St. Matthews Limited

Broomhill

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services caring?	Inspected but not rated

Summary of findings

Overall summary

This was an unannounced focused inspection, undertaken in response to concerns the care Quality Commission (CQC) had received in relation to two allegations of staff to patient assaults. The first report related to an allegation that a patient had been physically assaulted by a nurse on an acute ward. The second report related to an allegation that a patient had been assaulted by a member of staff on two separate occasions on a rehabilitation ward.

During the inspection, we looked at specific key lines of enquiry. Therefore, we have reported on the following domains:

- Safe
- Caring

We did not re-rate Broomhill as we did not inspect all aspects of the safe and caring domains.

- The service did not always have enough nursing staff, who knew the patients. The provider was using high levels of agency staff. In January 2021, the provider reported that agency staff had been used to cover 56% of all shifts. However, 33% of agency staff had been blocked booked.
- Staff did not fully understand how to protect staff from abuse or how to report it. The provider had not followed national guidance in the levels of safeguarding training provided. Staff were unable to apply training received into practice. The provider had not updated the risk register to reflect current concerns relating to safeguarding.
- Staff had not always managed risks to patients well. Patients had not always been protected from verbal and physical abuse from staff. Staff had not always ensured that patient care plans had been updated to reflect current patient risks.
- The service had not always managed patient safety incidents well, once reported. We viewed a total of 192 provider incidents from 01 January to 01 February 2021. Managers had not closed most of these within the agreed time frame. Of the 192 incidents, 181 (94%) were overdue for review and relevant action/s by managers.
- Staff had not always ensured that physical health observations were recorded after administration of rapid tranquillisation. The provider had not ensured that emergency medication had been prescribed before administration under the Mental Health Act.
- The provider had not ensured that staff on one ward had easy access to technology for them to maintain high quality clinical records on one ward.
- The provider had not ensured that all staff were up to date with their mandatory training in respect of the prevention and management of violence and aggression, basic life support and manual handling.
- Staff had not always treated patients with kindness and compassion. We were given an example where staff were mimicking and copying a patient behind their back. Patients and staff told us that they had heard staff talking in languages other than English in front of patients.
- Staff had not always involved patients in care planning and risk planning.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff followed infection control policy, including handwashing. Staff and visitors had their temperature recorded on entry to the building. The provider had ensured that staff had access to personal protective equipment (PPE).
- Staff completed risk assessments for each patient on admission, using a recognised tool and updated risk assessment after incidents.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inspected but not rated	We did not rate this service at this inspection. The current rating of acute mental health wards for working adults remains. For more information on our overall judgement please see the overall summary at the beginning of this report.
Long stay or rehabilitation mental health wards for working age adults	Inspected but not rated	We did not rate this service at this inspection. The current rating of long stay/rehabilitation wards for working adults remains. For more information on our overall judgement please see the overall summary at the beginning of this report.

Summary of findings

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Summary of this inspection

Background to Broomhill

Broomhill is an independent mental health hospital, which provides rehabilitation and acute care, treatment, and support to individuals with mental health concerns. Broomhill is part of the St. Matthews Healthcare Limited group, which consists of four care homes and four hospital locations in Northampton and Coventry.

Broomhill is based in a rural setting with access to the local town. Broomhill provides 99 beds across seven wards:

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

The last comprehensive inspection of Broomhill took place 11 to 14 February 2020. The provider received an overall rating of **Inadequate** with rating for each of the five key domains as follows:

- Safe: Inadequate
- Effective: Inadequate
- Caring: Inadequate
- Responsive: Requires Improvement
- Well Led: Inadequate.

Following this inspection, the provider was placed into special measures. Conditions were imposed in February 2020 and subsequently removed following improvements made by the provider. The provider remains in special measures.

Following the last comprehensive inspection undertaken in February 2020, three focused unannounced inspections have taken place. The first unannounced inspection took place 22 and 27 July 2020. This was undertaken further to receipt of complaints and whistleblowing concerns from patients and staff. These complaints included allegations of poor staff attitude, lack of support from management, concerns regarding the standard of patient care delivery and concerns regarding a lack of robust infection, prevention and control measures in relation to the management of Covid-19.

Further to the unannounced inspection in July 2020, the provider was told that they MUST take action to improve in relation to breaches of:

- Regulation 10(1): Dignity and respect
- Regulation 12(1)(2): Safe care and treatment
- Regulation 17(1)(2): Good governance.

In addition, the provider was issued with a Section 31 letter of intent**.** The provider was required to provide a written response to the CQC with an action plan. The provider complied with this request.

On 26 August 2020 a further complaint was received from a patient with allegation of poor practice from staff at Broomhill. The complainant raised concerns in relation to a range of issues which included:

Summary of this inspection

- Poor care and attitude of staff
- Staff member's inability to communicate effectively in English
- Staff talking in other languages in front of patients (picked up on previous inspection)
- Staff not conducting patient observations safely
- Lack of privacy and dignity
- Poor standard of medication management
- Poor standards of cleanliness (picked up on previous inspection) - environment, bedding
- Staff falling asleep and playing on their phones.
- Poor Standard of IPC measures (picked up on previous inspection)
- Poor standard of care and potential over sedation of a patient with Asperger's.

A further unannounced inspection took place in September 2020. The unannounced inspection found concerns relating to medication management, infection prevention and control, patient observation and governance arrangements.

In response, the provider was issued with a warning notice in relation to:

Regulation 12(1)(2) - Safe Care and Treatment - (Medication – Controlled drugs; dirty beds, bedding and pillows)

Regulation 17 (1) (2) – Good governance - (mattress audit and oversight of observations).

Progress against the warning notice has been closely monitored. The provider has addressed the actions in relation to patient observations, medication management and infection prevention and control. The action plan continues to be monitored in relation to overall governance.

The hospital did not have a Registered Manager in post at the time of the inspection. The provider had appointed a new hospital manager who had submitted their application. The provider recived confirmation on 18 March that the Registered Manager application had been approved. . The hospital has a nominated individual in place.

How we carried out this inspection

This inspection was an unannounced, focused inspection of Broomhill, in response to concerns regarding patient safety and safeguarding. The concerns related to the receipt of two safeguarding alerts, which alleged staff to patient assaults.

We looked at specific key lines of enquiry during this inspection therefore we have only reported in the following domains:

- Safe
- Caring

Before the inspection visit, we reviewed information from the service about recent incidents that had occurred. We also reviewed feedback information we held about the service from patients, staff (including whistleblowing concerns), and carers.

This inspection took place on the 12, 18 and 25 February 2021.

Inspection Team

Summary of this inspection

Two inspection managers, two inspectors and one Mental Health Act reviewer conducted this inspection.

Over the three days of inspection, our inspection team undertook the following activities:

- spoke with the hospital manager
- visited six wards
- interviewed 22 patients
- interviewed 21 ward staff, including staff nurses, senior care assistants, care assistants, Occupational therapist and occupational therapy assistants
- Reviewed 19 care records looking at incidents, safeguarding, risk assessments, risk management plans and patient care plans
- observed patient and staff interactions on two wards.

We also reviewed information provided by the service, including:

- incident data for three months prior to the inspection
- minutes of the CQC strategy meeting and ward meetings
- the hospital's risk register and minutes of the risk register meeting
- training, supervision and appraisal data.

Of 22 patients interviewed on inspection, 13 (59%) raised concerns about their care and treatment. Patients told us that staff had not always treated patients with compassion and kindness. Eight patients told us that they had observed staff talking in languages other than English in front of patients. However, nine patients (41%), were happy with their care and treatment.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements. This action related to both services.

- The provider MUST ensure that staff treated patients with compassion and kindness. (Reg (10) (1) (2)
- The provider MUST ensure that staff speak English in front of patients. (Regulation 10 (1))
- The provider MUST ensure that staff undertake physical health observations for all patients following the administration of rapid tranquillisation, line with the provider's policy, and guidance. (Regulation 12 (1) (2)(b))
- The provider MUST ensure that they had enough nursing and support staff who know the patients, in order to keep patients safe. (Regulation 12 (1))
- The provider MUST ensure that medication administered under section 62 of the Mental Health Act, had been prescribed prior to administration. (Regulation 12 (1))
- The provider MUST ensure that paper documentation is uploaded onto the electronic health record in a timely manner. (Regulation 12 (1)), (Regulation 17 (2)(c))
- The provider MUST ensure that all staff have adequate access to information technology at all times , in order to access patient records in a timely manner. (Regulation 12 (1))

Summary of this inspection

- The provider MUST ensure that all incidents are recorded in the patient's clinical records. (Reg 12(2)(b))
- The provider MUST ensure that patient risk management care plans are kept up to date in order to reflect patient risks. (Regulation 12) (1) (2))
- The provider must ensure that care plans are kept up to date in order to reflect patient risks and risk management plans. (Regulation 12 (1) (2))
- The provider MUST ensure that patients had been kept safe and protected from verbal, physical and psychological abuse. (Regulation 13 (1), (Regulation 12(1))
- The provider MUST ensure that it follows nationally published guidance in the provision and competency of staff in adult safeguarding roles. (Regulation 13 (1) (2))
- The provider MUST ensure that all safeguarding incidents are reported immediately. (Regulation 13 (1))
- The provider MUST ensure that all staff are aware of how to recognise, report and protect patients from abuse. (Regulation 13 (1) (2))
- The provider MUST ensure that the risk register is updated in order to reflect current concerns relating to safeguarding. (Reg 17(1) (2))
- The provider must ensure there is governance and oversight to highlight issues of non-compliance in all aspects of care and treatment. (Regulation 17 (1))
- The provider MUST ensure that all staff are up to date with all aspects of their mandatory training, including restraint training, manual handling and basic life support. (Reg 18(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated
Acute wards for adults of working age and psychiatric intensive care units	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Safe	Inspected but not rated
Caring	Inspected but not rated

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

Inspected but not rated

This was an unannounced focused inspection. We did not re-rate this key question.

- The service had 13 vacancies for staff nurses and were over-established by 19 health care support workers. The service had a 31% turnover rate for health care support workers, and a 20% turnover rate for staff nurses across the hospital. Managers had supported staff who needed time off for ill health and for those who needed to shield due to Covid-19.
- The service had enough numbers of nursing and support staff to cover shifts. Staff reported that the number of staff per shifts had improved since the last inspection. In January 2021, the provider reported that agency staff had been block booked to cover 56% of shifts. However, 33% of agency staff had been blocked booked. Managers reported that where possible they requested agency staff who were familiar with the service and block booked them for six months. Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. This meant that with 56% of shifts covered by agency staff, we were not assured that all agency staff knew patients well. Several patients and staff told us that agency staff often did not know the ward or patients.
- The service reported that as of January 2021, 78% of staff had completed their mandatory training. This was an increase of four percent from December 2020. However, three mandatory training completion rates were below 75%. The current training rate for the prevention and management of violence and aggression was 62%, manual handling 31% and basic life support 29%. We saw minutes of meetings that documented that despite specific training sessions for prevention and management of violence and aggression were delivered, staff attendance was 50%. The provider had identified compliance with training as a risk, and this had been recorded on the provider's risk register.
- Most staff had attended safeguarding training. The overall current figures for staff, across the hospital who had attended safeguarding training as of January 2021 was 84%. However, despite staff completing the training, all staff did not fully understand how to protect patients from abuse**.** Of eleven staff interviewed, five staff members were not able to fully explain what a safeguarding concern or how to report it.
- The provider did not ensure that they provided safeguarding training in line with nationally published guidance. We were not assured that staff, including agency staff, within the organisation had understood how to recognise, report and safeguard patients adequately despite training they had received. Managers monitored mandatory training and alerted staff when they needed to update their training.
- Managers told us that they ensured that bank and agency staff had an induction and understood the service before starting their shift. However, five staff and one patient reported that agency staff were not well trained. The provider confirmed that the induction for agency staff did not include the provider's safeguarding training. The provider told us that agency staff received safeguarding training from the agencies. However, agency staff did not fully understand what a safeguarding alert was, how to apply safeguarding to practice and how to raise an alert. During inspection, the registered manager told us they had sight of the training package for safeguarding training for one agency but did not have this for the other two agencies they used. The provider advised following inspection, that future hospital induction programmes will include agency staff and they will be trained to the same level as permanent staff. Following inspection, the manager confirmed that they were going to arrange a safeguarding convention with support from local stakeholders, in order to address safeguarding training concerns.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

- We reviewed risk assessment and risk management plans for 12 patients. We saw that risk assessments had been reviewed following an incident in 10 of the 12 records reviewed (83%).
- Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.
- Staff tried to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We found one incident which involved patient restraint. The incident form and daily nursing entries we reviewed, did not give details about which position staff had been in when involved in restraint. The registered manager told us this had been an option in electronic recording forms, but confirmed the clinical records lacked such detail.
- Staff had not protected all patients from abuse. Prior to inspection, we were informed that a patient on a rehabilitation ward, had been assaulted by staff on a further two occasions. However, the first assault had not been reported as a safeguarding concern. The provider took immediate steps to address these safeguarding concerns once reported, completed investigations and acted where staff disciplinary action was required, including the dismissal of staff.
- Most staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic. However, staff on one ward stated that they did not have easy access to electronic records. The ward only had one electronic tablet and two computers, which were always in use. This meant a delay in entering information into clinical records, such as daily notes or recording incidents. However, on the day of inspection, the provider had taken delivery of further electronic devices. Patient notes were generally comprehensive, and all staff could access them easily. Records were stored securely.
- The provider had not always used safe systems and processes to safely administer medicines. Staff had not always followed NICE guidance when using rapid tranquilisation. We reviewed two patient records where the patient had been given rapid tranquillisation intramuscularly. We found no evidence in the patient's records that the required physical health monitoring had taken place for either patient. However, the hospital manager later located a physical health monitoring form for one of the two patients. This was in the ward clinic.
- We reviewed documentation for one patient who had been given intramuscular medication under section 62 of the Mental Health Act. The medication was administered on 18 January 2021; however, the section 62 authorisation was dated 19 January 2020.
- We reviewed nine incidents alongside the patient's clinical records, risk assessment, care plans and other documentation. Staff had managed most patient safety incidents they had been made aware of. However, the provider had not always provided full details of the incident within the patient's clinical records. Staff had not recorded the incident number in five of the 12 (42%) patient clinical records viewed.
- Managers investigated incidents once they had been made aware of them. However, we found no evidence that patients and their families were involved in these investigations.
- The service had not always managed patient safety incidents well, once reported. We viewed a total of 192 provider incidents from 01 January to 01 February 2021. Managers had not closed most of these within the agreed time frame. Of the 192 incident 181 (94%) were overdue. The provider had recorded this as a concern in the risk register meeting.

However

- Wards were clean well equipped, well furnished, well maintained and fit for purpose. Staff followed infection control policy, including hand-washing. Staff and visitors had their temperature recorded on entry to the building. The provider had ensured that staff had access to personal protective equipment (PPE).
- Managers had accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.
- Staff had assessed and managed risks to patients. Staff completed risk assessments for each patient on admission, using a recognised tool and updated risk assessment comprehensively following incidents.

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

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Inspected but not rated

This was an unannounced focused inspection. We did not rate this key question.

- During our inspection, we spoke to 13 patients. Staff had not always treated patients with compassion and kindness. Staff had not always been discreet, respectful, and responsive when caring for patients. Two patients told us that their experience in the hospital was 'terrible'. Two different patients told us that they had observed staff shout at patients. Another patient described Broomhill as 'the worst hospital they had been in', adding that they were not happy with the care provided.
- Staff had not always been discreet, respectful, and responsive when caring for patients. Five patients and four staff members told us that they had observed staff talking in languages other than English in front of patients.
- Prior to our inspection, we had received an allegation of a separate incident where a staff member had been verbally and physically aggressive toward a patient. During our inspection, we viewed the internal investigation report. We found evidence that the provider had taken robust action in response to the allegation. Staff involved had been through a disciplinary process and had been dismissed. Agency staff involved in the incident had also been told not to return to work in the service.
- Patients told us that staff did not always give patients help, emotional support and advice when they needed it. One patient stated that the first course of action is always medication, and that staff were not available for 1:1 time when required. One patient told us that there was poor access to medical staff.
- We found that staff had not always involved patients in their care planning and risk assessments. The patient's view was not documented within the documentation and four of the risk management and care plans within the service, had not been written from the patient's perspective.

However:

- Four out of nine patients told us that they felt safe on the ward. One patient interviewed described permanent staff as 'good'.
- Patients could give feedback on the service and their treatment via a survey and staff supported them to do this.

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

Inspected but not rated

Safe	Inspected but not rated
Caring	Inspected but not rated

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

Inspected but not rated

This was an unannounced focused inspection. We did not rate this key question.

- The service had 13 vacancies for staff nurses and were over-established by 19 health care support workers. The service had a 31% turnover rate for health care support workers, and a 20% turnover rate for staff nurses. Managers had supported staff who needed time off for ill health and for those who needed to shield due to Covid-19.
- The service had enough numbers of nursing and support staff to cover shifts. Staff reported that the number of staff per shifts had improved since the last inspection. In January 2021, the provider reported that agency staff had been block booked to cover 56% of shifts. However, 33% of agency staff had been blocked booked. Managers reported that where possible they requested agency staff who were familiar with the service and block booked them for six months. Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. This meant that with 56% of shifts covered by agency staff, we were not assured that all agency staff knew patients well. Several patients and staff told us that agency staff often did not know the ward or patients.
- The service reported that as of January 2021, 78% of staff had completed their mandatory training. This was an increase of four percent from December 2020. However, three mandatory training completion rates were below 75%. The current training rate for the prevention and management of violence and aggression was 62%, manual handling 31% and basic life support 29%. We saw minutes of meetings that documented that despite specific training sessions for prevention and management of violence and aggression were delivered, staff attendance was 50%. The provider had identified compliance with training as a risk, and this had been recorded on the provider's risk register.
- Most staff had attended safeguarding training. The overall current figures for staff across the hospital who had attended safeguarding training as of January 2021 was 84%. However, all staff did not fully understand how to protect patients from abuse**.** Of the nine staff members interviewed, four staff members were not able to fully explain what a safeguarding concern or how to report it.
- The provider did not ensure that they provided safeguarding training in line with nationally published guidance. We were not assured that staff, including agency staff, within the organisation had understood how to recognise, report and safeguard patients adequately despite training they had received. Managers monitored mandatory training and alerted staff when they needed to update their training.
- Managers told us that they ensured that bank and agency staff had an induction and understood the service before starting their shift. However, five staff and two patients reported that agency staff were not well trained. The provider confirmed that the induction for agency staff did not include the provider's safeguarding training. The provider told us that agency staff had received safeguarding training from the agencies. However, agency staff did not fully understand what a safeguarding alert was, how to apply safeguarding to practice and how to raise an alert. During inspection, the registered manager told us they had sight of the training package for safeguarding training for one agency but did not have this for the other two agencies they used. The provider advised following inspection, that future induction programmes will include agency staff and they will be trained to the same level as permanent staff. Following inspection, the manager confirmed that they were going to arrange a safeguarding convention with support from local stakeholders in order to address safeguarding concerns.

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

Inspected but not rated

- We reviewed risk assessment and risk management plans for eight patients. We observed that risk assessments had been reviewed following an incident in seven of the eight records reviewed (88%). However, one of the risk assessments had not been updated for 17 days post incident. The care plans for two patients had not been updated. One patient's care plan had not been updated to include the patient's current risks. Two patient care plans had not been updated to reflect the need for medications to be administered intramuscularly, one under section 62 of the Mental Health Act.
- Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.
- Staff tried to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We found two incidents which involved patient restraint. The incident form and daily nursing entries we reviewed, did not indicate give detail which position staff had been in when involved in the restraint. The registered manager told us this had been an option in electronic recording forms, but confirmed the clinical records lacked such detail.
- Staff had not protected all patients from abuse. Prior to inspection, we were informed that a patient on an acute in-patient ward had been assaulted by a staff member on one occasion. During the inspection, we were informed by the same patient of two further staff to patient assaults, carried out by the same staff member. The provider took immediate steps to address these safeguarding concerns once reported, completed investigations and acted where staff disciplinary action was required, including the dismissal of staff
- The provider had not always used safe systems and processes to safely administer medicines. Staff had not always followed NICE guidance when using rapid tranquilisation. We reviewed two patient records where the patient had been given rapid tranquillisation intramuscularly. We found no evidence in the patient's records that the required physical health monitoring had taken place for either patient.
- We reviewed documentation for one patient who had been given intramuscular medication under section 62 of the Mental Health Act. The medication was administered on 17 January 2021; however, authorisation had not been given until 03 February 2021 and was, therefore unlawful.
- We reviewed seven incidents alongside the patient's clinical records, risk assessment, care plans and other documentation. Staff had managed most patient safety incidents they had been made aware of. However, managers were not aware of all incidents. Where staff had recognised incidents, staff had reported them appropriately. However, of the seven incidents reviewed, details of one incident and two incident numbers had not been documented within the patient's clinical records. One incident had not been recorded for 17 days.
- Staff had not always reported serious incidents in line with the provider's policy. We found evidence that a patient had reported an alleged staff to patient assault three times on the night of the alleged incident. Agency staff had made a record of their allegations in the daily entries, but the incident was not reported as an incident or safeguarded appropriately until four days after the incident, by a deputy ward manager. Staff had not recorded the incident or undertaken the necessary physical health checks for the patient. Staff examined the patient four days after the incident and found bruising consistent with the alleged date of assault.
- Managers investigated incidents once they had been made aware of them. However, we found no evidence that patients and their families were involved in these investigations.
- The service had not always managed patient safety incidents well, once reported. We viewed 192 incidents from 01 January to 01 February 2021. However, a high number of incidents had not been closed by the mangers within the agreed timeframe. Of the 192 incident 181 (94%) were overdue. The provider had recorded this as a concern in the risk register meeting.

However:

- Wards were clean well equipped, well furnished, well maintained and fit for purpose. Staff followed infection control policy, including handwashing. Staff and visitors had their temperature recorded on entry to the building. The provider had ensured that staff had access to personal protective equipment (PPE).

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

Inspected but not rated

- Managers had accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients.
- Staff had assessed and managed risks to patients. Staff completed risk assessments for each patient on admission, using a recognised tool and updated them comprehensively following incidents.
- Most staff had easy access to clinical information, – whether paper-based or electronic. Patient notes were generally comprehensive, and all staff could access them easily. Records were stored securely.

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

Inspected but not rated

This was an unannounced focused inspection. We did not rate this key question.

- During our inspection, we spoke to nine patients. Patients told us that staff had not always treated patients with compassion and kindness. One patient stated that staff 'had a bad attitude', one patient told us that some staff don't listen, and three patients stated that they did not feel safe. Another patient told us that staff spend time playing on their mobile phones 'out of the line of vision of the CCTV cameras'. The patient alleged he had filmed staff, however stated that he had been coerced by staff into deleting the footage. However, the provider informed us that this allegation had been investigated and the allegation had not been supported.
- Staff had not always been discreet, respectful, and responsive when caring for patients. Two patients and three staff members told us that they had observed staff talking in languages other than English in front of patients. However, were told that the frequency of staff speaking in other languages in front of patients had reduced. Patients also described difficulties understanding some staff due to language barriers.
- Prior to our inspection, we had received an allegation of a staff on patient assault on an acute ward. During our inspection, we viewed the internal investigation report. We found evidence that the provider had taken robust action in response to the allegation. Staff involved had been through a disciplinary process and had been dismissed. Agency staff involved in the incident had also been told not to return to work in the service.
- During our inspection, we were informed by a patient of a further two staff to patient assaults. The provider had not been informed of these alleged assaults. We informed the provider of the alleged assaults, and asked the provider to raise a safeguarding alert and notify the police. . Following inspection, the provider told us they had completed an investigation into the incident and has dismissed staff from the service.
- Staff did not always respect patients' privacy and dignity. We were also informed by a patient of an incident where staff had been laughing at and mimicking a patient with mobility difficulties behind their back. Two patients described being threatened by other patients.
- Two patients told us that staff did not always give patients help, emotional support and advice when they needed it. One patient stated that the first course of action is always medication, and that staff were not available for 1:1 time when required.

1. We found that staff had not always fully involved patients in their care planning and risk assessments. The patient's view was not documented within the documentation and the risk management and care plans of four patients across the service had not been written from the patient's perspective.

However:

- Three out of seven patients told us that they felt safe on the ward. Two patients interviewed described permanent staff as 'good'. One patient stated that Broomhill was the 'best hospital they had been in'.
- Patients could give feedback on the service and their treatment and staff supported them to do this.

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 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured that the risk register had been updated in order to reflect current concerns relating to safeguarding. (Reg 17(1) (2)) • The provider had not ensured that there was governance and oversight to highlight issues of non-compliance in all aspects of care and treatment. (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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured that staff undertake physical health observations for all patients following the administration of rapid tranquillisation, line with the provider's policy, and guidance. (Regulation 12 (1) (2)(b)) • The provider had not ensured that they had enough nursing and support staff who know the patients, in order to keep patients safe. (Regulation 12 (1)) • The provider had not ensured that medication administered under section 62 of the Mental Health Act, had been prescribed prior to administration. (Regulation 12 (1)) • The provider had not ensured that paper documentation was uploaded onto the electronic health record in a timely manner. (Regulation 12 (1)), (Regulation 17 (2)(c)) • The provider had not ensured that all staff had access to information technology, in order to access patient records in a timely manner. (Regulation 12 (1))

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that all incidents were recorded in the patient's clinical records. (Reg 12(2)(b))
- The provider had not ensured that patient risk management care plans were kept up to date in order to reflect patient risks. (Regulation 12) (1) (2))
- The provider had not ensured that care plans were kept up to date in order to reflect patient risks and risk management plans. (Regulation 12 (1) (2))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider had not ensured that patients had been kept safe and protected from verbal, physical and psychological abuse. (Regulation 13 (1), (Regulation 12(1)) • The provider had not ensured that all staff were aware of how to recognise, report and protect patients from abuse. (Regulation 13 (1) (2)) • The provider had not ensured that they had followed nationally published guidance in the provision and competency of staff in adult safeguarding roles. (Regulation 13 (1) (2))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider had not ensured that all staff treated patients with compassion and kindness. (Reg (10) (1) (2) • The provider had not ensured that staff speak English in front of patients at all times. (Regulation 10 (1))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

- The provider had not ensured that all staff were up to date with all aspects of their mandatory training, including restraint training, manual handling and basic life support. (Reg 18(2))