Bromley Road Hospital

Quality Report

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Date of inspection visit: 30 and 31 May 2017
Date of publication: 18/08/2017

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	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 this service as **requires improvement** because:

- The service did not have adequate medical cover to meet the needs of the patients. Regular reviews of patients care and treatment where not always taking place due to the lack of medical cover at the service.
- Staff did not always treat patients with dignity and respect. Patients we spoke with said that staff were not always caring towards them and some were rude towards them. We observed poor interactions between staff and patients.
- The service had some inappropriate restrictive practices in place. Staff conducted random weekly room searches on both units to support patients to maintain their bedroom environments. This was restrictive and not based on individual patient need.
- Whilst care and treatment records were holistic and personalised, these were not always updated when patients were reviewed by the consultant psychiatrist or met with their named nurse for one to one's.
- Effective systems to monitor, assess and improve the service were not always in place.
- Systems used to monitor compliance with some mandatory training were not effective and data relating to compliance rates for information governance and infection control training was not reliable.
- The manager had raised issues with staff about poor time management and poor team working in recent team meetings, but not about staff professional conduct towards patients
- The emergency resuscitation bag was missing some essential equipment, for example, suction tubing, which was a vital item to have in an emergency.

However,

- Following our last inspection of the service, in February 2016, we told the provider they must make improvements to ensure staff complete mandatory training, they submit all notifications to the CQC and that medicines management was safe. At this inspection, we found that the management team had effectively implemented changes.
- Staff assessed any risks to patients in detail, regularly reviewed and amended plans to manage the identified risks. Staff observed patients within the service as convex mirrors had been installed to mitigate blind spots. The service had a complete and up to date ligature risk assessment, to reduce the risk of ligatures being used.
- All staff had received training in safeguarding adults and children from abuse. Staff had received immediate life support training from the resuscitation council. Staff received an annual appraisal of their work performance and received regular managerial supervision.
- Staff undertook a comprehensive assessment of patients prior to admission. Patients had physical examinations and mental health assessments. The service specialised in taking patients with physical as well as mental health needs. Nursing staff were registered mental health nurses who had experience working in general and mental health services.
- Patients knew how to make a complaint about the service. Staff carried out investigations when patients complained. The service conducted a patient satisfaction survey in 2017.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	See overall summary

Summary of findings

Contents

Requires improvement

Bromley Road Hospital

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

Summary of this inspection

Background to Bromley Road Hospital

Bromley Road Hospital is an independent hospital for 24 adult patients provided by Elysium Healthcare Limited, who took over the provision of the service in December 2016. At the time of the inspection, 19 patients were receiving treatment at the service.

The service is registered with the Care Quality Commission to provide the following regulated activities:

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

The service has a registered manager.

The service is a locked rehabilitation unit and all patients are subject to detention under the provisions of the Mental Health Act at the point of admission. Patients using Bromley Road hospital have a primary diagnosis of mental illness such as schizophrenia, schizoaffective disorder, bipolar affective disorder or depression and may have additional complex needs, such as substance misuse or physical health problems.

We previously inspected Bromley Road Hospital in February 2016 when we rated the service as 'requires improvement' overall. At that time we rated safe and well-led as 'requires improvement' and effective, caring, and responsive as 'good'. At that inspection, we found that some legal requirements were not met. We issued three requirement notices for Health and Social Care Act regulations 12 and 18 and regulations 17 and 18 under the CQC (Registration) Regulations 2009.

Our inspection team

Team leader: Hannah Wightman

The team that inspected the service comprised four CQC inspectors and a specialist advisor. The specialist advisor was a consultant psychiatrist with experience in rehabilitation and community settings.

Why we carried out this inspection

We inspected this hospital as part of our ongoing follow up mental health inspection programme. This was a short notice announced inspection.

Following the February 2016 comprehensive inspection, we told the provider they must take the following actions to improve services:

- 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
- The provider must ensure that staff complete 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.

We issued the provider with requirement notices at the previous inspection. These related to the following regulations of the CQC (Registration) Regulations 2009 and HSCA (RA) Regulations 2014.

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- 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.

Summary of this inspection

- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

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?

We carried out a short notice announced comprehensive inspection on 30 and 31 May 2017.

We looked at information provided to us beforehand by the provider as well as information given to us on site and we requested additional information from the provider and stakeholders following the inspection visit.

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 six patients who were using the service
- spoke with the registered manager
- spoke with 13 other staff members; including doctors, nurses, occupational therapists and psychologists
- received feedback about the service from two care co-ordinators
- spoke with an independent advocate for the hospital
- attended and observed one multi-disciplinary hand-over meeting
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management on two wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six patients at the service. Four patients we spoke with told us that staff did not treat them with dignity and respect. They told us that staff often spoke amongst themselves and not to them. Patients told us that did not always speak to them in a polite way and could speak down to them. Patients said that they did not always get to speak to members of the multi-disciplinary team, including the consultant psychiatrist about their medication and leave.

However, two patients told us that staff were considerate and polite towards them. Patients said they were involved in their care and treatment plan and had opportunities to complete 'ward jobs'.

The provider conducted a patient satisfaction survey for 2016/2017. Eleven patients participated in the survey. Patients were asked whether they felt treated with dignity and respect. Three patients said they did not, one patient responded that they were treated with dignity and respect and five patients did not answer the question.

The result of the survey came out in May 2017, just before the inspection. The service had not yet identified appropriate actions but was in the process of doing this.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- The service had some inappropriate blanket restrictions in place. Staff conducted random room searches for all patients to support them to maintain their bedroom environments. This was not based on individual need or risk, placing unnecessary restrictions on patients.
- The emergency resuscitation bag was missing suction tubing, this was an essential item to have in an emergency.

However,

- The service had addressed the issues that had caused us to rate safe as requires improvement following the February 2016 inspection.
- Staff were able to observe patients within the service due to convex mirrors being installed to mitigate blind spots. The service had a comprehensive and up to date ligature risk assessment, to manage and mitigate the risks associated with ligature anchor points.
- Staff assessed any risks to patients in detail and regularly reviewed and amended plans to manage the identified risks. Staff reported incidents and shared learning amongst each other. The provider ensured a serious incident was investigated and an action plan implemented.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The service did not have adequate medical cover. Patients did not have regular access to the consultant psychiatrist who worked at the service one day a week. This affected patients care and treatment.
- The MDT aimed to review patients at least every 13 weeks. However for one of the eight patients whose records we looked at this target had not been met. We were told this was because of the limited availability of the consultant psychiatrist.
- Patient records were not always complete or accurate. Some parts of patient care plans were missing key information. Staff did not always record when patient one to ones with staff had occurred. We noted that this was an issue across the staff team, including medical staff.

However,

Summary of this inspection

- Staff received an annual appraisal of their work performance and received regular managerial supervision.
- Staff completed physical health checks. Staff regularly monitored patient's physical health and patients on high dose anti-psychotic medication.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Staff did not always treat patients with dignity and respect.
- We observed some poor quality interactions between staff and patients which were sometimes task orientated and paternalistic.
- Patients said that staff were not always caring towards them.
- The provider had not adequately addressed how staff behaved towards and in front of patients.

However,

- Patients were involved in the recruitment of staff.
- Staff involved patients and their relatives in planning and reviewing their care and treatment.

Are services responsive?

Good

We rated responsive as **good** because:

- The MDT provided and supported patients with meaningful recovery orientated activities throughout the week. The occupational therapist facilitated activities for social inclusion and therapeutic groups including local employment and educational services. This supported patients in their recovery to move on to independent living.
- Patients knew how to make a complaint at the service. These complaints were thoroughly investigated by staff and patients informed of the outcome.
- The service could meet the diverse needs of patients. A range of food was available and patients' individual dietary requirement could be met.
- Patients could personalise their room and had access to a garden.
- The service conducted a patient satisfaction survey in 2017. These results had recently been published. The service was working to develop services based on feedback.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

Summary of this inspection

- Whilst staff had access to dashboards and other key performance indicators, effective governance systems to monitor and improve the service were not in place. For example, issues regarding medical cover, updating patient records and the inappropriate use of some blanket restrictions had not been identified. In addition, some systems used to monitor compliance with mandatory training, such as information governance and infection; control did not produce reliable data.
- The service was aware there were issues with the quality of communication amongst the staff team. The manager had raised issues with staff about poor time management and poor team working in recent team meetings, but not about staff professional conduct towards patients.

However,

- The service had addressed the issues that had caused us to rate well-led as requires improvement following the February 2016 inspection.
- Staff were positive about the changes made to the service and about having a hospital director for the service.

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.

- Staff were trained in the Mental Health Act as part of their mandatory training. Ninety five percent of staff had completed this training. Staff had a good level of knowledge of the Mental Health Act (MHA).
- At the previous inspection in February 2016, we found that that MHA Managers' hearings did not take place within the period recommended by the code of practice. At this inspection, we found that MHA manager's hearings were taking place within an appropriate period.
- The service had a Mental Health Act administrator who monitored and reviewed documentation relating to the detention of patients and supported staff's implementation of the MHA. For example, they ensured applications for patient's appeals against detention and consent to treatment records were applied correctly. They did this through regular audits of the MHA, including detention expiration dates and patients' rights information.
- All patients were subject to detention under the MHA at the time of our inspection. We saw evidence that patients had their rights explained to them on a monthly basis. Patients' leave was recorded in their care and treatment records. Patient leave forms were appropriately completed and authorised.
- Staff completed consent to treatment forms for detained patients on admission. We saw certificates completed by a second opinion appointed doctor, where appropriate.
- Patients had access to an independent mental health advocate (IMHA) who visited the service each week. Patients knew who the advocate was and when they attended.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act (MCA) was mandatory for all staff. Ninety five percent of staff had completed training in the MCA and Deprivation of Liberty Safeguards. Staff had a good understanding of the MCA and the principles that underpin it.
- We saw examples of staff completing capacity assessments that were time and decision specific. For example, we saw a capacity assessment where there was a concern as to whether a patient had capacity to consent to an intimate relationship and we saw that they had been assessed as having capacity to make this decision.
- Where patients were assessed as lacking capacity for specific decisions, the MDT held best interests meetings in line with the MCA. We saw that a best interests meeting had been held recently for one patient regarding management of their diabetes. The patient's family had been involved in the best interests meeting and decision making process.
- There were no patients subject to a deprivation of liberty safeguard (DoLS) at the time of the inspection.
- Staff could contact the hospital director or the consultant psychiatrist for guidance on the MCA and DoLS at the service.

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	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- Bromley road hospital was a locked rehabilitation mixed gender service, split into two wards. Olive House provided six beds for female patients and 11 male beds, Jasmine House was a separate ward of seven beds for females only.
- There were some blind spots throughout the units where staff could not always view patients from communal areas. The service had taken appropriate steps to manage and mitigate the risks associated with blind spots. These included the installation of convex mirrors to assist staff in seeing blind spots. Staff also completed hourly checks on patients and the environment to reduce the risk.
- The service managed ligature risks appropriately and safely. A ligature point is anything that can be used to attach a cord or rope to for the purposes of hanging or strangulation. Staff implemented a ligature risk assessment to manage risk to patients who may self-harm. The provider had completed some refurbishment works in the service to make some fixtures and fittings anti-ligature. Staff completed a ligature risk assessment in February 2017. This identified any ligature anchor points within the service and rated the points based on severity. Staff included an action plan to show how they would reduce the risk, for example fitting anti-ligature taps and sinks and locking doors to unsupervised areas. Staff also undertook one to one observations of patients assessed to be at high risk of harm.
- The service had ligature cutters available in the event of an emergency and staff knew where these were located.
- The service complied with same sex accommodation guidance. Olive House was split into two corridors and an upstairs area comprising of two flats. Sleeping accommodation was in single rooms with shared toilet and washing facilities adjacent. The bathroom facilities were clearly designated either male or female. A designated member of staff monitored the corridors at all times. Access to the female corridor was through a locked door which staff and female patients had the key code. Jasmine House was in a separate annex, which accommodated females only. This unit had a female only lounge which female patients from Olive House were also able to access.
- The service did not have facilities to nurse patients in seclusion and patients were not secluded.
- The clinic rooms were visibly clean. Staff ensured all equipment was checked for cleanliness on a regular basis to maintain hygiene. Staff also checked the medicines fridge and room temperature readings each day and available records demonstrated that temperatures were maintained within an appropriate range.
- There was appropriate emergency equipment available for staff to use to check the health of patients. The service had two clinic rooms, one on each unit. Equipment in both clinic rooms included oxygen cylinders and blood sugar machines. Jasmine House's

clinic room contained a new echocardiogram (ECG) machine to check patient's heart activity. Staff ensured that all equipment had been checked and maintained. Emergency response bags were checked weekly and records kept by staff. These bags were kept in the clinic room and smaller ones in the staff offices for each unit. Bags were sealed to prevent interference between checks. However, we noted a suction tube was missing from the emergency response bag. This meant that staff may have difficulty clearing a patient's airway in a medical emergency. We informed the hospital director of this during the inspection and the items were subsequently ordered. Both staff offices on Jasmine house and Olive house had automated external defibrillators, in case a person suffered a cardiac arrest.

- Environmental risk assessments and checks took place monthly. These included fire safety checks, infection control and security checks. Weekly tests of the fire alarm took place and there was a fire drill every six months.
- The environment and furnishings were visibly clean and well maintained. Domestic staff cleaned both communal areas and patient bedrooms. Staff completed daily cleaning record checks. Fridge and food temperatures in the kitchen were within range. The service had two kitchens, a main one for catering staff and an occupational therapist kitchen for the patients. The main kitchen had food hygiene and hand washing information on display.
- Staff carried personal alarms on them whilst on duty, which meant they could summon assistance if there was an emergency. Staff knew how to use them. We observed an alarm being raised, all staff responded in a prompt and appropriate way. Staff also had two-way radios so that they could communicate with colleagues in other parts of the hospital. The occupational therapist offices and group therapy rooms were in a separate building located in the rear garden. Staff commented that it was a small space and could be difficult to leave in an emergency. Staff carried two-way radios with them when in this building. The panic alarms also worked in this section.

Safe staffing

- The service met safe staffing levels for nurses and support workers. The hospital director had systems in place to establish the amount of nursing and support staff needed on each shift. We attended the daily morning handover meeting where senior staff clarified and addressed the demands on staff time at the service. For example, when staff needed to leave the hospital to escort patients to appointments, the manager could make sure that there was enough staff on each ward to ensure patient safety.
- The service had established staffing levels of one nurse and two healthcare assistants for each day shift at Jasmine house. Olive house had an establishment of one nurse and two healthcare assistants. On the night shift, one nurse and one healthcare assistant worked together at Jasmine house. For Olive house, this was one nurse and three healthcare assistants. The manager and senior nurse lead were on call out of hours on a rota basis. This meant that there was extra staff support outside of normal working hours.
- There were no staff vacancies at the time of the inspection. The service had recently filled their vacancy for the post of registered nurse.
- The team leader was able to adjust staffing levels depending on patient need. The service used regular bank staff familiar with the unit to fill sickness and when the demands of the hospital increased. Agency staff was rarely used. Staff completed a tool after each shift to confirm the numbers of nursing staff on each shift. This was rated green, amber and red based on whether the shift was short staffed. The hospital director regularly reviewed this data. We looked at this tool for the last month and saw that each shift was either green or amber. A shift was rated amber when there were staffing pressures, but safe staffing levels had been met.
- The service had enough staff on duty to manage incidents safely. Staff were trained in how to manage violence and aggression.
- The service rarely cancelled patients leave due to short staffing. Whilst some patients said their leave had been cancelled due to short staffing, staff told us that that staffing levels were appropriate. We saw the records kept for planned leave and found none had been recorded as cancelled due to staffing shortages.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Both wards had a nurse present in the communal areas. Patients received regular one to ones with their named nurse, however, these sessions were not always recorded in patient's treatment records.
- A consultant psychiatrist was employed at the service one day a week. A ward doctor also worked at the service three days a week. Out of hours and at weekends the service could contact the consultant for advice and support.
- At the previous inspection of the service in February 2016, we found that the provider had not ensured staff completed mandatory training. Low completion rates for staff training were found with regard to breakaway, safeguarding and managing violence and aggression (MVA) training, which meant that patients were at risk of receiving care or treatment that may not be safe or meet their needs. At this inspection, we saw that compliance with mandatory training had improved. The average compliance rate for staff completing MVA training was 95%. One hundred percent of staff had completed breakaway and safeguarding training. Mandatory training completion rates included first aid at 92%, infection control 70% and equality and diversity 94%. New staff had completed an appropriate induction and had been scheduled for upcoming mandatory training sessions.
- At the previous inspection in February 2016, we also found that the provider had not ensured that staff were trained in use the defibrillator. During this inspection, we found that all staff were required to undertake training in immediate life support and that 92% of staff had completed this.

Assessing and managing risk to patients and staff

- There were no incidents of seclusion or long-term segregation in the last 12 months.
- In the period from 1 January 2017 to 31 May 2017, there were six occasions when patients were restrained. These episodes of restraint involved three different patients. Staff in the service had a good understanding of the provider's policies in relation to the use of restraint and de-escalation methods. Two members of staff were tutors in management of violence and aggression and attended yearly refresher courses.
- On one occasion, prone restraint was used. This is when a person is restrained lying on their stomach with their head facing down. This incident of prone restraint had been reported appropriately. For example, there were detailed records on how the restraint was carried out, the length of time that the restraint was maintained for and the physical health checks carried out afterwards. The patient was supported and reassured throughout the restraint and immediately afterwards. Staff were de-briefed after the restraint and shared learning from it.
- Patients were admitted from acute inpatient services around the country. When a new referral was received, the hospital director and nurse lead travelled to the patient and completed a comprehensive assessment that also addressed potential risks.
- Staff used a recognised risk assessment tool to assist their evaluations of patient's individual risk, the Welsh Applied Risk Research Network tool. This is an evidence based risk tool. We looked at eight patient risk assessments. All of the risk assessments we looked at were completed on admission, reviewed regularly and updated after incidents. Risk assessments were detailed and comprehensive, for example, we saw patients assessed as having potential risks for falls and self-harm risk assessments with risk management plans in place to reduce these risks to patients. We observed good staff communication regarding risk during the multi-disciplinary team daily handover. For example, staff discussed updates on any safeguarding concerns and any physical health problems that patients had experienced.
- Blanket restrictions were not always appropriately used. Staff carried out five random room searches per week. The rationale for this was for infection control reasons, this placed a disproportionate restriction on patients. Staff checked five patients' bedrooms, this was a way to support the patients to clean and tidy their bedrooms. Staff told us this worked well as some patients were at risk of self-neglect and needed support and prompting to tidy their room. However, addressing individual patient need with a blanket restriction was not appropriate as it meant that patients were at risk of not receiving appropriate levels of support in a manner that reflected their needs and preferences and was regularly reviewed.
- Since 24 May 2017, following on from an incident, the provider had introduced compulsory searches for

patients returning from unescorted leave. This included searches of patients bags and pockets and in some circumstances, could include staff "patting down" patients. Staff were trained in searching patients, which included "patting down" patients. We looked at the community meeting minutes for 26 May 2017 and could not see the new search policy discussed with patients. This meant that patients might not have been informed of this change in the search policy. A revised policy and procedure regarding searches had been produced and was available to staff. This change was discussed and implemented in the healthcare assistant's team meeting in May and cascaded to the nurses. The revised search policy for unescorted patients returning from leave was set for review after one month.

- Patients assessed of being at risk of misusing drugs or alcohol had random drug testing or breathalysing on return from leave.
- At the time of the inspection, there were no informal patients at the service. Where the hospital did admit informal patients. Staff understood the patients right to leave the hospital.
- Patients who were assessed as potentially presenting a risk to themselves or others could be nursed using enhanced observations, including one to one observations. The service had an observation policy in place and staff knew the protocols for observing patients. Where patients were subject to increased observation levels, these were regularly reviewed and promptly rescinded when the risks had sufficiently reduced.
- Staff used restraint as a last resort and de-escalation was used wherever possible, this was demonstrated through our discussions with staff and patients and our examination of patient treatment records. We saw evidence that where appropriate, staff developed individual patient behavioural support plans; these detailed the de-escalation techniques to be implemented prior to the use of any restraint. Staff could seek guidance and support from a managing violence and aggression lead.
- The service had a policy in place for staff when using rapid tranquilisation and the appropriate staff knew the protocols relating to this. The service's use of rapid tranquilisation followed the National Institute for Health and Care Excellence (NICE) guidelines. There was one incident of rapid tranquilisation at the service in the last 12 months; this was in March 2017. We looked at the records for this and saw that it was reported appropriately. For example, it was recorded in detail the checks staff made on the patient's physical health after rapid tranquilisation was administered.
- At the previous inspection in February 2016, we found that the providers absent without leave (AWOL) policy did not detail what action staff need to take when a patient was AWOL. At this inspection, the provider had addressed this issue. The policy appropriately outlined the steps staff should take if a patient was missing.
- Staff knew the service's safeguarding procedure and how to spot the signs of abuse in vulnerable adults. The service had reported five safeguarding concerns in the previous 12 months. The main themes were financial abuse, where two patients reported money going missing. The service supported the patients to report this to the police and conducted a full check of their room, with their permission.
- At the previous inspection in February 2016, we found that medicines had not been stored or disposed of correctly.Medicines that should have been refrigerated had been stored in a medicines cupboard. At this inspection, all medicines were stored appropriately. Nurses carried out daily medicines checks, including the temperature of the medicines refrigerators. All medicines were within their expiry dates. The stock levels of medicines were monitored to ensure there was always a supply of medicines available. We reviewed eight medicine administration records (MARs) at the service. MARs included patient information, such as allergies, and were kept with records of patients' blood tests and electrocardiograms. This meant that when medicines were prescribed, information regarding patients' physical health was readily available. The service was in the process of changing its pharmacy provider to improve monitoring and auditing of medicines.
- Children were not allowed to visit the service, as the hospital did not have an appropriate room to facilitate this. Patients with children were supported to see them away from the hospital.

Track record on safety

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- There had been one serious incident in the previous12 months. The provider had completed a root cause analysis (RCA) investigation that was distributed to the service shortly after the inspection. This included recommendations for the hospital.
- The recommendations from the root cause analysis report included a review of the clozapine checklist to include potential side effects and to ensure all staff was aware of the proposed changes to the checklist. Staff had also received additional training in clozapine related issues after the incident, prior to publication of the RCA report.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and the type of incidents that needed reporting. All incidents that should be reported were reported. In the six months prior to the inspection, the service had reported 79 incidents. Fifteen of these were classed as managing violence and aggression. Staff were experienced and trained in working with patients to reduce any aggressive behaviour.
- All incidents were reported onto an online system that the manager had oversight of. Incidents were signed off by two members of senior staff and by the staff member completing the report. We saw incidents discussed at team meetings so that learning could be shared. We saw evidence of staff being debriefed after an incident of prone restraint in March 2017.
- Learning was shared with staff when an incident occurred, for example, the manager described a recent incident that led to changes in the way that patient's money was monitored and kept safe. We also saw evidence of lessons learnt after an incident of rapid tranquilisation being administered. Staff acknowledged what went wrong when the medicines were administered during the incident and developed a plan to minimise the risks of future occurrence.

Duty of candour

- The service had a duty of candour policy. Duty of candour is the need for staff to be open and honest when things go wrong for a patient in their care. Staff understood the importance of being open, transparent and apologising when things went wrong. For example, the hospital director and Mental Health Act administrator told us about an incident when there was an error regarding a patient's leave. They knew that the patient needed to be informed of their error, had done so and apologised for this.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at eight patient care and treatment records in detail. Patients were assessed prior to admission by staff to ensure that their needs could be met. Staff completed a comprehensive assessment of patients' needs on their admission. These included the patients' mental health history, social circumstances and their rehabilitation needs. Patients could visit Bromley Road Hospital before admission to orientate themselves to the service.
- Staff assessed and monitored patient's physical health care, which included relevant details of the patient's medical history. Where appropriate individual physical health care plans for patients were in place. Staff used the national early warning score (NEWS) tool. This was a scoring system used by staff as a guide to check patients' blood pressure, pulse rate and weight and to escalate concerns if necessary. The service had a part time ward doctor and general nurse who checked patient's physical health. Some patients were prescribed anti-psychotic medications. These patients were monitored regularly to check for any adverse effects. Patients were registered with and received support regarding physical health from a local GP.
- Patients received an annual ECG in accordance with National Institute for Health and Care Excellence (NICE) guidance. To assess the cardio metabolic health of patients experiencing psychosis and schizophrenia, staff used the Lester tool to improve patient's physical health. Patients also received smoking cessation support at the service and staff were trained in this.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff did not keep all patient records up to date. Two of the records we looked at were not up to date in some areas. For example, in one patient record progress against identified goals had not been updated. We saw a patient's one to one with their named nurse had not been recorded. In addition, another patient only had a ward round recorded twice in 2017. The hospital director told us that the consultant had met with some of the patients we identified as not being regularly reviewed by the doctor but had not updated the care records on the system. The manager had raised this issue at the three monthly staff meeting in May 2017, and reminded staff to keep records up to date. Patient records not being kept up to date meant that important patient information might not be passed onto staff and the safety and continuity of care affected.
- Care plans were recovery orientated, holistic and addressed patient's rehabilitation needs. A number of patients at the service had long term, complex mental health needs and staff supported them with developing their daily living skills. We saw staff completing physical health, diabetic and positive behaviour support (PBS) care plans with patients. PBS care plans is a good way of supporting patients with behaviours that challenge. We saw evidence of activities for daily living care plans being completed with patients to support them with skills to move on into the community. In addition, patients had the opportunity to take part in "ward jobs" as part of their therapeutic plan. A patient was employed as a ward cleaner, with duties including wiping down surfaces after mealtimes.
- Patients also had one to one support from the nursing team as part of their therapeutic support plans. However, we saw that two patients did not have their one to one time recorded. We highlighted this to staff on the day of the inspection. Staff said that it was happening but that sometimes it was not being recorded.
- The service had recently started using a new online electronic system for recording and storing patient's care and treatment records. This meant patient records were stored securely to maintain confidentiality.

Best practice in treatment and care

- The consultant psychiatrist followed the Maudsley prescribing guidelines when prescribing medication. This was an evidence-based practice for prescribing medication that was in line with National Institute for Health and Care Excellence (NICE).
- Staff addressed the management of violence and aggression in care plans in accordance with NICE for those patients that needed supported with this.
- A psychologist was based at the service three days a week with two assistant psychologists, working an additional 30 hours per week, offering a range of psychological interventions. These included NICE recommended therapies such as cognitive behavioural therapy, mindfulness and distress tolerance groups.
- Patients were able to access specialist healthcare where needed. One patient was referred to the tissue viability nurse who visited once a week.
- Staff used the health of nation outcome scales (HONOS) to measure the health and social functioning of a person with complex and enduring mental health needs.
- The hospital manager had oversight of audits carried out at the service. This meant that senior staff could effectively monitor the quality of patients care and make improvements. Audits included checks on the quality of care plans; however, it did not include checks on whether patient records were updated. The manager ensured staff received feedback on the findings of audits and that actions took place to make any necessary improvements.

Skilled staff to deliver care

- The multidisciplinary team (MDT) included a consultant psychiatrist, a psychologist, an occupational therapist, nurses and healthcare assistants.
- The consultant psychiatrist was the responsible clinician and worked at the service one day a week. The consultant's limited availability affected the frequency with which the entire MDT reviewed some patients. Some patients fed back that they did not receive ward rounds regularly. We found three patient records where a ward round had not taken place for several months. For example we spoke to one patient who said they had tried to see the consultant psychiatrist as they wanted to discuss their medication. We looked at their records and found that the ward doctor had recorded a discussion with the patient on 16 February 2017 that

their concerns would be discussed at the next ward round. The patient's next recorded ward round was on 9 May 2017. We found another two patients where they had a ward round recorded every two months. The consultant also had to attend tribunals being held during that time. Staff prioritised weekly ward rounds based on level of risk. This had an impact on patient care, as there could be delays in accessing the consultant to discuss their medication, leave and detention.

- The MDT met to review patients every thirteen weeks. This included a review of all care plans and risk assessments. The therapeutic activities timetable was also reviewed at this time. However, for one of the eight patients whose records we looked at this target had not been met. We were told this was because of the limited availability of the consultant psychiatrist.
- The service manager recognised that medical cover was an issue. The manager said patients could specify if they wanted access to the consultant sooner than scheduled. The service was looking at ways to address the lack of medical cover by increasing the ward doctor post to full time within the next few months, but no specific date was given. The provider contacted the emergency services for patients who had urgent physical health problems.
- Staff at the service were appropriately qualified and experienced in working with patients with complex needs in a rehabilitation setting. An occupational therapist was new to post and delivered rehabilitation activities for the patients to gain independence skills. Staff were able to access external and internal training to develop their role. For example, a psychologist told us they were able to attend seminars and conferences to develop their skills.
- All new staff had an induction to orientate themselves to the service. The provider gave bank staff a one-day induction at the hospital to ensure they were familiar with the service and policies.
- At the previous inspection in February 2016, we found that the provider had not ensured all staff was receiving regular supervision. At this inspection, we found staff was regularly supervised. Records showed that staff were receiving supervision every 4-6 weeks. Where there was a gap in supervision this was due to staff sickness or maternity leave. All staff received an annual appraisal. The recent appointment of a psychologist meant that staff reflective practice groups were being held on a weekly basis. This is where staff discussed a particular case and how they would support the patient. Staff also attended team meetings once a month to discuss performance, staff morale and patient care needs.
- Staff received the necessary specialist training to support them to work with patients who had complex mental health needs. For example, the service had provided internal training in lithium and clozapine side effects and in rapid tranquilisation. Two staff were currently undertaking management and leadership training. All staff had received smoking cessation training to support patients with the service becoming smoke free.
- Poor staff performance was addressed in supervision and in team meetings. Minutes of a staff meeting in May 2017 showed that staff had discussed poor performance in regards to time-keeping and maintaining effective team working.

Multi-disciplinary and inter-agency team work

- The ward held regular and effective multi-disciplinary (MDT) meetings on a weekly basis. In addition, there were effective handovers between shifts. We observed an MDT handover, which took place every morning. Incidents, risk, staffing, safeguarding and daily appointments were amongst the issues discussed.
- The service had effective relationships with teams outside of the hospital. Two care coordinators fed back to us that they were involved in care programme approach (CPA) meetings. The hospital also provided them with regular reports regarding the patient's care and treatment.

Adherence to the MHA and the MHA Code of Practice

- Staff were trained in the Mental Health Act as part of their mandatory training. Ninety five percent of staff had completed this training. Staff had a good level of knowledge of the Mental Health Act (MHA).
- At the previous inspection in February 2016, we found that that MHA Managers' hearings did not take place within the period recommended by the code of practice. At this inspection, we found that MHA manager's hearings were taking place within an appropriate period.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The service had a Mental Health Act administrator who monitored and reviewed documentation relating to the detention of patients and supported staff's implementation of the MHA. For example, they ensured applications for patient's appeals against detention and consent to treatment records were applied correctly. They did this through regular audits of the MHA, including detention expiration dates and patients' rights information.
- All patients were subject to detention under the MHA at the time of our inspection. We saw evidence that patients had their rights explained to them on a monthly basis. Patients' leave was recorded in their care and treatment records. Patient leave forms were appropriately completed and authorised.
- Staff completed consent to treatment forms for detained patients on admission. We saw certificates completed by a second opinion appointed doctor, where appropriate.
- Patients had access to an independent mental health advocate (IMHA) who visited the service each week. Patients knew who the advocate was and when they attended.

Good practice in applying the MCA

- Training in the Mental Capacity Act (MCA) was mandatory for all staff. Ninety five percent of staff had completed training in the MCA and Deprivation of Liberty Safeguards. Staff had a good understanding of the MCA and the principles that underpin it.
- We saw examples of staff completing capacity assessments that were time and decision specific. For example, we saw a capacity assessment where there was a concern as to whether a patient had capacity to consent to an intimate relationship and we saw that they had been assessed as having capacity to make this decision.
- Where patients were assessed as lacking capacity for specific decisions, the MDT held best interests meetings in line with the MCA. We saw that a best interests meeting had been held recently for one patient regarding management of their diabetes. The patient's family had been involved in the best interests meeting and decision making process.
- There were no patients subject to a deprivation of liberty safeguard (DoLS) at the time of the inspection.
- Staff could contact the hospital director or the consultant psychiatrist for guidance on the MCA and DoLS at the service.

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

Requires improvement

Kindness, dignity, respect and support

- The majority of interactions between staff and patients in the communal areas of the hospital were task orientated.Staff focussed on getting tasks done rather than spending quality time with patients, which was paternalistic and not always enabling. Some of the interactions observed did not provide appropriate practical or emotional support and did not promote patient dignity and respect. For example, we observed a patient speaking to a staff member about their mental health and becoming agitated and not being dealt with in an appropriate and respectful way. We saw staff telling a patient to wait to be supported with their belongings when they were not busy.
- We also saw staff members discussing dissatisfaction and inconvenience at taking a patient out in front of the patient. This resulted in the patient not wanting to be taken to their emergency appointment by the staff member. We spoke with the manager after the inspection about the poor interactions between staff and patients. The manager understood the need to have caring staff and acknowledged that this was an issue with a small number of staff. The manager explained that this issue would be addressed through supervision and staff meetings with immediate effect.
- We did observe some members of staff interacting in a respectful way towards patients. For example, when a patient became agitated and wanting to speak further about their treatment, a staff member arranged to meet with them privately to discuss their concerns.
- Four of the six patients we spoke with fed back that nursing and support staff were rude and often did not respect them. For example, staff would talk amongst

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

themselves when in the communal areas and were rude when they spoke to them. Two patients gave positive feedback about the support they received, however, saying that staff were considerate and polite towards them and that they felt safe.

- The provider conducted a patient satisfaction survey for 2016/2017. Eleven patients participated in the survey. Patients were asked whether they felt treated with dignity and respect. Three patients said they did not, one patient responded that they were treated with dignity and respect and five patients did not answer the question.

The involvement of people in the care they receive

- Patients were able to visit the ward prior to their admission. During the admission process, patients received information about the service that supported their orientation to the unit.
- At the previous inspection in February 2016, we found that the provider did not ensure patients were fully involved in their care and understood the purpose of their personal folders. Personal folders included copies of patient care plans and the activity timetable. At this inspection, we found that patients were aware of their personal folders.
- Of the six patients, we spoke to most said they were involved in their care. Two patients told us they knew what was in their personal folder, but did not necessarily use it. We looked at eight patient records and saw that patients had been involved in their care plans. For example, patients commented on their goals and their discharge plans.
- Information about how patients could access independent advocacy was displayed on the wards. An advocate attended the ward once a week.
- Some patients asked for their families and carers to be involved in their care and treatment. When patients requested this, family members were invited to ward rounds where they could contribute to decisions about care and treatment.
- Patients were able to give feedback on the service. Patients attended a community meeting every week. At the previous inspection in February 2016, we found that staff were not providing patients with feedback from issues raised at community meetings. At this inspection, we found this had improved. We observed a community meeting taking place. Patients were asked what they wanted to do for the day and what trip outside they wanted to do. We looked at the community meeting minutes for several months and saw that found that patient issues were addressed and fed back to the meeting. Minutes from these meetings were displayed on the noticeboard in the communal corridor for patients to see.
- Patients were involved in making decisions about the running of the service. One patient had sat on the interview panel when the service was recruiting a new member of staff. The patient said they enjoyed this and compiled their own questions to ask the prospective employees.

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

Good

Access and discharge

- The service admitted patients from across the country. NHS trusts and Clinical Commissioning Groups across England referred patients to the service. Staff from the hospital went to assess eligible patients prior to admission and then discussed their assessment with the multidisciplinary team
- The average length of stay for the service was 35 months. However, a few patients had been at the service for a considerable number of years. These patients needed long term support due to their complex mental health needs.
- When patients returned from leave, there was always a bed available for them. Patients were only moved to other services if their needs could not be met, for instance if a patient required an acute admission because of deterioration in their mental state.
- Patients were discharged during the day when the appropriate levels of staff could facilitate this. In the last six months, there were no delayed discharges.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Patient care plans included discharge planning. Staff implemented discharge plans at an early stage. For example, we saw a discharge plan for a long-term patient that contained short-term goals to support the patient in working towards their long term aims. Upon discharge, the majority of patients were referred to supported accommodation in the community.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms to support patient's treatment. This included a large sized room upstairs used for staff meetings and sometimes patient support, a clinic room and an occupational therapy building in the garden for patients to attend therapy activities. A number of staff told us that the prefabricated building was too small. The building could hold up to about six people at any one time. Staff said this rarely occurred and if it did, there were alternative spaces that could be used. However, this may not always be practicable if other meetings were being held that day.
- Each house had a communal lounge and dining area, which contained sofas and a television. Olive house had an occupational therapy kitchen, which all patients accessed.
- The service had a designated visitor's room for patients to see family and friends. There was no quiet room, but there was the option for patients to use the therapy rooms to meet with staff.
- The service had a patient payphone in the corridor area. Patients also had their own personal mobile phones to make calls from.
- The service had a garden area, which was a good size. Patients could access this at all times.
- Patients' gave mixed feedback regarding food. The service had a full time chef who prepared and cooked meals for the patients. Four of the patients enjoyed the food and felt there was enough choice and flexibility. Two said the food was not their particular choice and that it was of poor quality.
- Patients were able to make hot drinks and snacks at any time of the time. The patient kitchen was kept open at all times.
- Patients were able to personalise their rooms. Patients were able to lock their room and had their own keys.
- Staff supported patients with activities throughout the week. The occupational therapist facilitated activities for social inclusion and therapeutic groups including local employment and educational services. This supported patients in their recovery to move on to independent living. . However, there were limited activities in the evenings and weekends.

Meeting the needs of all people who use the service

- The main entrance to the service was located at ground floor level. Both Jasmine and Olive house had bedrooms located at ground floor level. The communal lounge and kitchen area was also located at ground level. Patients with decreased mobility could access these areas without assistance.
- A notice board that contained information on advocacy, complaints and community meetings was fixed in the communal area. Patients could also use their personal folders to retain information about the service.
- The service had arrangements in place for staff to be able to access interpreting services if required.
- Patients were able to have a choice of the meals. These incorporated patient's dietary and cultural needs. Meal choices and options were discussed during community meetings.
- The service did not have a multi faith room, but patients could also pray and worship in their own bedrooms.

Listening to and learning from concerns and complaints

- The service had effective systems in place to deal with complaints. Ninety seven percent of staff were trained in dealing with complaints. The provider's policy outlined the process and periods for dealing with complaints and had a two-stage process. Complaints could be dealt with locally or formally. The manager reviewed the complaint and responded to the complainant within 24 hours with an outline of timescales. Depending on the seriousness or the contents of the complaint, the manager shared information with other agencies, including the police if necessary. For example, we saw a complaint received regarding a patient's money. Staff reported it to the police and to the local safeguarding team.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- In the previous six months, the service received three formal complaints. These related to staff attitudes towards patients. The most recent complaint of this nature was in May 2017 and was in the process of being investigated.
- None of the complaints had been referred to the independent sector complaints adjudication service or the parliamentary health service ombudsman (PHSO). The provider had partially upheld one complaint with another investigation still on going. Once the investigation of the complaint was concluded, the manager wrote a letter to the complainant explaining how the complaint had been investigated and its outcome.
- Informal complaints were not routinely recorded. However, they were discussed and recorded in the monthly community meetings. The minutes of these meetings showed that staff identified the actions that needed to be taken to address any informal complaints.
- Patients told us they knew how to complain about the service they were receiving. However, when patients were asked in the provider's survey, 45% of patients said they did not know how to complain. Not all patients responded, with 36% of patients stating they knew how to complain.

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

Requires improvement

Vision and values

- The current provider took over the service in December 2016. The provider aimed to "put the patient at the heart of all aspects of hospital life". Staff emphasised the importance of working in collaboration and offering the best care possible to patients.
- Senior managers from the provider visited the service frequently and staff knew who the senior managers were.

Good governance

- Overall, the service did not have effective systems established to ensure the quality and safety of the service was assessed, monitored and improved. The systems in place had not captured issues such as incomplete patient records, insufficient medical cover and the inappropriate use of blanket restrictions. However, the service had a ward to board dashboard. This monitored information on incidents, numbers of restraint, episodes of leave, care plans, referrals and discharges and complaints. The provider was in the process of transitioning to revised policies and procedures.
- The service had moved to an electronic care notes system, which staff said, was working well and made it easier to monitor recording of patient information. However, we found a number of patient records that had not been updated to include recent reviews by the consultant psychiatrist or one to one's with named nurses.
- The hospital director and senior nurses used a tool to monitor levels of safe staffing on each shift. Staff supervision was recorded on a spreadsheet, which management used to keep track of monthly supervision. The provider had ensured that the appropriate pre-employment checks had been carried out; these included criminal record (DBS) checks, employee references and professional registration checks.
- At the last inspection in February 2016, the provider had not ensured that all staff completed their mandatory training. Whilst this had improved during this inspection, the completion rates for information governance and infection control were lower at 77% and 70% respectively. However, these compliance rates were not accurate. This was due to a problem with the system for staff completing mandatory training, as the competencies section for both training courses was not working properly. This meant that whilst staff were completing the training this was not reflected in their training record. Therefore, accurate information relating to some staff training was not available to the hospital director.
- The hospital director attended monthly clinical governance meetings. Regional managers of other services within Elysium healthcare limited attended this. The meetings shared learning across the region and

discussed clinical governance. Minutes from these meetings included an action log to follow up from the last meeting, policy, ward to board dashboards and learning shared from other services.

- The hospital director had support from a hospital administrator who also was the service's Mental Health Act administrator. They compiled reports and data for the hospital director to use in the effective running of the service.
- A hospital risk register was used to assess and address potential risks to the provision of the service. We looked at the risk register dated May 2017. There were four risks identified, including the change over to the new provider, staff skill levels and environmental risks. Each risk had a measure to reduce the risk and an action point identified. For example, the differing level in staff skill identified training and regular supervision to reduce this risk and identified how this would be implemented.
- At the last inspection, in February 2016, the provider was not submitting required notifications to the Care Quality Commission (CQC). During the inspection, we saw that all incidents that should be notified to CQC had been notified. For example, a safeguarding referral made by staff regarding a patient in August 2016 had been notified to CQC.

Leadership, morale and staff engagement

- The hospital director took up their post in March 2016, after a period where the service had no permanent manager in place. Staff felt this had improved the service and that they were supported.
- The hospital director engaged staff working at the service. This included the distribution of a staff newsletter every three months, which informed staff about latest vacancies and recruitment, supervision, and general hospital updates.
- Staff we spoke with told us their morale was good and they enjoyed working at the service. The sickness rate at the service in May 2017 was 3% this included one member of staff on long-term sick leave. There had been no reported cases of bullying and harassment at the service in the last 12 months. Staff knew the Whistleblowing procedure and felt able to raise concerns with their manager.
- The hospital director addressed poor performance and staff attitudes in team meetings. The hospital director and team leader told us they were aware that there were some issues with negative patient and staff interactions. The hospital director produced the minutes of the staff meeting in May 2017 to show that the concerns of some staff behaving in an unprofessional way towards patients had been discussed. The minutes included discussion of poor staff performance in regards to time keeping and team building but did not include discussion around the poor staff interactions with patients. After the inspection the provider sent us documents to show that they were addressing poor staff performance in regards to dignity and respect of patients. These documents included mediation between two staff members. However, the document did not record that poor staff attitudes towards patients had been discussed.

Commitment to quality improvement and innovation

- The service did not have any improvement methodologies in place. The manager told us that the provider planned to identify and introduce quality improvement programmes and innovative practices in the future, although no date was fixed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff provides respectful and appropriate practical and emotional support that promotes patient dignity.
- The provider must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced medical staff to meet the needs of patients.
- The provider must ensure that a complete and contemporaneous record in respect of each service user is maintained, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The provider must review their use of blanket restrictions to ensure that patients are appropriately supported to maintain their bedrooms based on their individual needs and preferences.
- The provider must ensure that they assess, monitor and improve the quality and safety of the service provided.

Action the provider SHOULD take to improve

- The provider should ensure that the online learning system for staff training provides accurate information regarding staff completion rates.
- The provider should ensure that the equipment in the emergency response bags includes suction tubing at all times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users must be treated with dignity and respect.** Staff did not always treat patients with dignity and respect. Patients reported that staff were rude to them. We observed poor staff and patient interaction in the communal lounge area. This was a breach of regulation 10(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The service had not provided care and treatment that was appropriate and met the needs of patients.** Individual patient needs, for example support with maintaining bedroom environments, was inappropriately provided through the use of blanket restrictions such as random room searches. This is a breach of regulation 9 (1) (a)(b)(c)

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 HSCA (RA) Regulations 2014 Good governance **The establishment and operation of effective governance systems and processes.** The provider had not ensured there was a complete and contemporaneous record of the care and treatment provided to each client. Staff did not update some patient records when care and treatment was given. This is a breach of regulation 17(1) (2) (c) The provider had not ensured effective systems were in place to monitor, assess and improve the quality of the service. This is a breach of regulation 17 (1) (2) (a)
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 **The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients.** Patients did not have access to regular reviews with medical staff to discuss their treatment, including their detention or medication. This was a breach of regulation 18(1)