they had moved to the new unit in October 2013. This meant that the risks of the new environment, and living with people they had not lived with before, had not been assessed which could impact on their safety.

Staffing levels and quality of staffing enables safe practice

We saw that sufficient staff were employed to ensure the safety and wellbeing of people who used the service. A range of therapists were employed in the units to enable people to safely receive the care and treatment they needed. Several staff spoken with told us that staffing levels had improved in the last few months and agency staff were rarely used to cover shifts.

All staff spoken with told us they had received training in how to safeguard vulnerable adults from abuse and harm. However, records showed, and one member of staff told us, that a third of staff needed updated safeguarding training and this was now being booked. All staff spoken with in Snowdon unit showed that they had a good awareness of how to safeguard people and felt they would be confident to whistleblow if they suspected or witnessed abuse.

All staff spoken with in Malvern unit told us they had found training in management of actual and potential aggression (MAPA) useful and that staff were skilled in using this. They said this had reduced the need to restrain people who used the service which improved their safety and that of staff.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Demonstrate collaborative multi-disciplinary working across all services

We found that a team of professionals worked with people who used the service so that they had specialist input to ensure their needs were met. Staff spoken with in the units

Long stay/forensic/secure services

told us that they attended multi-disciplinary team meetings with people who used the service they worked with and that their views were listened to and valued by the clinical staff.

We found that from speaking with staff that qualified nurses, psychologists and unqualified care staff worked together to facilitate groups for people to enable their treatment plans to be carried out and support their recovery. We saw that staff had good knowledge about how to run the groups and that working together was effective in supporting people.

From speaking with staff across all units, and from records we sampled, we found that generally each unit worked in isolation and did not share best practice across the units in Brooklands. This meant that some peoples' care might not be effective in meeting their needs.

Staff told us how they ensured that people's physical health needs were met. We saw in records that people were supported to have annual health checks with the practice nurse who was based at Brooklands. We saw that where needed, appropriate referrals were made to specialists as a result of these checks. We saw that people were supported by staff to attend physical health appointments in other hospitals and clinics where needed to promote their wellbeing.

Quality of care measured and managed

Several people who used the service told us they did not like the food. They said that they had limited choice and it was tasteless and nasty. Food was cooked off site and brought to each unit in ready portions where it was reheated by staff in an oven specially designed to do this. We looked at the minutes of meetings with people, advocates and the operations manager and saw that meals were discussed. People were told that dietician input was provided to ensure that food was safe and nutritious and that people could make sandwiches and bake cakes in the therapy kitchen if they wanted to. We saw that a dietician had attended a meeting in September 2013 to inform people why these meals were provided. Staff suggested to people at this meeting that they could complete questionnaires so that menus could be changed. People we spoke with were unaware that menus could be changed and although they said they did make snacks, this did not

provide a substitute to the food they did not like. More support could be given to ensure that ways to measure the quality of care that people experience is effective and they can influence changes where possible.

Suitably qualified and competent staff

People who used the service in Malvern unit told us that they were bored. They told us that they had more to do during the week days as day services staff were provided but that evenings and weekends were boring. We saw in records we sampled that people did more activities during weekdays. This meant that the service was not effective in ensuring that staff had enough time to provide responsive and appropriate care to people at all times.

In Eden unit two people spoken with told us that regular activities were provided and that regular meetings were held with people who used the service. One person told us that they had weekly sessions with the psychologist. This meant that the service was effective in providing people with their appropriate care and treatment.

Are long stay/forensic/secure services caring?

Is there choice and are people enabled to participate

We saw in records and people told us that they had regular meetings and minutes of these were kept. This helped to ensure that their views were listened to and showed that people were encouraged to express their views.

People participate in a review of needs

Records showed and some people we spoke to told us that they had agreed to their care plan so ensuring staff would know how to support them to meet their needs.

People receive the support they need

One person told us that they had completed the 'Thinking Skills' group as part of the treatment they required and said they had found this really useful. They told us that it had enabled them to change how they behaved. They said they could manage their anger now and could walk away. They told us that they were now taking the relationship group which lasted for 8-12 months as the next stage of their treatment. They told us they did regular activities which they enjoyed and helped them to develop skills as part of

Long stay/forensic/secure services

their treatment plan. They said they did art, made models, went to the gym, did gardening and attended the computer group. This showed staff supported people to help in their treatment and recovery.

Privacy and dignity respected

We saw in Janet Shaw that the bathrooms were in need of refurbishment. The areas around the showers were stained, the decoration was worn and the flooring had lifted in places. This did not show that people's dignity was respected.

One person in Janet Shaw told us that when staff observed them by looking through the observation panel in their bedroom, they sometimes saw them naked. The person was aware that staff needed to observe them to ensure their safety, but they felt their privacy was not always respected. They told us that sometimes staff left their observation panels open so that other people who used the service and visitors could see into their bedroom also. They told us that they had raised this at the meeting with people who used the service but some staff still did this, which impacted on their privacy and wellbeing.

Are long stay/forensic/secure services responsive to people's needs? (for example, to feedback?)

Individual needs met

Staff told us that the move from two wards to Malvern unit was not well planned. This was because some people needed rehabilitation and support to move on and others were in an earlier stage of their treatment. This caused some people to be frustrated and others, who were known not to have got on with each other previously, had been moved to live together. Staff gave us an example of how one person copied another person's behaviours and had self-harmed regularly since they had moved to Malvern. This person told us how often they had self-harmed since the move there.

Staff told us that a doctor had stated in the past that one person should not be moved to live with certain other

people who used the service but this had happened and was not in people's best interests. Staff told us, and we saw, that one person was isolated due to their social anxiety and would not sit in the lounge as they were anxious about being with people they did not know or get on with. Staff told us, and we saw in records, that people had not been assessed as to what was best for them. The two wards had been merged together as Malvern unit because the unit was to be an acute mental health ward but it was not commissioned as such. This meant that people's individual needs were not always being met.

We saw in Snowdon unit that people were supported to meet their religious and cultural needs. This meant that staff responded to people's individual needs to promote their wellbeing.

Are long stay/forensic/secure services well-led?

The governance framework is coherent, complete, clear, well understood and functioning

Staff spoken with in Snowdon unit told us that some senior managers had visited the unit and supported them to ensure that improvements, where needed, were made. Staff spoken with across Brooklands told us they did not feel led by the directors of the Trust and they did not visit them in the units.

Leadership within the organisation is effective, maintained and developed

We were told that both the clinical lead and the ward manager were in charge in Eden unit. This meant that it was not clear who was accountable for the safety of people who used the service and staff which could mean that leadership of the unit was not as effective as it could be.

From speaking with staff across all units and from records we sampled, we found that generally each unit worked in isolation and did not share best practice across the units in Brooklands. This meant that some people's care might not be effective in meeting their needs.

Child and adolescent mental health services

Information about the service

1 and 3 Tuxford are six bedded units within Brooklands. They provide assessment and treatment for children and adolescents who have a learning disability and other associated problems. The units are two separate, but adjacent, two storey houses adapted for their current use and linked by a passage on the upper floor.

Summary of findings

We saw that the units were well staffed so that the individual needs of the children could be safely met.

Parents spoken with told us they had no concerns about the safety of their children when they were at the unit.

We found that some children displayed extreme behaviours of self-harm and violence towards others. However, this was managed by staff safely so as to promote children's wellbeing.

Staff were qualified and competent so that the treatment children received was effective in meeting their needs and enabled them to move on to more suitable placements.

We observed that staff engaged well with each child and ensured they received the care and support they needed.

The environment in Tuxford units should be improved to ensure that children benefit from a caring and supportive environment.

We saw that staff responded to children's individual needs so that their religious and cultural needs were respected.

Some children placed there were a long way from their home. Staff responded to this by ensuring that children had regular contact with their family.

Staff spoken with told us that they were valued by the leaders of the Trust and felt their views were listened to.

Staff told us, and we saw, that there were plans to refurbish the building however there were no firm dates and timescales set for this.

Child and adolescent mental health services

Are child and adolescent mental health services safe?

Understand and manage risk to the person using services and others with whom they may live with

The needs of the children on the unit included extreme self-harm and violence towards others. All had one to one support except for one child who had two to one support. We saw that parental contact was maintained and supported and that hospital advocates were available and used.

Staffing levels and quality of staffing enables safe practice

The unit was well staffed and had an occupancy level that allowed individual needs to be catered for safely. We were told that where agency staff were working on the units, these were regular staff who were familiar and comfortable with the children and knowledgeable about how to meet their needs. We found this to be the case when we spoke with two of the agency staff and observed their interactions with the children.

One parent we spoke with told us the staff have treated me really nice, they are respectful. Another parent said they'd never seen any cruelty from staff but were aware that staff had to be firm. We saw staff being quite directive at times with one child. This was part of agreed practice to help that child to manage their condition. Comments from parents showed they were supportive of the unit's individual approaches. One parent told us the staff had been assessing daily. Another parent told us that they took their hat off to them, the staff are really calm and brilliant with him.

We were given examples of how children with particular risks were supported to safely access wider facilities in the community. Staff told us of how they were alerted to respond to incidents inside and outside Brooklands, and in the community. Staff told us how they defused potential incidents, often using distractions before an incident developed and we observed this during our inspection. We saw that staff were pro-active in calming or diverting children when they showed signs of distress.

Are child and adolescent mental health services effective?

(for example, treatment is effective)

Demonstrate collaborative multi-disciplinary working across all services

Staff told us it was rare for children to return home; they usually moved on to other more local residential units. To prepare for this, the unit had developed strategies to help ensure that future placements were successful.

Quality of care measured and managed

Staff told us the unit had only had two re-admissions since it opened in 2004. We were told that stays were generally between six months and a year, with the shortest stays being three to four months. The longest current stays were one year and 14 months respectively. Staff told us that the child who had been there a year was still on active treatment, and the child who had been there for fourteen months was awaiting discharge to an agreed location.

Suitably qualified and competent staff

We saw that some of the children on the unit displayed extremely challenging behaviours, including self-harm. We saw there were clear and consistently applied strategies in place to reduce damaging behaviours.

Staff demonstrated how they used agreed techniques in which they were all trained to calm a child. Staff recognised that learning sessions were more successful for one child if they had been on an escorted walk prior to the activity. We saw that children with very challenging behaviours were engaged and absorbed in activities.

We saw low level restraint being used to prevent a child from self-harming. We saw how this had gradually been relaxed in a measured way. We saw this care and support was balancing the child's choice and independence with the need to keep them safe from self-harm. We saw that this child was making progress since being admitted to the hospital and that staff were alert to their needs.

Evidence-based clinical guidance, standards and best practice

Staff told us they worked on separate units but swapped round periodically to share best practice. Staff told us this helped prevent 'burn out' and ensured they developed a good knowledge of children on both units.

Child and adolescent mental health services

One parent told us they were pleased as their child was on a lot of medication when they were admitted, but now they were not. This meant that the service had enabled the child to develop other strategies to manage their behaviour and ensure their wellbeing.

Are child and adolescent mental health services caring?

Is there choice and are people enabled to participate

One member of staff we spoke with, told us that they needed to engage with the children; adults (in other parts of Brooklands) can occupy their time more independently. We saw that children were engaged and occupied at all times, except when they made it clear they wanted time by themselves. We saw that at these times staff were available and either directly observed the child or monitored them to ensure their wellbeing.

People receive the support they need

We saw that staff had a good rapport with individual children and showed a passion for helping them to make progress. Many staff had worked at Tuxford for a number of years which helped to provide a stable staffing environment. Staff shared a real desire to see the children make progress. We saw that staff managed very challenging behaviour in a calm, firm but supportive way.

We saw that the physical environment varied. The classrooms used by children a lot during the day were bright, child-friendly and stimulating. However, many of the bedrooms and other communal areas were bare and lacked personalisation. While there may be clinical reasons for this in some instances, the bare décor made many areas look institutional. One parent we spoke with praised how staff worked with their child but expressed fears of their child remaining in an institution. The appearance of much of the environment may not have helped to allay those fears.

Are child and adolescent mental health services responsive to people's needs? (for example, to feedback?)

Individual needs met

The child and adolescent mental health service is a national one, which meant that some children were a long distance from their parents. Staff told us that one family had to travel many miles and hours to visit. The service used technology to maintain contact and worked to ensure that visits allowed for maximum 'quality' family time for children. Staff told us about how they recently had supported a visit by a whole family including younger siblings.

We spoke with one parent who raised the cost of travelling to visit as a problem, but added that they thought they were doing pretty well. One parent said they wished their child to attend church. We checked with staff who said they had identified a church and intended to arrange for them to attend but that the child's particular behaviours and risks had not allowed this to happen so far.

We saw that children's individual dietary needs, for example halal meat, were catered for.

Provider acts on and learn from concerns and complaints

One member of staff, who had worked at Brooklands for many years, told us there were clinical support meetings every week at which they were able to give suggestions. This meant that the views of staff were listened to so that the needs of each child could be met.

Are child and adolescent mental health services well-led?

There were high levels of staff engagement; cooperation and integration; responsibility and accountability

The managers of each unit on Tuxford said they felt well supported both clinically and by managers within the Trust. They said they were able to maintain occupancy levels that met the individual needs of the children.

Child and adolescent mental health services

Staff concerns dealt with; risks identified, managed and mitigated

One issue that staff and managers raised consistently as a concern was the age and suitability of the building. They said there were plans to build a new alternative, purpose-built unit.

One member of staff told us the Trust was very supportive in respect of whistleblowing. They told us of an unsatisfactory experience at a previous employment and compared the Trust very favourably with this. They said the Trust listened to their concerns and ensured they were properly investigated and necessary action taken.

Services for people with learning disabilities or autism

Information about the service

Amber and Jade are specialist assessment and treatment services for people with learning disabilities and autism. Both units are for up to fifteen people of both genders.

At our last inspection to Brooklands on 10 July 2013 we visited Amber unit due to a number of concerns that had been identified there by visitors. These included concerns about the safety and treatment of people who used the service, staff safety, staff not understanding the safeguarding procedure and a high number of incident reports that had not been processed appropriately. During our inspection on 10 July 2013 we found that people and their relatives were not involved in their care plans. We saw that sometimes people's privacy and dignity were not respected by staff. Care plans were not always person centred and had not been regularly reviewed to reflect people's changing needs and risks. We made compliance actions following this inspection. We found that during the inspection in January 2014 that the compliance actions made had been met.

Summary of findings

All staff had received training in safeguarding vulnerable adults from abuse and processes were in place so that staff knew how to ensure that people were safe.

Systems for secluding people where needed to ensure their safety and that of others needed to be improved to promote people's safety and wellbeing.

In Amber unit we found that staff responded to people's behaviours by placing restrictions on them and the response was not based on individual's risks which could impact on people's safety and wellbeing.

There were enough staff to ensure people's safety in Amber unit. However, in Jade unit there were sometimes insufficient staff with the appropriate skills to meet people's complex needs and ensure their safety.

We saw that professionals worked together to meet people's individual needs and ensure that their care and treatment were effective.

People did not participate in regular meaningful activities to ensure their treatment was effective and met their needs.

We saw that people's physical health care needs were monitored and met.

We observed that staff interacted well with people who used the service and knew how to support them to meet their needs.

We saw that staff respected people's religious and cultural needs to promote their wellbeing.

We found that some staff lacked awareness and the environment was not suitable in Amber unit for people who had autism, impacting on their wellbeing. However, plans were in place to improve this to benefit those who used the service.

It was unclear what the role of Jade unit was, as it was for people from a wide age range and needs requirement. Staff were not sure what the purpose of the unit as a whole was which meant that some people could be at risk of not having their needs met.

Staff spoken with told us they were well supported by their managers however, they did not feel valued by

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senior managers in the trust and told us they did not have contact with them. This could mean that they were not clear of their role within the trust and how it impacts on the Trust as a whole to benefit people who use the service.

Are services for people with learning disabilities or autism safe?

Learn from incidents and improve standards of safety for people who use services

In Jade unit we saw that a clear process was in place that staff could follow if there was an incident where a person needed to be safeguarded from harm. We looked at records about an incident and saw that the correct process was followed and appropriate action taken to safeguard people. Some unqualified staff told us that they filled in incident forms as required and followed the correct process. However, they said they do not always have a de-brief after incidents and did not get feedback from senior staff after incidents. This would ensure that all staff had an opportunity to reflect on the incident, how they dealt with it and if they could have dealt with it differently to ensure the person's safety and wellbeing.

Staff spoken with in Amber unit, were aware of how to report incidents, and to report to the local safeguarding team if needed, to ensure that people who used the service were safeguarded from harm. We saw that all staff had completed training in safeguarding vulnerable adults from abuse and harm.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services

Staff in Amber unit demonstrated that they knew the risks to individual people's safety and what action to take to reduce these. Staff told us that when a person's needs had changed, and they needed to be observed more or less often, then this was communicated to all staff during staff handovers to ensure the person's safety.

Staff in Amber unit told us that seclusion was not used that often and they could not remember the last time it was used. However, in records we looked at we saw that one person had been secluded at the beginning of January 2014. We saw that a nurse had initiated the person's seclusion but it was not recorded that a senior nurse had been informed of the seclusion as per the Trust seclusion policy. Records showed that the person had been monitored every ten minutes during the time they were secluded. The record sheet had been pre-printed for observations every ten minutes, which suggested that this

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was not dependent on the person's individual risk. This might mean that the person was not observed as often as they should be which could impact on their safety and wellbeing.

Understand and manage risk to the person using services and others with whom they may live with

In Jade unit we looked at records of two safeguarding alerts that were made in the week before our inspection. These involved incidents between people who used the service where one had hit another. We saw that alerts were made to the local authority and the appropriate process was followed to safeguard people from harm. However, staff spoken with told us that incidents between people who use the service were not always reported. Staff did not know why this was but said there were more incidents than were reported. This could mean that appropriate action was not taken to ensure the safety of people who used the service.

We found examples of staff practice where staff had placed restrictions and it was not evident in records seen, they had looked for solutions or explained these fully. This could have an impact on people maintaining their independence skills.

In Amber unit we found that none of the people who used the service could use their mobile phones during the week, but they could use them at the weekend whenever they wanted to. It was unclear what the reason for this was and individuals had not been assessed to ensure that the risk of them using a mobile phone at any time did not have a detrimental impact on their safety and wellbeing. People we spoke with told us that this was an unnecessary restriction that had been placed on them.

We saw that a complaint had been made by a relative as to how staff had responded to their relative's behaviour. The relative told us that their relative's toilet roll holder had been knocked off their wall and had not been replaced. This meant that the person did not have access to toilet rolls for long periods of time but had to ask staff.

We saw in Amber unit that there were three rooms that staff described as 'enhanced care suites'. Staff were unable to explain what these were used for, but people were being cared for there. The modern matron said they would ensure that a care plan for each person was developed and a process put in place as to the reasons why each person

was there. They told us that people cared for in these areas were supported by staff at all times, were not locked in or prevented from leaving the area and had access to activities.

Staffing levels and quality of staffing enables safe practice

We saw that people's assessments of their risks and care plans, assessed what levels of observation they needed from staff to help to keep them safe.

In Amber unit, staff told us that there were enough staff and this was adjusted depending on people's needs and how often they needed to be observed to ensure their safety. We saw, and were told, that bank and agency staff were only used for unplanned absences and emergencies. We both saw, and were told by one person, that if there were not enough staff then sometimes they could not go in a group to the shops which they liked to do.

In Jade unit staff told us that having the right amount of staff available to observe people as much as they needed could be difficult. However they told us that they took the action needed each day to minimise the risks of harm to people who used the service. The operations manager told us that five members of staff were absent following assaults by people who used the service. They said their shifts were covered by staff working overtime and bank or agency staff. Some staff told us that some of the bank or agency staff did not have the skills to deal with the complex needs of people who used the service which is why some staff had been assaulted. There was no risk plan in place to manage this which could put people's safety at risk

All staff had received training in safeguarding and the management of actual and potential aggression (MAPA). We saw and staff spoken to told us that this helped them to keep people who used the service safe. We found that some staff had not received training in intermediate life support which could put people at risk of harm.

Are services for people with learning disabilities or autism effective?
(for example, treatment is effective)

Evidence-based clinical guidance, standards and best practice

We saw in records and staff told us, that one person had been in Brooklands for four years and had moved around

Services for people with learning disabilities or autism

different units. This person had now been moved to Amber unit which we were told was for people requiring assessment and treatment. People would normally go to assessment and treatment first if their needs could be met in the community. This person's care pathway was not based on best practice which could impact on their wellbeing.

Demonstrate collaborative multi-disciplinary working across all services

We found that the Trust worked in partnership with the local authority to ensure that people were discharged to suitable placements. We saw in records, and staff told us, that they had made a safeguarding referral to the local authority, as the discharge of one person had been delayed due to a suitable placement not being available.

In Jade unit we saw a person's discharge plan which was confusing. It stated that a placement had been identified but then an entry was made in August 2013 that said the social worker was looking for a placement for the person. There were no further entries made or an update of the discharge plan. This meant that discharge planning had not been effective to ensure this person's wellbeing.

Suitably qualified and competent staff

In Amber unit we looked at the activity schedule. We saw that there were only a maximum of two activities planned for each person per day and often the activity was 'relaxing'. We saw that there were several staff available but very little activity or engagement with people was observed to promote their recovery and wellbeing.

Are services for people with learning disabilities or autism caring?

Is there choice and are people enabled to participate

We observed from interactions that staff respected people who used the service. People told us that staff treated them as adults.

People participate in a review of needs

In records we looked at, and from staff telling us, in Amber unit people who used the service and their relatives were involved in decisions about their care and treatment. We saw that advocates were provided and people were regularly visited by their doctor who discussed their treatment with them.

In Jade unit staff spoken with, were aware of the need to involve the person in their care plan. They told us that if a person lacked the mental capacity to make a decision about their care and welfare, the team of professionals who worked with them discussed this and the decision was made in the person's best interests.

People receive the support they need

In Amber unit we saw that generally staff were knowledgeable about how to support people who used the service. However, we found that staff lacked understanding about why one person behaved in a certain way. The person told us that they did not like wearing their glasses because they were scared that other people in the unit might hit them and break them. Staff spoken with told us that they did not realise this but thought the person just did not like wearing them.

Two people we spoke with told us about their background and the reasons for their admission to Amber unit. We spoke with staff and looked at their records but did not see any evidence that these people had been supported with appropriate counselling that might enable them to cope with their issues and support their recovery. We observed that staff had a positive approach to people who used the service and cared about them. Some staff we spoke with showed that they were genuinely excited about how one person had progressed during their time in Amber unit and how successful their treatment had been.

In both units we saw in records, and people and staff told us, that people's physical health needs were monitored and met.

Privacy and dignity respected

In Jade unit we saw that people's bedrooms were not separated according to their gender which did not promote their privacy and dignity and was not in line with best practice guidelines. The manager was unable to explain how the risks to people's privacy and dignity had been assessed to protect them from harm.

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Individual needs met

In Amber and Jade units we saw that people's religious and cultural needs were generally being met. However, it had been identified that one person needed information to be provided in their first language but this had not been done. This meant that the person would not be able to understand all the information about their care and treatment which could impact on their wellbeing.

We spoke with an advocate on Jade ward and we observed that the environment there was not suitable for some people who had autism. We saw that the sound echoed around the unit and the strip lighting was noisy which would have a detrimental impact on some people. Some people who have autism can be hyper sensitive to sound and light and the environment we observed would exacerbate this.

Some staff we spoke with were unaware of and how this impacted on people and their behaviour. The lead occupational therapist told us that they were presenting a business case to the Trust board the following week and hoped that funding would be provided for an area in Amber unit to ensure that the needs of people who had autism could be better met there. They also told us that there would be more input from therapists to work with the people who had autism to meet their sensory needs.

Providers work together during periods of transition

Staff, and records, told us that once a suitable placement was identified for someone, they worked with the new provider to ensure a smooth transition and reducing the likelihood of readmission to the hospital. Relatives spoken with told us that they had been involved in discharge planning and their input had been valued by staff.

Are services for people with learning disabilities or autism well-led?

The governance framework is coherent, complete, clear, well understood and functioning

We saw in Jade unit that there were ten beds for people aged between 16 to 25 years old and there were five beds available for people over 25 years. It was not clear of the role and function of the unit and staff spoken with were not sure of the admission criteria. This meant that when people were admitted to the unit it may not be clear to staff what their care and treatment would be and how to support them.

Staff concerns dealt with; risks identified, managed and mitigated

In Amber unit some staff spoken with were clear about the purpose of the unit and how the service needed to be led to ensure that risks to staff were identified and managed well. They told us that staff performance and development was driven by the modern matron and this had enabled the service to move forward to benefit people who used it.

There were high levels of staff engagement; cooperation and integration; responsibility and accountability

Some staff in Jade unit told us they were well supported by their line manager. However, they told us that they would not recognise the Trust directors as they did not have any contact with them. A senior member of staff told us that they had been to an open day where they had met the directors. However, the directors had not visited the units and they did not feel that the Trust vision and values had been embedded into the units and systems in Brooklands.

They thought that the Equal Active Partners programme that was being run by the Trust had made some improvements and gave employees a say and valued them. We saw and staff told us that the operational manager showed good management and leadership and the service had improved as a result of this. We saw that training was planned to develop staff so improvements could be made. However, we found that staff were not led by senior managers in the Trust and staff in the units were not involved in the Equal Active Partners programme. This did not promote the wellbeing of staff to ensure that they were well-led to improve the service and benefit the people who used it.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	<p>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.</p> <p>How the regulation was not being met:</p> <p>People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because the design and layout of seclusion rooms was not suitable or safe and the security measures in place were not safe.</p> <p>Regulation 15 (1) (a) (b).</p>