Bromley Road Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Bromley Road Hospital as requires improvement because:

- There were low completion rates of mandatory training. Many staff had not completed essential safeguarding, managing violence and aggression and breakaway training and the provider had difficulty in providing clear data regarding the completion of mandatory training amongst the staff group.
- There were low rates of supervision amongst the nursing team, which meant that staff did not have regular monthly support in line with the provider's supervision policy.
- Patients were prescribed high dose anti-psychotics, which heightened the risk of cardiac problems. However, the records of the numbers of staff who had been trained to use the defibrillator prior to February 2016 were not available.
- The provider's management of medicines was not robust. They had not actioned all aspects of the pharmacy audit. Staff had stored and disposed of medicines incorrectly. There were out of date vacutainers being used to collect blood samples.
- The provider had not responded in a timely manner to the issues regarding the lack of hot water at the hospital.
- The provider had not notified the Care Quality Commission of all the events that they should have. The provider had not notified the CQC of the unauthorised absence of a person detained under the Mental Health Act 1983.
- The provider failed to notify the CQC of two incidents that had been reported to or investigated by the police

However:

- All areas of the hospital were clean. There was ongoing refurbishment work to improve the condition of the hospital.
- Patients were involved in the development and review of their care plans.
- The provider undertook an annual patient survey and used the responses from patients to improve the service.
- There was a mix of recovery-orientated and leisure activities every day. Activities took place both at the hospital and in the community.
- The service valued the diversity of patients by supporting patients with their religious and spiritual needs and celebrating events like Black History Month and World Mental Health Day.

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Background to Bromley Road Hospital

Bromley Road Hospital provides care, treatment and rehabilitation for people with mental health problems. The service is a 24 bedded locked rehabilitation hospital for male and female patients with complex mental health needs. At the time of the inspection, there were 22 patients at the service. All the patients were detained under the Mental Health Act 1983. Partnerships in Care (PiC) took over the running of the hospital in April 2015.

Bromley Road Hospital is registered to provide the following regulated activities:

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

There was no registered manager for the service at the time of the inspection, but the service was recruiting a manager.

The service received the majority of its referrals from NHS organisations inside London.

We have inspected Bromley Road Hospital four times since 2010, most recently in October 2013. At this inspection, Bromley Road Hospital met all the essential standards, now known as fundamental standards. These inspections were undertaken under the old methodology.

Our inspection team

The team that inspected Bromley Road Hospital was comprised of:

- Three inspectors
- Two specialist advisors, with experience of working in long-term rehabilitation mental health services
- One pharmacist inspector
- One mental health act reviewer
- One assistant inspector

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location. We requested feedback from commissioners.

During the inspection visit, the inspection team:

- visited the two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the regional operations manager and the provider's regional directors

Summary of this inspection

- spoke with seven staff members; including doctors, nurses, catering staff, occupational therapist, psychologist and social inclusion staff
- received feedback about the service from two care co-ordinators or commissioners;
- spoke with the independent mental health advocate for the hospital
- attended and observed a community meeting, a patient presentation about the hospital and a ward round
- looked at five care and treatment records of patients
- carried out a specific check of the medication management at the hospital and looked at a range of policies, procedures and other documents related to the running of the service.

What people who use the service say

We spoke with five patients. The majority said that they received good care and treatment from staff. Patients said that they felt safe. Two patients were highly complimentary about the support they received from the staff. The patients described staff as friendly, approachable and supportive.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Many staff had not completed essential safeguarding, managing violence and aggression (MVA) and breakaway training. There were low rates of completion of mandatory training of less than 75%. It was unclear how many staff had been trained to use the defibrillator.
- The provider's management of medicines was not robust. Staff had stored and disposed of medicines incorrectly. The staff had used expired blood collection tubes to collect blood samples.
- The provider had an "absent without leave policy" (AWOL). The policy gave staff guidance as to what constituted a patient being absent without leave. However, it did not outline the procedures the staff member should follow if a patient went AWOL, which meant that might not respond appropriately.

However,

- All areas of the hospital were clean.
- The provider had undertaken a ligature risks audit.
- There was ongoing refurbishment work at the hospital to reduce the number of ligature anchor points.
- All equipment was clean and maintained appropriately.
- The provider complied with same sex accommodation guidance and managed this well.
- The outcomes of incidents and investigations were fed back to staff. The provider made changes to the service as a result of feedback from incidents.

Are services effective?

Good

We rated effective as good because

- The staff monitored patient's health needs and made referrals to specialists.
- The service considered National Institute for Health and Care Excellence (NICE) guidance when prescribing medication and offered a wide range of psychological interventions.
- All staff working at the hospital had received an induction.
- Following risk assessment, some patients were able to keep their own mobile phones.
- The provider was not adhering to their supervision policy. There were low levels of supervision for staff between September

Summary of this inspection

2015 – January 2016. The provider had not supervised staff monthly as required. However, there were alternative sources of support for staff, which included informal drop in for staff with senior management.

Are services caring?

Good

We rated caring as good because:

- Staff involved patients in all aspects of their care including developing and reviewing care plans. Families were also involved if appropriate.
- Staff communicated with patients sensitively, and in a kind and respectful manner. Staff spoke about patients as individuals. The majority of patients described staff in positive terms.
- Patients chaired the daily community meeting. The patients discussed issues that were relevant to them and were able to provide feedback to staff about anything they were concerned about. The provider conducted an annual patient survey and used feedback to improve the service.

However,

- The staff had not explained to all patients the purpose of the personal folders.
- Patients did not always get timely feedback on the issues they raised in ward community meetings.

Are services responsive?

Good

We rated responsive as good because:

- All admissions to the hospital were pre-planned.
- Patients had keys to their bedrooms. They were able to personalise their bedrooms.
- The provider met patients' dietary needs. Patients could request kosher, halal and vegetarian meals if they wished. The majority of patients were positive about the food.
- There was a mix of recovery-orientated and leisure activities every day. Activities took place both at the hospital and in the community.
- The service supported patients who were religious. Patients could pray in their room if they wished. The staff escorted patients to places of worship if necessary.
- The service valued the diversity of its patients and celebrated Black History Month and World Mental Health Day.
- The provider responded promptly to complaints and gave feedback to the complainant. The provider changed the patients' menu following patient complaints.

However,

Summary of this inspection

- There was one very small visiting room. This meant that patients had to limit the number of visitors and could not have visits from their children.

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- The provider had not notified the CQC of all events that they should have. Which was a breach of regulation.
- Staff had not received regular monthly supervision and there were low completion rates of mandatory training. The provider was unable to provide accurate data regarding the completion rates of some staff training. The provider had not ensured that staff had mandatory training and had not actioned all aspects of the pharmacy audit.

However,

- the managers and staff were enthusiastic about the changes that were taking place in the hospital.
- There was evidence that the staff had a commitment to the provider's values.
- The managers were highly visible throughout the service and met regularly with the staff group.
- Staff at the hospital were given opportunities for development and career progression. The provider recognised the achievements of staff through the staff awards scheme.
- The provider had systems in place to ensure the quality of the service was assessed, monitored and/or improved.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The provider had trained 46% of staff in the Mental Health Act 1983 (MHA). This training was mandatory for all grades of staff.
- All the patients at the hospital were detained under the Mental Health Act at the time of the inspection.
- Patients had access to an independent mental health advocate who could support them. The advocate for the service reported a positive working relationship with staff at the service. Staff referred patients to the IMHA if they felt that they needed additional support. Patients were also able to self-refer to the advocacy service.
- A mental health act administrator was based at the hospital. They managed all the MHA paperwork. The administrator had support and could access legal advice if required.
- All of the patient's detention paperwork was up-to-date. Staff informed patients of their rights under the MHA when admitted to the hospital and on renewal of their section. The mental health act administrator sent alerts to staff when each patient was due to be reminded of their rights.
- Staff recorded patients' current leave (s.17) arrangements clearly. The forms used for recording where in line with COP guidance. The forms had details of conditions of leave, frequency and duration. Old leave forms were stored separately, to avoid confusion. Staff had not crossed through these forms in all cases.
- The responsible clinician (RC) prepared the renewal of detention reports. However, there were delays in arranging Mental Health Act Manager's hearings for two patients. This was not in accordance with the Mental Health Code of Practice (CoP) guidance.
- The doctor undertook capacity assessments for treatment. The doctors at the service adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medicine administration records. The RC made requests for a second opinion appointed doctors when appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) policy.
- The provider had trained 46% of staff in the Mental Capacity Act. This training was mandatory for all grades of staff. Despite the low levels of training, the nursing staff and clinicians had a good understanding of the MCA.
- The provider had not made any DoLS applications in the last six months.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- The service was mixed gender and had 24 beds. Olive house had six beds for female patients and 11 beds for male patients. Jasmine house had seven beds for female patients.
- The provider kept the front door to the hospital locked at all times. The staff monitored the front door via closed circuit television (CCTV). Staff were unable to observe all patient areas. There were no convex mirrors in place to assist staff in observing blind spots. Staff undertook hourly checks around the building to mitigate this risk. These hourly checks were documented. As part of the refurbishment of the hospital, the provider had audited the environment and planned to fit convex mirrors to assist staff to monitor blind spots.
- The service complied with same sex accommodation guidance and managed this well. Olive house was a mixed gender ward. The male and female bedrooms were on separate corridors. Access to the female corridor was via a locked door. Only female patients and staff had the code for the lock. The service also had a member of staff monitoring the corridors to ensure that patients did not go into each other's rooms. Jasmine house was a female only ward and was in a separate building to Olive house. This ward was for vulnerable female patients only. Patients had keys to their bedrooms and could access their rooms throughout the day. None of the bedrooms on either ward was en-suite. Jasmine house had a female only lounge.
- Refurbishment works were taking place at the hospital. The provider estimated that these works would take 18 months. The provider had fitted new flooring and seating and refurbished the communal showers. Redecoration of the patients' bedrooms was being completed. The provider had ensured that there was minimum disruption from the building works. The redecoration of the building took place during office hours. Hospital staff supervised and monitored contractors undertaking the building work to ensure the safety of the patients.
- The provider had undertaken a ligature audit in January 2016, which identified the ligature anchor points in the service. A ligature point is an environmental feature or structure which is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. There was an action plan in place to replace certain fixtures and fittings in the service, this included replacing taps in the showers. Staff mitigated the risks by ensuring high risk patients did not have access to these areas unsupervised.
- There were no wall mounted alarms or call points in patients' bedrooms. Staff had personal alarms, which meant they could summon assistance if there was an emergency. There were weekly tests on the alarms to ensure they were not faulty. Staff also had two-way radios so that they could communicate with colleagues in other parts of the hospital. Each shift had an identified nurse in charge of security.
- Environmental risk assessments and checks took place regularly. These included fire safety checks and security

checks. Weekly tests of the fire alarm took place and there was a fire drill every six months. The last fire drill was in January 2016. Regular drills ensured people knew what to do in the event of a fire. The hospital had an assessment of the fire risks in January 2016. The report made a number of recommendations including replacing the doors to the patients' bedrooms with fire doors. The provider was having this work done on the day of the inspection.

- There had been problems with the hot water at the hospital for at least three months. Patients stated that water was not warm enough. The water from the kitchen taps was tepid. The catering staff boiled the kettle in order to have sufficient hot water to hand wash the dishes. The dishwasher had been broken for four weeks. When we returned on the 26 February 2016, the water from the taps was very hot. There was a risk of burns and scalds because of the faulty boiler. We informed the provider. The provider took action immediately and confirmed that the boiler was repaired on the same day. They stated they would monitor the water temperatures every week.
- Staff cleaned the environment daily and completed cleaning records.
- There were clinic rooms in both Olive and Jasmine house. Both clinic rooms were small and cramped. Both clinic rooms had accessible resuscitation equipment, blood glucose monitoring machines and a sphygmomanometer for measuring blood pressure. There were calibration and cleaning records for the equipment that showed they were fit for purpose.

Safe staffing

- The provider undertook pre-employment checks on staff, which included references and a criminal records check (DBS). There was evidence that there had been appropriate pre-employment checks in the 10 staff files we reviewed.
- The hospital had 53 substantive staff. There were 12 nurses (11 full-time and one part-time) and 23 health care assistants (18 full-time and five part-time). There was a vacancy for a psychologist, a registered manager and a nurse. The posts for the registered manager and the nurse had been vacant since December 2015. The provider was recruiting for these three posts. In a three-month period, bank and agency staff had filled 24 shifts. Twenty one shifts were unfilled.
- In the previous year staff sickness was 2.5% and staff turnover was 25% (13 staff had left).
- The provider had at least three qualified nurses on duty during the day shift and two qualified nurses on a night shift. There was also a nurse on call out of hours.
- The provider was able to adjust the staffing levels at the hospital when necessary. For example in September 2015, the management noted that the patient group had become challenging due to new admissions. To ensure the safety of staff, management had increased staffing levels.
- The provider tried to use bank and agency staff that were familiar with the hospital and the patient group whenever possible.
- The provider rarely cancelled pre-arranged escorted leave and activities due to a shortage of staff.
- All patients had a primary and secondary nurse who they could meet with regularly.
- The consultant psychiatrist for the service worked one day per week. He was on call at other times. There was full time speciality doctor who was available 9am – 5pm during the week. A local general practitioner managed patients' physical health problems. The provider contacted the emergency services for patients who had urgent physical health problems.
- The completion rates of mandatory training amongst the staff group were low. All aspects of mandatory training except "dealing with complaints" and "health and safety" were below 75%. The provider had difficulty in producing accurate data regarding training completion because they were in the process moving to an electronic system to record training completion rates. The provider had an action plan to ensure that all staff were appropriately trained.
- Safeguarding training was mandatory for all staff. Eighteen staff (36%) had undertaken safeguarding adults training. The provider planned to train an additional 17 members of staff by the end of March 2016. The lack of recent safeguarding training meant there was a risk that staff may not be sufficiently aware of possible safeguarding concerns amongst the patient group. This aspect of training was prioritised the provider's action plan.
- Managing violence and aggression (MVA) training was also mandatory. Four staff out of 50 (8%) had been trained. The provider had an action plan to train 24 more staff between May and August 2016. Breakaway training was also mandatory; the provider had trained

32 out of 50 staff (64%). The low rates of staff trained in both MVA and breakaway meant that there was a risk that staff might not be aware of any recent changes in practice and may not respond appropriately when managing violence or aggression from a patient. There was an action to increase the numbers of staff trained in MVA.

- The provider had purchased a new defibrillator in August 2015. Defibrillators are used to treat people who have a sudden cardiac arrest. The provider was unable to provide any records of staff prior to February 2016, who had been trained to use the defibrillator. The provider stated that the staff had received defibrillator training as part of first aid training, but could provide no evidence of this. The provider had trained nine staff in February 2016. There was also an action plan to increase the number of staff trained in first aid.
- The provider had trained 46% of staff in the Mental Health Act 1983 (MHA). This training was mandatory for all grades of staff.

Assessing and managing risk to patients and staff

- Staff met with patients prior to admission. This gave them opportunity to assess whether the patient would be suitable for the hospital.
- We reviewed five patient risk assessments. There was evidence that staff updated the risk assessment after incidents in the majority of cases. There was one patient risk assessment that had not been updated to reflect a change in the patient's circumstances. The provider used a risk assessment tool, which they had developed to undertake a comprehensive assessment of the risks posed to the patient and by the patient.
- Patients' children could not visit the hospital due to a lack of suitable facilities. Patients saw their children away from the hospital.
- There was no seclusion room and there were no instances of de facto seclusion at the service. De facto seclusion occurs when a patient is not free to leave a room even though they want to.
- There had been two incidents of restraint between May 2015 – November 2015. They had involved the same patient. The patient's care plan stated that physical interventions might be used. Prior to being restrained the patient was offered positive behaviour support. One of the incidents of restraint had been in the prone position. The incident of prone restraint lasted 30-40 seconds. A staff member told us they offered support and reassurance to the patient throughout the restraint.
- Some patients had returned to the hospital in possession of illicit drugs. This had caused difficulties on the unit. Staff searched some patients on their return to the unit. Staff made efforts to conduct searches in the least intrusive way possible. High risk patients had random drug screening tests. The hospital had built links with the local police. The police visited the hospital occasionally on an informal basis.
- The multi-disciplinary team (MDT) made decisions regarding additional restrictions based on individual patient risk factors and these were recorded in the patients care records.
- If staff had safeguarding concerns, they were able to discuss this with the head nurse. The provider also had a designated regional lead for safeguarding. The service displayed information regarding safeguarding and contact numbers for the local authority safeguarding team on the noticeboard.
- The provider had an independent pharmacy audit undertaken during March 2015. However, the provider had not acted on all of the recommendations made by the audit, which included ensuring that medicines were stored properly. The provider's management of medicines was not robust.
- During the inspection, we found that staff had made errors in checking the stock medication of tramadol. The drug stock did not tally on the 15/2/16 and 16/2/16 and there had been an error in the counting of the number of tramadol tablets. We found medicines that should have been refrigerated, including insulin had been stored in a cupboard; this may have reduced their efficacy. Staff had put a salbutamol inhaler in the sharps bin and this would have posed a risk of exploding when the bin was incinerated. Staff had opened epiderm cream but the date of opening was not noted. There were over the counter medicines in the clinic rooms of Jasmine and Olive house but it was unclear whom they were for as they were unlabelled. Medicines belonging to a patient who had died in September 2015 had not been disposed of and this increased the risk of medicine errors.
- Staff had put medicines in dossette boxes for patients who were going home on leave. Dossette boxes are used to organise medication. However, the medication was

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

unlabelled, which meant in an emergency they could not be identified easily. The staff told us that they would no longer do this and would ask the pharmacy to dispense medication for patients going home on leave.
- Staff had not checked the expiry date of the blood collection tubes used to collect blood samples. There were a number of blood collection tubes being used, which had expired in May 2009, (the blood collection tubes were disposed of on the day of the inspection). The provider contacted the phlebotomy department at the local hospital to check that no patients had been put at risk because of using out of date blood collection tubes.

Track record on safety

- There had been 138 incidents at the hospital between May 2015 and October 2015. There were a broad range of incidents reported, which included incidents related to the environment, patients and staff. Thirty-six per cent of incidents related to patient aggression. Nine per cent were incidents of self-harm and 25% related to patients attempting to abscond or absconding from the hospital.
- None of the reported incidents had been categorised as serious.

Reporting incidents and learning from when things go wrong

- Staff stated that incident reporting had improved in the past year. The head of nursing reviewed all incident reports. If there were any immediate concerns, the provider made plans to address these concerns. Staff involved in the incident were offered a debrief and support. The staff discussed incidents in the monthly staff meeting and tried to identify themes to prevent a re-occurrence. The provider had an incident log, each month there was a summary report prepared of all incidents at the hospital. Staff discussed incidents and relevant learning at the monthly team meeting.
- There was evidence of learning from incidents. The provider had made changes to the gardens because of a patient jumping over the garden fence. The garden doors were now doubly alarmed and there was improved outdoor lighting. The management supported staff through supervision and the staff forum meetings to deal with incidents of patient aggression.
- The provider had an "absent without leave policy" (AWOL) dated July 2014. The policy gave staff guidance as to what constituted a patient being absent without leave. However, it did not outline the procedures the staff member should follow if a patient went AWOL. For example contacting the police for patients considered particularly vulnerable or subject to Ministry of Justice (MOJ) restrictions, contacting the patient's relatives and sending the relevant notifications to the CQC.

Duty of candour

- The provider had a duty of candour policy in place and had trained managers in the hospital in the duty of candour. There had not been any incidents in the service which triggered this duty.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff undertook a comprehensive assessment of patient need when they were admitted to the service.
- Staff undertook routine physical health examinations. There was ongoing monitoring of patient's health needs and referrals to specialists, where needed. Staff had referred a patient to cardiology, and another patient to the chiropodist.
- We reviewed the care plans and progress notes of five patients. Staff wrote the notes in plain English, and all the notes were specific to the needs of individual patients. The patients' views and wishes were evident in three records. For example, clinicians had adjusted a patient's medication when they had complained about side effects and when another patient expressed anxiety about going out on leave. Staff had noted on the care plan the support that would be provided to the patient around this. Clinicians from another hospital supported one patient. The patient had expressed some concern about travelling to this hospital. Staff had organised for clinicians from that hospital to visit the patient. The care plans covered a range of patient needs. For example, patient diagnosis, medication, physical health

monitoring, and religious and cultural needs. For one patient the physical health care plan had a step-by-step plan outlining how staff should to manage the wounds of the patient.

- Patients' clinical records were stored securely. The provider used a paper-based system to store records but planned to move to an electronic system by the end of March 2016. The provider had trained staff in the electronic system. The provider had a two week migration plan to upload all the paper records onto the electronic system to ensure that no patient information was lost.

Best practice in treatment and care

- Staff prescribed medicines in accordance with guidance from the National Institute for Health and Care Excellence (NICE).
- The service was able to offer a wide range of psychological interventions. Psychologists used cognitive behavioural therapy (CBT) and mindfulness when working with patients.
- The staff registered patients with a local GP. Patients underwent regular blood tests in the service, where relevant, to identify potential ill effects from particular prescribed medicines. Staff made referrals to specialists for patients who had additional physical health needs.
- The staff used recognised to tools to measure patient outcomes. The service used health of the nation outcomes scales (HoNOS) to assess patient progress. The multidisciplinary team reviewed patients' HoNOS scores on a monthly basis. Staff also used the 'recovery star' with patients. This is a widely recognised tool to support and monitor patients progress. Staff recorded patient outcomes using the recovery star. Patients had copies of their completed recovery stars in their personal folders. The assistant psychologists offered 1 to 1 sessions with each patient to complete anxiety and depression scales to monitor each patient's change in mood and mental state and to assess the need for further therapeutic input.
- The doctors had undertaken two clinical audits in January 2016, into the physical health monitoring of patients being prescribed lithium or high dose antipsychotics. Both audits recommended that patients should have physical health monitoring in line with the Maudsley Prescribing Guidelines. The audits also recommended that staff should use a standardised tool to monitor all patients receiving lithium or high dose antipsychotics. The monitoring forms should be included in the drug chart of each patient and staff would audit these forms quarterly. Doctors would use the auditing process to identify if there were any physical health investigations that required urgent completion. Staff had not implemented the recommendations of audit at the point of the inspection.
- Staff prioritised the recovery of patients and staff offered opportunities and activities to promote independence. Some patients were undertaking voluntary work within the local community. There were activities that improved independent living skills and patient health. For example, individual cooking sessions and attendance at the gym. The activity co-ordinators ran a goal setting workshop on a weekly basis patients. Patients were provided with personalised OT timetables. The hospital provided a number of activities outside of the hospital on a weekly basis, including attending the cinema and community outings.

Skilled staff to deliver care

- All new staff had an induction. Permanent staff attended the corporate week long induction and a three day local induction at the hospital. The provider gave bank staff a one day induction at the hospital to ensure they were familiar with the service and policies.
- Health care assistants were undertaking the care certificate qualification to develop their knowledge and skills.
- The provider's supervision policy for nursing staff stated that nurses should receive supervision every month for one hour. Between August 2015 and January 2016, 68% of staff had received supervision on three occasions or less in the last six months.
- The provider was not adhering to their supervision policy. Clinical supervision ensures that staff work within professional codes of conduct and boundaries and training needs are identified. Supervision can help ensure that patients receive high quality care at all times from staff that are able to manage the personal and emotional impact of their practice. The lack of formal clinical supervision could have impacted on patient care, even though there were other informal forums for staff to discuss concerns. There were no records of what was discussed in informal meetings.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Twenty nine of 31staff had received an annual appraisal at the time of the inspection.
- The staff had access to regular team meetings and the hospital director had informal drop-in sessions for staff. During these sessions, staff could raise issues relating to their work with the hospital director.
- The provider addressed poor staff performance promptly. There were examples of management dismissing staff that performed poorly. In staff supervision notes there were also examples of the manager identifying areas of poor work performance and offering additional training to the member of staff. For example, offering nursing staff training to improve their skills related to medicine management.
- Some staff had undertaken additional training. One staff member had completed drug and alcohol awareness training and another was undertaking management training.

Multi-disciplinary and inter-agency team work

- A ward round was held every week and members of the multi-disciplinary team (MDT) attended. The MDT met every weekday morning to discuss patients, staffing levels and what activities were taking place that day.
- A commissioner of the service fed back to us that they were involved in the care programme approach meetings. The hospital also provided them with regular reports regarding the patient's care and treatment.
- There were effective working relationships with other organisations. Two commissioners spoke positively about the service. The provider had developed a close working relationship with the local GP. The staff had invited the community police officers to the patients' forum meeting as a way of fostering a good working relationship.

Adherence to the MHA and the MHA Code of Practice

- The provider had trained 46% of staff in the Mental Health Act 1983 (MHA). This training was mandatory for all grades of staff.
- All the patients at the hospital were detained under the Mental Health Act at the time of the inspection.
- Patients had access to an independent mental health advocate, (IMHA) who could support them. The advocate for the service reported a positive working relationship with staff at the service. Staff referred patients to the IMHA if they felt that they needed additional support and could refer themselves.
- The provider's mental health act managers met quarterly to discuss and review and comment on the hearings that had taken place during the previous three months.
- The provider had a mental health act administrator based at the hospital. They managed all the MHA paperwork. The administrator had support could access legal advice if required.
- All of the patients' detention paperwork was up-to-date. Staff informed patients of their rights under the MHA when admitted to the hospital and when their section was renewed. The mental health act administrator sent alerts to staff to remind patients of their rights.
- Staff recorded patients' current leave (s.17) arrangements clearly. The forms used for recording were in line with code of practice (CoP) guidance. The forms had details of conditions of leave, frequency and duration. Old leave forms were stored separately, to avoid confusion. However, not all of these had been crossed through to show they were no longer valid.
- The responsible clinician prepared the renewal of detention reports. However, there were delays in arranging the Mental Health Act Manager's hearings for two patients. The delay exceeded five months in both cases. This was not in accordance with the Mental Health Act Code of Practice (CoP) guidance. The CoP states that before the current period of detention ends, it is desirable that a managers' panel considers a report made under section 20 or section 20A and decides whether to exercise its discharge power to discharge patients from detention.
- The doctor undertook capacity assessments for treatment. The doctors at the service adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medicine administration records. The responsible clinician (RC) made requests for a second opinion appointed doctors when patients refused treatment and the RC assessed the patient as not having capacity.

Good practice in applying the MCA

- The provider had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy.
- The provider had trained 46% of staff in the Mental Capacity Act. This training was mandatory for all grades of staff. Despite the low levels of training the staff we spoke to had an understanding of the act

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The provider had not made any applications for DoLS authorisations in the last six months.

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

Good

Kindness, dignity, respect and support

- Staff were warm and kind towards patients and spoke with them respectfully. Commissioners provided feedback that staff appeared attentive to the needs and wishes of the patients.
- Staff showed respect and kindness towards patients when they attended the ward round to discuss their care and treatment.
- The majority of patients said that staff were caring.
- Some patients' health needs or behaviour affected other patients. When patients raised these issues, staff dealt with these issues promptly and sensitively.
- The service supported patients to visit families and friends. For example, staff had arranged overnight stays for people whose families lived far from the service.

The involvement of people in the care they receive

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- Patients had personal folders in their bedrooms that contained information about the service, copies of their care plans and information that was important to them as individuals. Staff had given these folders to a number of the patients on the day of inspection. One patient said that staff had not explained the purpose of these folders and they did not know what it was for.
- Patients and staff attended a daily community meeting to discuss issues that were relevant to the patient and to plan the activities for the day. A patient chaired the meeting and patients could choose to attend it. There were brief notes recorded of the daily community meeting. The staff member taking the notes did not always date them. Patients raised issues. However, it was unclear which staff member was responsible for following things up. There was little evidence in the notes of patients being provided with feedback. For example, patients had complained 17 times since December 2015, that the water from the showers was cold. Staff had given patients very little information as to how this issue would be resolved.
- We observed the community meeting on the day of the inspection. During the meeting, patients had the opportunity to raise issues and to suggest activities for the day, which included how they wished to use their leave. Some patients requested a trip to the cinema and another patient had requested to go to the bank. The provider facilitated both these requests. We observed staff supporting patients who had speech difficulties. They ensured that these patients had the opportunity to contribute to the meeting.
- The provider conducted an annual patient survey to get feedback about the service. The provider used the results from the survey to make improvements.
- The multi-disciplinary team met with patients at least every four weeks in the ward round to discuss their care and treatment. The meetings were patient focused and provided the patient with the opportunity to be involved in their care. Staff invited patients and their families to care programme approach (CPA) review meetings. These meetings also included the patient's care co-ordinator. Staff took into consideration the view and wishes of the patients and their families during CPA review meetings.
- The provider ensured that the patients had access to advocacy services. An independent mental health advocate visited the service regularly and attended the patient's community meeting. The advocacy service also provided individual support to patients at ward rounds and CPA meetings.
- The provider had consulted with patients about the refurbishment work taking place at the hospital and patients had chosen new furniture for the hospital.

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

Good

Access and discharge

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- NHS organisations referred patients to the service and all admissions were pre-planned. The average bed occupancy at Jasmine House in the six months prior to the inspection was between 93% and 88% on Olive House. The service did not accept emergency or unplanned admissions. Although the hospital took referrals from across the country, the majority of the patients came from south London.
- The provider ensured that when patients went home on leave, their in-patient bed was available on their return.
- Discharge planning started early due to a significant number of patients having complex needs which sometimes made it difficult to secure suitable long term supportive accommodation for some patients. This meant that there were sometimes delays in moving patients to other facilities Four patients had been at the hospital for over 3 years. All these patients had complex needs and required ongoing specialist care and treatment.
- The provider had transferred four patients to other placements but these placements had broken down. The provider had readmitted these patients to Bromley Road Hospital. One patient was offered another placement but had decided that they did not want to move to that placement. The provider was working with partnership agencies to secure suitable and safe moves to other placements as early quickly as possible for all four patients.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms to support treatment. These included an activity room, patient kitchenette and clinic rooms. As a part of the service's refurbishment programme, the provider was adding an occupational therapy kitchen to the hospital. The provider was making efforts through their refurbishment programme to make the environment more comfortable for the patients and they were encouraged to contribute their opinions regarding the choice of décor and soft furnishings.
- There was one very small visiting room, which was in Olive House. It was too small for lengthy visits and restricted the number of visitors a patient could see.
- There was a garden area at the rear of Olive and Jasmine House. The provider had recently landscaped and improved the lighting in the garden for Jasmine House. New non-slip decking and been laid and the provider had purchased new garden furniture. Patients were able to access the garden area at any time.
- Patients were able to personalise their bedrooms. There were no restrictions on patients about how they did so. All patients had keys to their bedrooms. They could keep their personal belongings and valuables secure.
- Patients could make private phone calls and a number of patients following a risk assessment had mobile phones.

Meeting the needs of all people who use the service

- The building had disabled access. Patients with impaired mobility could use the lift to access the bedrooms on the upper floors of the building.
- The provider had conducted a patient survey in June 2015. Twelve out of 21 patients had responded. The patient survey indicated that 50% of patients felt that the service met their religious needs. There was no multi-faith room in the hospital but patients could pray in their bedrooms. Staff supported patients to attend a place of worship, for example, a mosque or church, should they wish.
- The patient survey in June 2015 showed that 42% of patients were unhappy with the food. The menu had changed following an increase in patient complaints. The hospital provided meals which met the cultural and religious needs of patients. There was always a healthy option provided. There was always a vegetarian choice at mealtimes.
- The service considered the needs of transgender patients. The hospital accommodated patients in the area of the ward that related to the gender they identified themselves with.
- The service had details for interpreters when they were required. There was a range of information available for patients about local services, advocacy, the therapy timetable and how to complain.
- The service made efforts to recognise the diversity of the patient group. They celebrated black history month and world mental health day. Staff supported patients to buy black hair care products and cosmetics if they wanted them.

Listening to and learning from concerns and complaints

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The provider had a complaints policy, which outlined the process and time frames for dealing with complaints. The policy had a two-stage process. Complaints could be dealt with locally (stage 1) or formally (stage 2). Ninety per cent of the staff had received training in how to deal with complaints.
- The service had complaints boxes mounted on the walls in the communal areas on both units, which were visible to all staff and patients. Leaflets on how to make a complaint were in a variety of community-based languages. The service supported patients to make complaints. The service accepted both verbal and written complaints. The manager reviewed the complaint and responded to the complainant within 24 hours. Depending on the seriousness or the contents of the complaint, the manager shared information with other agencies, including the safeguarding team if necessary.
- The provider had received nine complaints from November 2014 – August 2015. The provider had responded to the complainant within 24 hours for seven of the complaints. None of the complaints had been referred to the independent sector complaints adjudication service or the parliamentary health service ombudsman (PHSO). The provider had upheld five complaints. Two complaints were about the environment and the provider had provided a satisfactory response to these complaints. Where there was conflict between two patients, the staff had offered mediation. In response to a complaint from a patient, the provider had sent a letter of concern to staff reminding them about their conduct whilst at work.

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

Requires improvement

Vision and values

- Managers and staff spoke with enthusiasm about the values of the provider and the implementation of them in the team. All staff emphasised the importance of working in collaboration, being respectful and offering the best care possible to patients.
- The provider's stated values were valuing people, caring safely, integrity, working together and quality. Staff we spoke with reflected these values.

Good governance

- The hospital was going through a period of significant transition in terms of management and was introducing new systems.
- The provider undertook a provider compliance assessment visit in October 2015 to assess the quality and standard of care provided at hospital. The report noted that staff were using the previous owner's policies. The new provider was in the process of embedding the new policies. To minimise staff confusion, the provider had updated the staff induction plan with information about the policies and had the policies stored electronically.
- There were systems or processes established to ensure the quality and safety of the service was assessed, monitored and/or improved. Managers from the hospital attended regional management committee and clinical governance group meetings with colleagues from other parts of Partnerships in Care to discuss issues and share learning across the organisation. The provider shared information as part of the hospital's monthly clinical governance meetings, monthly management and team meetings. Minutes from meetings recorded the action taken by named staff to improve the safety and quality of the service. The hospital had a clinical governance plan, which staff were aware of. The plan included introducing electronic monitoring systems (EPR), redesigning the new policies and introducing a clinical dashboard to help clinicians make timely decisions regarding patient care.
- The provider monitored targets through visits from head office and internal review at staff forums and meetings. The provider anticipated that the new EPR would allow them to monitor and collect data more easily and they would be able to review the data in regional management and senior manager meetings to ensure the quality of care and targets were maintained at a satisfactory level.
- Staff actively participated in audits. These audits included an audit of the physical health monitoring of patients being prescribed lithium or high dose anti-psychotics, infection control, health and safety and an environment audit.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff had not received regular monthly supervision and there were low completion rates of mandatory training. The provider was unable to provide accurate data regarding the completion rates of some staff. The introduction of the new electronic training monitoring system would allow the provider to do this more easily.
- The provider had failed to notify the CQC of incidents that had been reported to or investigated by the police in December 2015 and January 2016, which involved concerns around illegal drugs on the premises. The provider was required to notify the CQC of the unauthorised absence from the hospital of patients who were detained under the Mental Health Act 1983. The provider had failed to notify the CQC on two occasions in January and February 2016 of the unauthorised absence from the hospital of patients detained under the Mental Health Act. These failures took place after the previous manager left in December 2015, prior to this notifications had been provided in line with regulations.

Leadership, morale and staff engagement

- The registered manager had left in December 2015 and the provider was recruiting for a replacement. The hospital directors and the head of nursing had provided interim management cover at the hospital.
- Staff sickness in the previous year was 1.41%.
- There had been one bullying and harassment case in the past 12 months. The case had been resolved but the provider identified that disciplinary processes had not been followed correctly. The hospital management had reviewed the circumstances of the case and recommended managers should always consult the human resources department when considering formal disciplinary action against staff. The hospital director and the human resources department monitored all grievances and disciplinary issues.
- The management team were visible to patients and staff. The regional director and nurse in charge had informal drop in sessions (breakfast group) at the hospital. Staff were able to meet with managers to discuss any issues of concern.
- The provider had a number of ways to involve staff. Nurses had fed back in April 2015 that they wanted to have a staff support group. The provider had listened to the feedback and had set up a staff forum. The psychologist facilitated these sessions and staff were encouraged to attend. The nurses' workplace satisfaction questionnaire completed in September 2015 showed the majority of the nursing team felt able to learn on the job and said it was rewarding to see patients make progress. However, there were some problems within the team and over 80% of staff did not feel supported by colleagues or part of the team. The provider had organised informal social gatherings for staff. The provider had introduced a monthly awards scheme as a way of improving morale amongst staff and recognising staff achievements. These initiatives had been successful. During the inspection all staff said that they enjoyed working at the hospital. They felt supported by their colleagues and felt part of the team.
- The provider did not conduct exit interviews for staff that had resigned but planned to introduce this as a way of getting feedback regarding the reasons why staff left.
- Staff were aware of the providers' whistleblowing policy and said they could raise concerns with the management team. Staff were confident that any concerns they raised would be responded to appropriately.
- The staff had opportunities for development. A member of the nursing team was undertaking a management course. Another member of the team was undertaking a mentoring course.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff administer, store and dispose of medicines safely.
- The provider must ensure that CQC is notified when incidents are reported to or investigated by the police and of any unauthorised absence from the service of detained patients as failure to do so is a breach of regulations.
- The provider must ensure that staff complete their mandatory training.
- The provider must ensure that staff complete mandatory training in the Mental Health Act 1983 and Mental Capacity Act 2005 and understand how the legislation affects their practice.

Action the provider SHOULD take to improve

- The provider should ensure that they have clear records of staff that have been trained to use emergency lifesaving equipment (defibrillator).
- The provider should ensure that patients are fully involved in their care and understand the purpose of their personal folders.
- The provider should ensure that staff provide patients with feedback regarding concerns and issues, which are raised in the community meetings.
- The provider should ensure that the 'absent without leave' policy is reviewed and revised to ensure that it includes all action staff need to consider when a patient is absent from the service without authorisation.
- The provider should ensure that Mental Health Act managers' hearings take place within the time frame recommended by the code of practice.
- The provider must ensure all staff have regular supervision.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines had not been stored or disposed of correctly. The staff had stored medicines that should have been refrigerated in a cupboard. This was a breach of regulation 12(2)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff had received appropriate training to enable them to carry out the duties they were employed to perform. Significant numbers of staff had not completed required training in safeguarding, managing violence and aggression (MVA), Mental Health Act 1983, Mental Capacity Act 2005 and breakaway training. This was a breach of regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 **Notification of death or absence of person detained under the Mental Health Act 1983** **The provider failed to notify the CQC of two occasions of unauthorised absence from the hospital of patients detained under the Mental Health Act.** **This was a breach of regulation 17(1)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider failed to notify the CQC of two incidents that had been reported to or investigated by the police in December 2015 and January 2016.** **This was a breach of regulation 18 (2)(f) of the (Registration) regulations.**

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.