Broomhill

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

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

- The service had several ligature risks, many of them in bedrooms and bathrooms. Staff had not conducted a ligature risk assessment to assist in mitigating these risks.
- The clinic had a defibrillator, however no emergency drugs or oxygen cylinders were available.
- All medication apart from Clozaril came from a local pharmacy. Prescribing was undertaken by the local general practitioner (GP) and not the responsible clinician.
- There was no evidence of learning from incidents or complaints being fed back to the staff.
- Despite having a structured activity programme, staff did not provide any psychological therapies to benefit the patient group.
- Staff did not use any recognised outcome tools to measure patient progress.
- Staff audited Mental Health Act compliance. No other clinical audits were undertaken.
- Three T3 forms (certificates of second opinion) did not have the correct hospital address on them.
- We interviewed four patients who all stated they had copies of their care plans but only two stated they were involved in developing them.
- Of the entire staffing at Broomhill only 66% had received an appraisal, whilst supervision records showed only 44% of staff had received supervision in August/ September 2015.
- Only 66% of staff had completed all the mandatory training.
- Only one qualified staff member worked at weekends at night. This raised concerns about patient safety if there was an incident and staff working long hours without a break.
- The service did not have a risk register, meaning the management team did not robustly manage potential risks to the service.

However:

- Staff undertook patient risk assessments upon admission and recorded these in their notes. Weekly ward round notes show that risk assessments were updated regularly.
- Staff read patients their rights every three months and the mental health act administrator recorded this. Mental Health Act section papers were appropriately stored and in date.
- Staff treated patients with kindness and respect. We saw that staff understood individual needs and were aware of patients' preferences.
- Patients were able to choose their own diet to meet their needs either by going out shopping or accessing the menu at Broomhill.
- Staff were aware of the senior managers who visited the unit regularly, and staff spoke highly of the manager at Broomhill.

Summary of findings

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

Summary of this inspection

Background to Broomhill

Our inspection team

Inspection Manager: Lyn Critchley

Lead Inspector: Martin Stanton

The team that inspected the service comprised one inspection manager, two Care Quality Commission (CQC) inspectors, a pharmacy inspector, one Mental Health Act reviewer, an assistant inspector, two specialist professional advisers, one of whom was a consultant psychiatrist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location

During the inspection visit, the inspection team:

- visited Broomhill, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the manager
- spoke with five other staff members including nurses and an occupational therapist
- collected feedback from five patients and one carer using comment cards
- looked at six care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service
- carried out an additional unannounced visit during the night of 7 April 2016.

Information about Broomhill

Broomhill is part of the St. Mathews Healthcare group. Broomhill is registered to provide the following regulated activities:

- The assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The hospital provides care to 15 male patients with mental health needs. This unit provides a service for people with mental health needs requiring a long stay rehabilitation pathway.

Summary of this inspection

The unit provides security, activity and therapy for those clients who have enduring mental health needs, but whose recovery is anticipated at a slower pace and whose movement the Ministry of Justice or other legal bodies may restrict.

Broomhill was last inspected by the Care Quality Commission in August 2013. At this time, it was inspected under the previous methodology and was found to be compliant in the outcomes for consent to care and treatment, care and welfare of people who use services, staffing, supporting workers and complaints.

The registered manager is Ms Helen Tankeh.

What people who use the service say

We collected patient feedback through individual interviews and comment cards. They told us that the service was great, with professional and caring staff. They felt safe and told us that staff promoted their dignity at all times. They felt they were treated with respect by staff. Patients told us that the food was usually good.

Patients knew how to complain, and said they were provided with this information upon admission. Patients felt listened to and said that staff were responsive to their needs if they told staff they were struggling.

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:

- Broomhill had an up to date environmental risk assessment however, when it highlighted a higher risk in an area there was no follow up risk assessment to demonstrate how the risk was to be managed.
- The service had several ligature risks, many of them in bedrooms and bathrooms, away from direct staff observation.
- The clinic had a defibrillator, however no emergency drugs or oxygen cylinders were available.
- Only one qualified staff member worked at weekends at night. This raised concerns about patient safety if there was an incident and staff working long hours without a break.
- Broomhill had a blanket restriction on patients smoking after 21.45 until 05.45. Four patients' cigarettes were locked away in the clinic room, and they were reliant on staff to access them.
- Broomhill had a reporting structure and policies, which staff in the unit knew how to access however there was no evidence that learning from incidents was fed back to the staff.
- St Matthews's group did not provide an on call medical rota, meaning there was an expectation of all doctors to be available 24 hours a day.

However

- Broomhill had a nursing call system in each patient bedroom, and another system on walls around the unit for staff to use in case of an emergency.
- Broomhill had some informal patients who were allowed to leave and signs outlining their rights were displayed at the entrance.
- There was a separate area detached from the main unit where children could visit relatives as children could potentially be at risk if they were to visit the main ward.
- Staff had conducted a ligature risk assessment to assist in mitigating risks in patient bedrooms.

Are services effective?

Requires improvement

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

Summary of this inspection

- Medication, apart from Clozaril, was prescribed by the local general practitioner (G.P). Clozaril was prescribed by the responsible clinician, who had overall management of patient care.
- Broomhill had a consultant psychiatrist, occupational therapist and nursing staff however did not have dedicated psychology or social work input.
- Despite having a structured activity programme, staff did not provide any psychological therapies to benefit the patient group.
- Staff did not participate in clinical audit. The only audits undertaken were completed by the manager and related to training, sickness and supervision.
- Only 66% had received an appraisal, whilst supervision records showed only 44% of staff had received supervision in August/ September 2015.
- Staff were not routinely trained in the Mental Health Act and the Mental Capacity Act. Staff could not describe the local policy on Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS).
- Consent to treatment forms were attached to the medication charts. However, three T3 forms (the certificate of a second opinion doctor required, if a sectioned patient refuses to consent to take their medication) did not have the correct hospital address on them.

However:

- Staff undertook patient risk assessments upon admission and recorded these in their notes. Weekly ward round notes show that risk assessments were updated regularly.
- Staff undertook a physical examination of patients upon admission and monitored their physical health at weekly ward rounds. This was confirmed in patients' notes.
- Broomhill ensured that all patients were registered at the local GP practice. Any physical health needs were met by the GP. All patients had completed Waterlow and Malnutrition Universal Screening Tool (MUST) assessments in their clinical notes.
- Staff read patients their rights every three months, which was recorded by the Mental Health Act administrator. Mental Health Act section papers were appropriately stored and in date.
- Staff used recognised outcome tools to measure patient progress.

Are services caring?

We rated caring as **good** because:

Good

Summary of this inspection

- Staff treated patients with kindness and respect. We saw that staff understood individual needs and were aware of patients' preferences.
- Patients fed back that staff were kind, caring, and spent time with them on the ward. We observed health care assistants interacting well with patients.
- Patients who used the service told us that they felt supported by staff and were confident in raising any issues with their named key worker.
- Patients stated that they were orientated to the unit and introduced to other patients upon admission.
- Staff encouraged patients to maintain their independence by encouraging them to self-care and cater for themselves.
- Patients told us their families could contact the service at any point to get updates on their progress.

However:

- We interviewed four patients who all stated they had copies of their care plans but only two stated they were involved in developing them.
- Patient involvement in their care plans varied, as did the level of personalisation. Some care plans were written very similarly across the patient group.
- Patients at Broomhill were not involved in making decisions about the service.

Are services responsive?

Good

We rated responsive as **good** because:

- The staff planned all discharges and transfers to and from Broomhill. If patients went on leave, their beds were kept open for them.
- Broomhill was a spacious building with many rooms to support a caring environment where patients could find private areas to sit when required.
- All patients had private rooms, which they could personalise. Following a risk assessment, patients could have kettles to make hot drinks or keep snacks in their rooms.
- Staff ensured there was information available on noticeboards about advocacy services and the complaints process.
- Patients had their own mobile phones, but Broomhill did not provide a private area if patients needed to use a landline phone.
- Broomhill had disabled access into the building with a bedroom downstairs for access for those who needed to use a wheel chair.

Summary of this inspection

- Patients were able to choose their own diet to meet their needs, either by going out to do their own shopping or accessing the menu at Broomhill.

However:

- If any patient became acutely unwell, they were transferred back to their local area for treatment, as Broomhill does not have the ability to manage acutely unwell patients.
- The clinic room was small and did not contain a bench to examine patients.
- Staff reported that managers did not give staff direct feedback from complaints.

Are services well-led?

Requires improvement

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

- Staff could not state the organisations values and objectives.
- Staff audited Mental Health Act compliance but no other clinical audits were undertaken.
- Of the entire staffing at Broomhill, only 66% had received an appraisal, whilst supervision records showed only 44% of staff had received supervision in August/ September 2015.
- Only 66% of staff had completed all the mandatory training.
- Only one qualified staff member worked at weekends at night. This raised concerns about patient safety if there was an incident and staff working long hours without a break.
- The service did not have a risk register, meaning the management team did not robustly manage potential risks to the service.
- The systems and processes for reporting incidents were robust, but there was no feedback to the unit on any lessons learnt.

However:

- Staff were aware of the senior managers, who, visited the unit regularly, and staff spoke highly of the manager at Broomhill.
- Staff audited MHA paperwork, and they ensured that patients were read their rights quarterly, and this was recorded in their notes.
- All the personnel files reviewed were complete and included qualifications, training records, Disclosure and Barring Service (DBS) checks, references, an employment contract and interview records.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff were not trained in the Mental Health Act and Mental Capacity Act.

All the detention paperwork was correct and up to date and stored appropriately.

There was evidence of documentation in clinical notes that patients had their rights read to them on admission and periodically thereafter.

Staff ensured that consent to treatment forms and medication charts were kept together However, we saw three examples where the responsible clinician had not amended the address to the current provider on the T3 certificate of second opinion form. Broomhill were advised to amend this. Broomhill employed an administrator whose role was to oversee all mental health documentation and ensure patients' rights were reviewed regularly.

Administrative staff carried out monthly audits of MHA documentation and recorded that this had happened. However, the audits had not identified incorrect addresses on three T3 certificate of second opinion forms.

Advocacy posters were displayed on noticeboards for patients. Staff told us that they let patients make self-referrals to this service if they wish.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of inspection, there were 13 patients admitted to the unit who were subject to the Mental Health Act, and one patient who was subject to a DoLS application.

Staff were not trained in the Mental Capacity Act. Staff could not describe the local policy on Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS).

Staff completed three monthly Mental Capacity Assessments with patients. The mental health administrator audited the use of the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Information about the service

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

Requires improvement

Safe and clean ward environment

- Broomhill was a male only service. It had a variety of lounges and space for patients however there were many blind corners, which did not allow clear lines of sight.
- The service had several ligature risks, many of them in bedrooms and bathrooms. Staff had not conducted a ligature risk assessment to assist in mitigating these risks.
- The clinic room was positioned off the dining room and appeared clean. It was small but functional however, it did not have a couch. Medication was individualised and locked away appropriately. The clinic did have a defibrillator, however no emergency drugs or oxygen cylinders were available.
- Broomhill did not have a seclusion room and did not admit patients who required that level of intensive support.
- Broomhill was clean and tidy with furnishings, which were fit for purpose. The property was well maintained.
- Broomhill had an up to date environmental risk assessment, however if a risk was identified, there was no follow up risk assessment or plan in place to demonstrate the management of the risk.
- Broomhill had a patient call system in each patient bedroom, and another system on walls around the unit for staff to use in case of emergency.

Safe staffing

- Broomhill's staffing was determined by the St Matthews group and comprised of one qualified nurse and five health care assistants (HCA) during the 07.15 to 19.45 shift and one qualified nurse and three HCA during the night shift.
- During the hours of Monday to Friday from nine until five, the unit manager, who was a qualified nurse, was on duty. The manager covered the qualified staff breaks however, there was no provision for qualified staff to have breaks during weekend or night shifts.
- The manager had the authority to alter staffing levels when needed to cover emergencies or planned activities. Broomhill used agency staff regularly. One qualified agency nurse worked regularly on nights.
- Staff told us that they could not always spend quality time with the patients. Time with their named nurse had to be scheduled. The service employed a total of three and a half qualified nurses.
- The majority of Broomhill patients had access to unescorted leave. The manager did report that activities requiring staff support did sometimes have to be cancelled due to staff sickness, or in response to staff managing a difficult situation on the unit.
- Medical cover at Broomhill was undertaken by the responsible clinician. St Matthews's group did not

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

provide on call rota, and there was an expectation for doctors to be available 24 hours a day. Medical emergencies were covered by calling emergency services.

Assessing and managing risk to patients and staff

- Staff undertook patient risk assessments upon admission and recorded these in their notes. Weekly ward round notes show that risk assessments were updated regularly.
- Broomhill had a blanket restriction on patients smoking after 21:45 until 05:45. Four patients had cigarettes locked away in the clinic room, and they were reliant on staff to be able to access them.
- Broomhill had some informal patients who were allowed to leave and signs to that effect were displayed at the entrance.
- Broomhill had an observation of patients' policy.
- The service used minimum restraint. The last restraint occurred in February 2016 and was used after de-escalation had failed. Rapid tranquilisation was not prescribed.
- Staff were aware of safeguarding policies, with seven safeguarding referrals made to the local authority during a 12-month period ending December 2015.
- Staff stored all medicines in locked cupboards in a locked clinic room. Each patient's medication was stored individually and dispensed by a qualified nurse when prescribed.
- All medication, apart from Clozaril came from a local pharmacy. This prescribing was undertaken by the GP and not the responsible clinician. The responsible clinician only prescribed Clozaril on a separate prescription dispensed at a separate pharmacy.
- Staff stated there was a separate area detached from the main unit where children could visit relatives as children could potentially be at risk if they were to visit the main ward.

Track record on safety

- Broomhill uses minimal restraint, the last being February 2016. The manager reported that Broomhill has not had any recent serious incidents.
- During our inspection, the provider gave us details of all incidents since September 2015. These were collated and reported for all incidents occurring across the providers four hospital sites. There had been 136 incidents between September 2015 and February 2016 at the four hospital sites. The senior management team had reviewed incidents via the quality improvement group meeting to reduce the risk of reoccurrence.

Reporting incidents and learning from when things go wrong

- Broomhill had a reporting structure and policies and staff in the unit knew how to access this.
- Staff meetings were held bi-monthly, which was requested by the staff. The meetings had previously taken place monthly. The unit manager met monthly with their manager for supervision. However, there was no evidence of any learning from incidents being fed back to the staff during these meetings.

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

- Staff ensured that risk assessments were completed for all patients upon admission. Assessments were recorded in their notes.
- Staff undertook a physical examination of patients upon admission, and monitored their physical health at weekly ward rounds. Evidence of ongoing physical health monitoring was found in patients' notes.
- The care team at Broomhill ensured that care plans were in place for all patients. However, patient involvement in their care plans varied as did the level of personalisation. Not all care plans were individualised.
- Staff stored all patients' notes in the nursing office in a lockable cupboard. The clinical notes were in paper form with the files kept tidy, making it easy to access information.

Best practice in treatment and care

- Staff ensured that medication prescribed was within British National Formulary (BNF) standards. However, all medication apart from Clozaril was prescribed by the local GP. The GP did not have responsibility for the day-to-day clinical management of the patient.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Broomhill did have a structured activity programme, but this did not contain any psychological therapies to benefit the patient group.
- Broomhill ensured that all patients' were registered at the local G.P practice. Any physical health needs were met by the GP. All patients had Waterlow and Malnutrition Universal Screening Tool (MUST) assessments in their clinical notes.
- Staff did not consistently use any recognised outcome tools. One patient had the 'Hamilton anxiety rating scale' and three patients' had the 'model of human occupation screening tool' used by occupational therapists however, other patients had no outcome measures assessed or recorded.
- Staff did not participate in clinical audit. The only audits undertaken were by the manager and were in relation to training, sickness and supervision.

Skilled staff to deliver care

- Broomhill had a consultant psychiatrist, occupational therapist and nursing staff. They did not have any psychology or social work input.
- Of the entire staffing at Broomhill, only 66% had received an appraisal, whilst supervision records showed only 44% of staff had received supervision in August/ September 2015.
- Training was available to staff which was suitable to their post however not all staff had undertaken this. Bi-monthly team meetings were held to discuss ward issues however there were no specific agenda items. Issues around staff performance were dealt with appropriately within the provider's disciplinary process.

Multi-disciplinary and inter-agency team work

- Staff at Broomhill worked long day shifts starting at 7.15am and finishing at 7.45pm. This allowed just a 15-minute handover period between day and night shifts, for the updates on the 14 patients to be given.
- Broomhill records showed weekly ward rounds were attended by the multi-disciplinary team.
- Patients were referred to Broomhill from neighbouring counties. Broomhill staff liaised with many local authorities as a result, and we saw evidence of this in a recent DoLS application.

Adherence to the MHA and the MHA Code of Practice

- Staff were not trained in the Mental Health Act and Mental Capacity Act.
- Consent to treatment forms were attached to the medication charts.
- Staff read patients their rights every three months, and the MHA administrator recorded this. MHA section papers were appropriately stored and were in date.
- Detentionpaperwork was filled in correctly,up to date and stored appropriately.
- Administrative staff carried out monthly audits of MHA documentation and recorded that this had happened. However, the audits had not identified incorrect addresses on three T3 certificates of second opinion forms.
- Advocacy posters were displayed on noticeboards for patients. Staff told us that they let patients make self-referrals to this service if they wish.

Good practice in applying the MCA

- Broomhill had a policy covering the use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff were not trained in the Mental Capacity Act. Staff could not describe the local policy on Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS).
- Staff discussed capacity and consent periodically with patients in the ward round and recorded the discussion in their clinical notes.
- We found evidence that staff rarely used restraint. In the last six months, there had been just one incident of restraint.
- Broomhill had one patient detained under DoLS. Staff had liaised with the person's home area and recorded this appropriately.

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

Good

Kindness, dignity, respect and support

- Staff treated patients with kindness and respect. We saw that staff understood individual patient needs and were aware of patients' preferences.
- Patients who used the service told us that they felt supported by staff and would be confident raising any issues with their named key worker.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The involvement of people in the care they receive

- Staff encouraged patients to maintain their independence to self-care and cater for themselves.
- We interviewed four patients who all stated they had copies of their care plans but only two stated they were involved in developing them.
- Patient involvement in their care plans varied as did the level of personalisation. Some care plans were written very similarly across the patient group.
- Patients stated they were aware of the available advocacy service, but three patients stated they would use their solicitor instead.
- Patients told us their families could contact the service at any point to get updates on their progress.
- Patients could access six weekly community meetings.
- Patients at Broomhill were not involved in making decisions about the service.

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

(for example, to feedback?)

Good

Access, discharge and bed management

- Broomhill patients were from a number of different counties and accessed the service following assessment by the clinical team at the service.
- Patients stated that they were orientated to the unit and introduced to other patients upon admission.
- The staff planned all discharges and transfers to and from Broomhill. If patients went on leave, their beds were kept open for them.
- If a patient became acutely unwell, contingency plans were in place for them to be transferred back to their local area for treatment, as Broomhill did not have the ability to manage acutely unwell patients.
- Broomhill did not have any delayed discharges.

The ward optimises recovery, comfort and dignity

- Broomhill was a spacious building with many rooms to support a caring environment where patients could find private areas to sit. It was placed in large grounds for patients to walk in regularly.
- The clinic room was small and did not contain a bench to examine patients. Staff stated they would use patients' bedroom for physical examinations.
- Patients had their own mobile phones, but Broomhill did not provide a private area if patients needed to use a landline phone.
- All patients had private rooms that they could personalise and where appropriate. Following risk assessment patients could be allowed kettles to make hot drinks and could keep snacks and cold drinks in their own rooms.

Meeting the needs of all people who use the service

- Broomhill had disabled access into the building with a bedroom downstairs for access for those who needed to use a wheel chair.
- Broomhill staff stated that they would access interpreting services when necessary by making a request to the senior managers.
- Staff ensured there was information for patients on noticeboards about advocacy services and the complaints process.
- Three patients attended the local church on Sundays when they wanted to.
- Patients were able to choose their own diet to meet their needs, either by going out shopping or accessing the menu at Broomhill.

Listening to and learning from concerns and complaints

- Patients stated they knew how to complain. During the 12 months prior to inspection, 16 complaints had been made. Of these two had been upheld.
- Staff reported that Managers did not give staff direct feedback from complaints.

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

Requires improvement

Vision and values

- Staff were aware of the senior managers, who visited the unit regularly.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff could not state the organisations values and objectives when asked about them.
- Staff spoke highly of the manager at Broomhill.

Good governance

- The service did not have a risk register, meaning the management team did not robustly manage potential risks to the service. We found a number of concerns including staffing, environmental issues and medication management. These had not been highlighted by the providers own governance system.
- Broomhill had an up to date environmental risk assessment however, when it highlighted a higher risk in an area there was no follow up risk assessment to demonstrate how the risk was to be managed.
- Broomhill's manager undertook audits on training, sickness and supervision. There were no other clinical audits undertaken.
- Only 66% of staff had received an appraisal, whilst supervision records showed only 44% of staff had received supervision in August/ September 2015. Only 66% of staff had completed all the required mandatory training.
- Managers covered the unit with one qualified staff per shift. Monday to Friday, the manager who was a qualified nurse was on duty to offer support and facilitate qualified staff having breaks. However, the manager was not available at weekends or nights, meaning there was only one qualified staff member on duty. This raised concerns about staff working long hours without a break.
- Ward managers said they had sufficient authority to do their job, and felt able to carry out their role effectively.
- Staff ensured that Mental Health Act paperwork was audited and patients were read their rights quarterly. This was recorded in their notes.
- The systems and processes for reporting incidents were robust, but there was no feedback to the unit on any lessons learnt.
- All the personnel files reviewed were complete and included qualifications, training records, Disclosure and Barring Service (DBS) checks, references, an employment contract and interview records.

Leadership, morale and staff engagement

- Staff reported no cases of bullying or harassment and told us they understood how to report incidents if they did occur.
- Staff said they had good levels of job satisfaction and they enjoyed their jobs. There was evidence of team working.
- Broomhill had a high turnover of staff for the year ending December 2015 at 38% however, at the time of the inspection they were fully staffed.
- All the staff we spoke to said they knew how to whistleblow if they had any concerns. They said they would do this by speaking to the Care Quality Commission about concerns they may have.

Commitment to quality improvement and innovation

- Broomhill was not registered with any quality improvement or innovation schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that environmental and ligature risks are assessed, mitigated and managed.
- The provider must ensure that learning from incidents or complaints is fed back to the staff.
- The provider must ensure there are sufficient staff to ensure that patient's needs are met and that there are sufficient breaks available for qualified staff at weekends and at night.
- The provider must review its medical on call arrangements to ensure the safety and welfare of both patients and staff.
- The provider must ensure that patients receive psychology and social work support.
- The provider must ensure that staff have access to emergency drugs and equipment in case of emergency.
- The provider must ensure staff have access to regular supervision and appraisal and undertake required mandatory training.
- The provider must review the process of medication prescribing being undertaken by the local general practitioner (GP) and not the responsible clinician.
- The provider must ensure that Mental Health Act paperwork have the correct details for the patient recorded on them.
- The provider must ensure staff have a full understanding of the Mental Health Act and the Mental Capacity Act.
- The provider must ensure patients have access to psychological therapies and social work.
- The provider must consider the use of clinical audit and recognised outcome tools to measure patient progress.
- The provider must ensure there is effective governance and that they robustly manage potential risks to the service.

Action the provider SHOULD take to improve

The provider should review its medical on call arrangements

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 9 HSCA (RA) Regulations 2014 Person-centred care **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:** **Regulation 9: person centred care** • There were no psychological therapies available to benefit the patient group • Three T3 forms (the certificate of a second opinion doctor required, if a sectioned patient refuses to consent to take their medication) did not have the correct hospital address on them. This was a breach of regulation 9(1)(b), 9(2) and 9(3)(d)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:** **Regulation 12: Safe care and treatment.** • Not all environmental and ligature risks were assessed, mitigated and managed • No emergency drugs or oxygen cylinders were available. • Prescribing was undertaken by the local general practitioner (GP) and not the responsible clinician. This was a breach of regulation12(2)(a-b, f-g)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:** **Regulation 17: good governance** • The provider did not use clinical audit or recognised outcome tools to measure patient progress. • The provider had not ensured effective governance and that they robustly managed potential risks to the service. • The provider had not ensured that learning from incidents or complaints was fed back to staff. This was a breach of regulation 17(2)(a-b, f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing.** • There were not always sufficient qualified staff to ensure all patient needs were met or staff could have breaks as required. • The provider did not provide on call medical cover rota, and there was an expectation for doctors to be available 24 hours a day. • Not all staff had received supervision and appraisal on a regular basis. • Not all staff had undertaken required mandatory training. • Staff were not routinely trained in the Mental Health Act and the Mental Capacity Act. This was a breach of regulation 18(2)(a).