Deepdene Care Limited 1-101656493

Brook House

Quality Report

Wards visited for inspecting this location
Name of service Brook House
Name of CQC registered Location Brook House
Tel: 0161 209 8138
Website: www.deepdenecare.org.uk

Date of inspection visit: 2 and 3 December 2014
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by people who use the services, the public and other organisations, and other information gathered by CQC, including information from our 'Intelligent Monitoring' system where available.

Summary of findings

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Summary of findings

Overall summary

There were a number of systems in place to check the health, safety and cleanliness of the building. Staff were aware of the individual risks to and from patients' mental health needs and how the observation, support and monitoring of patients was used to manage risk within the environment. There were sufficient staff on duty to provide appropriate care and treatment to patients. There was good multi-disciplinary input for the size of the mental health hospital as the provider employed an occupational therapist and a social worker.

Patients told us that staff were approachable and they gave them appropriate care and support. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and understanding manner. Patients were treated with dignity and respect. Patient's relatives were complementary about the respectful care their loved ones received. There was a range of activities that patients could participate in. Information about the providers' complaint procedure was clearly displayed on the hospital noticeboards. Patients told us that they felt well supported by staff in making complaints. There were some rules due to the nature of the locked rehabilitation role of the hospital. Managers of the hospital should clearly articulate the rationale for any local rule or restriction to both staff and patients through information and policy development.

Staff undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Patients were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys. Information was analysed and action taken to maintain and sustain quality services. Regular audits were carried out by various levels of staff within the organisation. The audits themselves were of a good standard and issues identified within audits were usually addressed to improve the quality of services for patients. Whilst staff and managers were committed to providing quality services, it was not fully clear that audits and innovation were embedded within a co-ordinated clinical governance framework.

Brook House could have been more effective because care planning documentation did not always explicitly include sufficient written evidence of holistic individual discharge plans or provide evidence that ongoing baseline assessment and progress based on rehabilitation and recovery principles. The location had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act Code of Practice. However there were issues with section 17 leave recording, a lack of medical scrutiny of detention papers and staff did not have ready access to copies of detention papers at all times.

We did not identify any regulatory breaches on the inspection. We have asked the hospital to consider what they should do to improve services further in some areas.

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.

We carried out routine Mental Health Act monitoring visit in September 2014. Where we found issues relating to the MHA on these monitoring visits, managers of Deepdene Care provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice. On this inspection we saw that many of the issues raised had been addressed, for example improved advocacy access had been arranged and the section 17 leave proforma had been amended to ensure patients received a copy.

The hospital had a Mental Health Act administrator who ensured that the responsibilities of the Mental Health Act were met. There were good systems in place to support adherence to the Mental Health Act. The records we saw relating to the Act were generally well kept. The exceptions were:

- the recording of section 17 leave including section 17 leave forms being amended numerous times. The parameters of section 17 leave were also recorded on specific days of the week which did not permit flexibility.
- Staff on the unit did not have access to detention papers out of hours.
- There was no evidence of medical scrutiny of detention papers.

Summary of findings

We found that staff at this location were aware of their duties under the Mental Health Act (1983). Staff had received relevant mandatory training.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff spoken with demonstrated an awareness of the Mental Capacity Act. All but one of the patients at Brook House was detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were therefore made under the legal framework of the MHA. We saw that patients' mental capacity to consent to their care and treatment had been assessed as required under the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues. The one informal patient on the unit had consented to stay on the unit and was living in the annexe. This person had a high degree of autonomy, including being able to leave the hospital without any significant restrictions.

Deepdene Care had a policy and a checklist for the consideration of Deprivation of Liberty Safeguards (DoLS). The checklist supported staff to consider whether a person was being deprived of their liberty – managers may wish to review this checklist in light of the recent case law (for example, the Cheshire West case). There was non-one subject to DoLS.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

• There were a number of systems in place to check the health, safety and cleanliness of the building.

• Staff were aware of the individual risks to and from patients' mental health needs and how the observation, support and monitoring of patients was used to manage risk within the environment.

• The hospital provided a locked rehabilitation service and whilst there were ligature risks; patients' risk had been assessed and the risk of a ligature incident identified as low. This information was based on proper assessment prior to admission to ensure that patients accepted into the service were not known to pose these risks, information from risk assessment of patients prior to and after admission and ongoing assessment following reviews of care.

• There were sufficient staff on duty to provide appropriate care and treatment to patients and managers were authorised to increase staffing levels when required.

• There were good arrangements in place to monitor the physical health of patients and equipment was located on site if a medical emergency occurred. Staff had training in basic lifesaving.

• Staff were aware of the systems in place to report serious and safeguarding incidents.

• The hospital recorded a low number of untoward incidents and safeguarding within the service.

• Patients told us they felt safe living at Brook House and there was a low use of restraint within the service.

However, whilst there were generally good arrangements for the management of medicines, we identified that different trade versions of one type of medication were stored together in the same box and the batch number or expiry date had been cut off the blister packs of some of these. This meant staff may not be able to identify the batch number or expiry date should there be a manufacturer's alert or recall about a particular batch of tablets.

Despite checks on the health and safety of the building and risks being mitigated by admission assessment together with ongoing risk assessment and observations of patients; some fixed ligature

points were not included as part of the risk assessment of the premises. Staff could not understand why additional security measures had been introduced which meant they had to check and lock away cutlery.

Are services effective?

• Care planning documentation did not always explicitly include sufficient written evidence of holistic individual discharge plans or provide evidence that ongoing baseline assessment and progress based on rehabilitation and recovery principles.

• It was not always clear that patient needs were assessed and addressed as part of an overall care plan for patients to help them with their rehabilitation and ultimate discharge For example ensuring that needs relating to daily living skills, educational or vocational skills, money management, offender based work (where relevant), self management, or psychology input were properly considered.

• Section 17 leave forms were amended rather than rewritten and on occasions it was not always clear what the current conditions were

• The parameters of section 17 leave were usually recorded on a specific days of the week which did not permit flexibility. This was exacerbated by the fact that leave decisions were not generally made outside of the regular MDT meetings. Some patients raised issues with section 17 leave.

• There was no evidence of medical scrutiny of detention papers when people were admitted or when detention was renewed.

• Staff on the unit did not have ready access to copies of MHA detention papers at all times. Original papers were kept in the MHA office and these were not available out of hours for staff to refer to and assure themselves that people were appropriately detained.

We found effective multi-disciplinary working (MDT) within the hospital to meet patients' needs as the provider employed an occupational therapist and a social worker. The exception was a lack of on-site psychology input. The location had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act Code of Practice. Advocates were available to patients throughout the hospital.

Staff confirmed that they had received mandatory training and additional training and this was confirmed by those records seen. We found that staff had access to regular supervision and staff had received annual appraisals.

Summary of findings

Are services caring?

• Patients told us that staff were approachable and they gave them appropriate care and support.

• We observed staff speaking with patients and providing care and support in a kind, calm, friendly and understanding manner

• Patients who used the service were treated with dignity and respect.

• Patient's relatives we saw were complementary about the respectful care their loved ones received.

• The provider had systems to encourage patients to be involved in their assessment, care planning and reviews and to comment on the overall service.

• An independent mental health advocate (IMHA) had recently started visiting the hospital twice a week. Despite this, some patients told us IMHA support was inconsistent. This may be expected as a new IMHA service had only recently started visiting Brook House.

• Patients said they wanted to be more involved in their care plan and set goals for discharge planning to help them progress further.

However some patients told us they were not aware of their rights or consent to treatment and did not have sufficient information about the medication they were prescribed. However records showed that patients were usually provided with this information.

Advance decisions were not always being considered or recorded to support patients when they were in crisis. Patients said this would help staff support them better because when they were in crisis so staff would have information on how they wanted to be supported.

Are services responsive to people's needs?

• The hospital was clean and comfortable with individual bedrooms.

• There was a range of activities that patients could participate in.

• There were identified areas for patients to have visits with family, friends or professionals for privacy.

• Patients had access to an outside area to smoke and this was flexible for them to have a smoke at night.

• Staff worked with patient's local mental health teams to ensure that patients were supported to move back to their home areas.

• Information about the providers' complaint procedure was clearly displayed on the hospital noticeboards for patients to read.

Summary of findings

• Patients told us that they felt well supported by staff in making complaints.

• Patients said changes to the menu had been made following their comments about the lack of choice and availability of fresh fruit and vegetables. Patients said there had been some changes to menu choice but overall the food served was generally the same.

Patients said there were some rules in the hospital they did not necessarily agree with. Examples of these were patients reporting that they were discouraged from leaving their bedroom between midnight and six o clock in the morning as well as only being allowed one towel a week for their personal hygiene. The managers of the hospital agreed to look into these patient comments.

Are services well-led?

• Staff told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role.

• Most staff reported the manager was approachable and the provider senior managers were effective leaders.

• Patients and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys

• Information was analysed and action taken to maintain and sustain quality services.

• Regular audits were carried out by various levels of staff within the organisation. The audits themselves were of a good standard and issues identified within audits were usually addressed to improve the quality of services for patients,

• The hospital had identified a number of next steps to improve the service – these largely related to specific identified areas such as improving patient involvement and to reach out more to the local community rather than innovation being embedded within a co-ordinated clinical governance framework.

However as the audits had been developed on an incremental basis a number of audits overlapped or duplicated areas to be considered and there was no clear sense of how audits were co-ordinated into a robust and streamlined assurance framework. Most staff reported support from the manager, though some staff did not understand the reason as to why the levels of security checks had increased.

Summary of findings

Summary of findings

What people who use the location say

We spoke with eight patients who used the service – with most patients being seen by the expert by experience. Patients told our expert by experience that staff were available to support their care and treatment but would like more time for staff to sit and talk to them. Patients told us there had been a lot of recent changes to the décor of the home and new televisions and furniture had been bought as well as the building being decorated.

Patients told us that there was a good variety of activities available to them, including swimming and badminton. Patients said they had access to an outside area to smoke and this was flexible for them to have a smoke at night. Some patients said there were some rules in the hospital they did not necessarily agree with. Examples of these were patients reporting that they were discouraged from leaving their bedroom between midnight and six o clock in the morning as well as only being allowed one towel a week for their personal hygiene.

Most patients told our expert by experience they did not understand the term 'care plan' and only one of the eight patients said they had access to their care plan. Patients said they wanted to be more involved in their care plan and set goals for discharge planning to help them progress further. Patients told us they were not fully aware of their rights or consent to treatment and did not have sufficient information about the medication they were prescribed. Records we saw showed that patients had been given information on their rights. Patients said advanced decisions were not always being recorded to support them when they were in crisis. Patients said this would help staff support them better when they were in crisis and staff would have information on how they wanted to be supported.

Patients said changes to the menu had been made following their comments about the lack of choice and availability of fresh fruit and vegetables. Patients said there had been some changes to the menu choice but overall the food served was the same.

Some patients had concerns about accessing section 17 leave. Patients complained about the frequency of section 17 leave. One person told us section 17 leave was less frequent at Brook House than they had experienced in other places they had been accommodated at. The Mental Health Act states that section 17 leave decisions can only be approved by the Responsible Clinician.

Areas for improvement

Action the provider SHOULD take to improve

- Medicine storage should improve so that medicines supplied by different manufacturers with different batch numbers and use by dates are not stored in the same packages when different supplies were provided by the pharmacy.
- There should be a comprehensive environmental risk register which includes identifying ligature points throughout the building and how these risks are managed within the context of a rehabilitation unit, for example, through assessment and observations of patients.
- The written plans and pathways to promote recovery, rehabilitation and discharge for each individual patient should be improved. The provider should ensure that patients are clear about their individualised progress towards recovery and discharge, including what further treatment and interventions are required with indicative milestones and timescales.
- Patients should be included in the planning and development of their care plan and care pathway, where possible so patients are supported to identify their own personal goals to recovery and to ensure staff take account of patients' wishes and advance decisions about their care.
- The recording of section 17 leave should be improved to ensure that parameters of leave are clearly recorded and ensure there is an appropriate balance between prescribing conditions of leave whilst permitting flexibility.

Summary of findings

- Copies of detention papers should be available at all times so that staff can be assured that they have the proper authority to detain people and the system for medical scrutiny of detention paperwork needs to be improved.
- Managers of the hospital should clearly articulate the rationale for any local rule or restriction within the locked rehabilitation environment to both staff and patients through information and policy development.
- The clinical governance and audit system should be reviewed to ensure that there is a more focused and streamlined audit process within a comprehensive and functioning clinical governance system.

Good practice

There was good multi-disciplinary input for the size of the mental health hospital as the provider employed an occupational therapist and a social worker.

Brook House

Detailed findings

Services we looked at: Brook House which is a long stay/rehabilitation hospital for working age adults

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Team Leader: Brian Burke, Interim Inspection Manager, CQC

The team that inspected this location were a CQC inspection manager, a CQC inspector, a Mental Health Act reviewer, a consultant psychiatrist, a registered mental nurse, an occupational therapist, a senior governance manager and an expert by experience.

Background to Brook House

Brook House provides care and rehabilitative support for up to 12 male adults experiencing complex mental health needs in a locked rehabilitation unit. All but one of the current patients were detained under the provisions of the Mental Health Act (1983). It is located in a residential area of Old Trafford. Brook House was able to facilitate the progression of patients into the community with the provision of an attached supported community housing annex that enabled individuals to prepare for independent living that was determined by them. Brook House is part of a rehabilitation pathway and there are other residential services within close vicinity for patients to move onto dependent upon their care needs. These include two other locations - Clifton House, which shares the same address as Brook House, and Norton Street, which is also in Old Trafford.

Deepdene Care provides services at seven other locations across England, mainly residential care homes for adults with mental health needs. Brook House is the only independent hospital operated by Deepdene Care. Deepdene Care has operated Brook House since February 2013.

All seven locations operated by Deepdene Care have been inspected in the last two years and all were compliant when we visited in December 2014. We last carried out an inspection to Brook House in June 2013. We looked at regulations in relation to care and welfare, co-operating with other providers, safety and suitability of premises, staff recruitment processes and assessing and monitoring the quality of the service. We found that the provider was compliant with these regulations.

Why we carried out this inspection

We inspected this location as part of our comprehensive inspection programme of independent health care providers of mental health services. We are not yet rating independent health care providers of mental health services.

Detailed findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting this location, we reviewed information which was sent to us by the provider and considered information we held about the service.

We carried out an announced visit to this location on 2 and 3 December 2014. During the inspection visit, the inspection team:

- looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with eight patients who were using the service and two relatives
- spoke with twelve front line staff including nursing staff and support staff, the social worker, the occupational therapist, the mental health act administrator and the lead responsible clinician (RC) for the location
- interviewed three senior managers with responsibility for these services, including the proposed registered manager
- spoke with the independent mental health advocate who has started to regularly visit the unit
- spoke with two lay hospital managers who carry out the duties of the hospital managers under the Mental Health Act
- attended and observed a hand-over meeting and a multi-disciplinary meeting.

We also:

• looked at treatment records of five patients.

• carried out a specific check of the medication management in the hospital and looked at all relevant prescription charts and

• looked at a range of policies, procedures, audits and other documents relating to the running of the service.

The team would like to thank all those who met and spoke to the inspection team during the inspection. People were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at this location.

Is the service safe?

Our findings

Safe and clean ward environment

There were weekly checks on the health, safety and cleanliness of the building; however ligature points were not included in the audits. We saw the level of the risk was mitigated due to the hospital providing a locked rehabilitation service where patients' risk had been assessed and the risk of a ligature incident identified as low. This information was based on historical information about individual patient risk and information from risk assessment of patients prior to and after admission and following review of their care. At Brook House we found that a ligature point risk assessment had not been fully completed. We found there were some fixed ligature points in the building with bedroom door handles and pedestal taps in bathrooms.

Daily security checks included the location of the ligature cutter and staff showed us where this was kept so they had easy access to it.

The environment of the hospital was good. The building was clean, well maintained and comfortably furnished. The provider had a system for monitoring the standards and cleanliness of equipment, furniture, appliances and decoration of the building. At a previous Mental Health Act monitoring visit on 11 March 2013, we identified concerns of cleanliness and maintenance of the environment. We saw the provider had addressed these concerns.

Patients told us that there had been a lot of recent changes to the décor of the home and new televisions and furniture had been bought as well as the building had recently been redecorated, which allowed more comfortable seating in the hospital.

Checks on the environment included a weekly walk around the building to check the health, safety and cleanliness of it and daily monitoring by the manager. This included daily cleaning schedule records and checks on the operating and storage of food temperatures of fridges and freezers in the kitchen and clinic fridge for the storage of medicine.

Staff had training on the use of the defibrillator and oxygen equipment on site. This equipment was available in the clinic room and we saw the records to confirm the oxygen equipment was checked weekly and defibrillator daily. Managers may wish to consider having practice emergency resuscitation drills to help staff be fully confident if a real emergency occurs.

There was a community pharmacy service which provided the medicines prescribed to patients and other medicines ordered on an individual basis. This meant that patients had access to medicines when they needed them. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature as recommended by the manufacturer. No controlled drugs were stored.

Whilst there were generally good arrangements for the management of medicines, we identified the following issue: We saw a prescribed sedative called Lorazepam was prescribed for several patients. We saw three examples where medication was supplied from different manufacturers for patients. When we checked the stocks of Lorazepam we found different trade versions of Lorazepam (identified by different colours and shapes with a blue capsule shaped tablet and a round white tablet) were stored together in the same box. The batch number or expiry date of the blue tablets had been cut off the blister packs of some of these. This meant staff may not be able to identify the batch number or expiry date should there be a manufacturer's alert or recall about a particular batch of tablets. In addition staff may not know the date of expiry and patients could be at risk of receiving unsafe or out of date medication.

Some patients told us they did not receive information about the medicines they were prescribed to help them understand the medication prescribed to them as part of their care and treatment. However we did see the Responsible Clinician spend time explaining fully to patients about medication within the multi-disciplinary meeting we observed.

We reviewed all the medication arrangements for patients detained under the Mental Health Act. This showed that the rules for treatment for mental disorder was being met with people being given medication authorised on the appropriate legal certificates. The only exception was that in one case, we saw an antipsychotic medicine had been prescribed on an 'as required' basis but was not included on the appropriate legal certificate (in this case, a T3 which is the legal certificate completed by a second opinion appointed doctor). This medication had not actually been

administered. We saw audits had been completed for medicines management including the use of T2 and T3 forms. The audits had not picked up the minor errors in prescribing or storage of medicines we found.

Safe staffing

There were four members of staff on a day shift and 3 members of staff on a night shift to provide care and support for upto 12 patients. In addition there was an occupational therapist, a social worker, domestic and kitchen staff and a manager who was a registered nurse. There were normally two registered nurses on duty during the day, especially when there was a multi-disciplinary meeting (MDT) as a registered nurse was required to attend these. One staff member who worked at the hospital for several years said staffing levels had been reviewed and on some days there was only one registered nurse on duty. The manager was available to cover any additional nursing duties as required. A doctor was on call 24 hours a day.

Additional staff were requested using the review of patients' care over the previous 24 hours or dependent upon risk assessment of patient needs. If patients had appointments with health or social care professionals at hospital or with their GP and needed support, additional staff were rostered on duty. Most staff reported flexibility of staffing numbers to be able to respond to the need for enhanced observations, though we were told this at times this impacted upon planned group or social activities. One staff member told us: "groups have been cancelled because we have to observe patients. We don't have additional staff at weekends as this is the patient's rest time, or chance for them to see their families". Patients told us that staff were available to support their care and treatment but would like more time for staff to sit and talk to them. The hospital did not use a recognised tool to identify staffing levels but staffing levels appeared appropiate to meet patients' needs and nursing staff rotas were planned four weeks ahead. Staff told us staffing levels were based on historical staffing figures but could rise or decrease dependent upon the needs of patients.

The records showed the provider had recruited permanent and bank staff and there was a low use of agency staff. Staff did not report difficulties with staffing levels other than obtaining additional staff at short notice, when patients needs were more acute was difficult. One staff member told us, "I have worked here for…. months, and did the induction training. More is planned". Another staff member said, "I am only bank at the moment, but hope to get a permanent job as I like working with the patients and the staff seem to be supported". This all meant that there were sufficient staff on duty to provide appropriate care and treatment to patients and managers were authorised to increase staffing levels when required.

At the time of our visit the manager was not registered under the Health and Social Care Act 2008 Regulated Activities Regulations 2010. We had received an application by the manager to register them and this was being considered following our inspection.

Assessing and managing risk to patients

The hospital used the standard tool for assessment of risk (STAR) to assess patients' risk to themselves and others. This looked and at and took account of current and historical information about patient's past risk associated with their mental health, including alcohol and substance misuse. The risk assessment also took account of the physical health risks associated with smoking and alcohol. On a small number of risk assessments for newly admitted patients, the specific dates that key historical risk incidents with patients were not always recorded.

The records seen demonstrated patients were having their physical healthcare needs assessed and met effectively by the service. Patients had access to a local GP and on call out of hour's service. Staff had access to the procedure to follow and contact numbers for the GP and on call services.

Patient risk assessments detailed the required actions staff needed to take to minimise the risk to individual patients. Information about risk included indicators of patients relapse symptoms and behaviours and coping strategies to support patients to lessen their distress. For example, staff assessed and supervised some patients on escorted leave due to the risk of them trying to obtain alcohol or illicit drugs. Patients were also screened for the use of drugs and alcohol, including when returning from unescorted leave. We saw evidence patients had agreed to drug and alcohol screening as well as room and 'pat down' searches of them and their property as part of managing risks.

The hospital used the daily shift planner to allocate staff to observe or escort staff. Staff said they could not understand some of the recent security measures introduced into the service. For example cutlery security checks, when the numbers of knives, forks and spoons had to be counted in and out. Some staff said this gave the impression the

hospital was a more secure service and not a locked rehabilitation ward. We saw a comment recorded in patients' care records in their review of care which said, 'this place is more like medium secure'. Managers of the hospital should clearly articulate the rationale for any local rule or restriction within the locked rehabilitation environment to both staff and patients through information and policy development.

Staff received training on the prevention and management of violence and aggression (PMVA). The training record we saw from the provider recorded six of the seventeen staff were due to undertake refresher training on PMVA and the remaining eleven staff were due to complete this in January 2015. Staff told us they had used restraint only once in the last twelve months when prior to the inspection, staff had to manage an incident between two patients. We saw from the incident report this had been managed by the use of holding the patient's arms for a few minutes while staff used their knowledge and relationship with the patients involved to diffuse the situation. Patients told us they felt safe within the hospital and one of the reasons given was the low use of restraint within the service. There was a personal alarm system to summon assistance and when an incident occurred, however there was no zoned panel of the building for staff to see where assistance was required.

Staff told us they were given information about safeguarding reporting procedures at induction and we saw the policy and procedure for reporting safeguarding incidents was available for staff. We spoke to four staff and the responsible clinician (RC) about reporting safeguarding incidents and training. Staff were able to describe the safeguarding reporting process in the hospital. Staff described they reported any incidents to the nurse in charge or manager. This would then be referred to the local authority and NHS trust which had placed the patient at Brook House. We saw the provider which operated Brook House had its own safeguarding policy and procedure, which included all the provider services. The policy guided staff to follow the local authority/NHS safeguarding procedures. Brook House had copies of the relevant Manchester local authority and NHS trust safeguarding policies and procedures for staff reference.

Reporting incidents and learning when things go wrong

Staff were aware of the systems to report and record incidents and had access to the paper incident/accident reporting forms. We saw as part of the audit process the manager collated reported incidents onto a monthly spreadsheet and this included any actions taken and the outcome of incident analysis. We saw no serious incidents had occurred at the hospital other than staff having to use physical intervention on one occasion. Other incidents recorded included verbal altercations between patients and patients returning late from leave.

We observed a handover and saw incidents were discussed as well as being entered into the communication book so staff could update themselves about incidents if they had been off duty for several days. Team meetings referred to incidents but the minutes we saw did not always detail the discussion around this. Staff reported that debriefs took place after incidents.

Is the service effective?

Our findings

Assessment of needs and planning of care

Care plans were developed under the Care Programme Approach (CPA) and each person had an identified key worker. We reviewed three patients who had recently been admitted to the hospital and their care plans and saw an assessments taking place prior to admission and for the first 72 hours after admission.

Care records had clear plans and guidance for staff on how to support patients who used the service. We saw evidence of patients' diverse needs being met within care plans, for example information about patients' cultural or spiritual needs. We saw that most care plans were developed with patients' involvement. However only one of the eight patients interviewed was aware of the term 'care plan'. Other patients said they had access to a care plan. Some patients told us that they kept a copy of their care plan.

Patients said advance decisions were not being recorded to support them when they were in crisis. Patients said this would help staff support them better when they were in crisis as staff would have information on how they wanted to be supported.

Patients had a physical health examination and an annual health check with additional assessment and care plans as required such as for smoking cessation. There were links with the local GP surgery for physical health checks and the GP did a full physical examination of patients at surgery. There were arrangements for the GP and RC to cover the hospital for mental and physical health out of hours requests.

The provider carried out audits to ensure care plans relating to patients' care and treatment were reviewed regularly.

Best practice in care and treatment

Patients on the CPA process were reviewed every three months and care coordinators attended these meetings. The RC said the hospital was successful in treating patients with 'treatment resistive schizophrenia', which was part of the criteria for admission of patients with severe untreatable psychosis. They told us eight of the 12 patients had been in the hospital for over one year and four patients for one-two years. They said two of the patients would need to be at the hospital on a longer term basis due to their complexity of need where Brook House had been agreed as the placement to meet these needs.

The RC described their role in the rehabilitation of patients as monitoring and management of patients' mental health through diagnosis and treatment using medication. Occupational therapist (OT) and social worker input on site also contributed to the rehabilitation of patients with activities which were OT lead. Patients had input from other disciplines which could be accessed if this was relevant. Patients did not have direct access to psychology input within the hospital. The RC felt that the service would be enhanced by the input of a psychologist but this was something they would need to discuss with the provider.

When we carried out a MHA monitoring visit in September 2014 we reported that discharge planning was not fully evident which should be considered for all patients within a rehabilitation setting. In response the hospital said that patient discharge care plans had been developed. On this inspection we found that care planning documentation did not always explicitly include sufficient written evidence of holistic individual discharge plans and action taken to move towards discharge from hospital. For example it was not always clear that issues such as daily living skills, educational or vocational skills, money management, offendor based work (where relevant), self management, or psychology input were being robustly assessed and addressed as part of an overall care plan for patients to help them with their rehabilitation and ultimate discharge. It was not always clear therefore that patients were prepared for discharge from hospital. The hospital had moved some people on in the recent past so we did see evidence of discharge arrangements working. In addition the hospital had a draft care pathway which included key milestones working toward rehabilitation recovery and discharge; these milestones could easily be recorded or monitored on individual files as part of a rehabilitation and discharge planning process but this was not occurring on any of the files we saw.

It was reported since the new manager had been appointed that bringing drugs into the hospital had been reduced through more engagement with patients and drug and alcohol screening. The hospital adhered to the National Institute for Health and Care Excellence (NICE) guidance on prescribing. The RC sat on the Royal College of

Is the service effective?

Psychiatrist (RCP) working group for physical health promotion. The hospital did not formally participate in quality initiatives in the rehabilitation of patients used in the service such as the RCP peer review network which provides accreditation of rehabilitation services. The hospital used NICE guidance recommendations on rehabilitation and used a recovery model. The provider had not audited themselves against NICE guidance.

The RC was a physician who had received special training to be an approved clinician. The RC had access to the local mental health trust pharmacist for advice on prescribing.

We case tracked one particular patient who had a history of self harm when their mental health deteriorated. Staff were aware of the minor self harm the patient used when unwell. We saw that, at these times, staff were monitoring the patient on a regular basis and were aware of the self harm incidents. This did not involve serious injury, and the outcome was the patient's level of distress was reducing. Staff told us about the treatment of patients using antipsychotic medicines and how this was effective in the treatment of complex psychosis and said, "I requested …. notes to gain a more detailed history went through current and historic paper and electronic records and spoke with previous psychiatrists and … family about his mental health. We established he had tried Clozaril before. We had discussed with him having a further trial. We just don't decide we will try antipsychotic medication we have researched this thoroughly".

Outcomes for patients were also assessed through use of nationally recognised assessment tools such as Health of the Nation Outcome Score (HoNOS). OT staff used assessment tools to measure patients' progress. We saw the Model of Human Occupation Screening Tool (MOHOST) was in use and this provided evidence of how patients were progressing.

Skilled staff to deliver care

We spoke with a number of staff including the proposed registered manager, registered nursing and non-registered nursing staff and other professionals including the social worker and occupational therapist. Staff we spoke with were positive and motivated to provide quality care.

Staff confirmed that they had received mandatory training and this was confirmed by those training records seen. We found that staff had access to regular supervision and had received annual appraisals.

In interview with our expert by experience, one patient told them they experienced painful injection sites from intramuscular injections and they had 'lumps' where injections were given, despite staff giving the injections on alternate sites. As a result we looked at the records of three patients who were prescribed intramuscular injections. We noted on the records of administration for the injections and daily records, staff were not always recording which area on the body they were administering the injections into. This meant that it wasn't always clear that patients were being injected in the different areas to avoid causing painful injection sites.

Multi-disciplinary and inter-agency working

Brook House had an identified multi-disciplinary team including doctors (Consultant Physician and a Consultant Neuro Psychiatrist) nursing, and support worker staff. The hospital also had an occupational therapist (OT), and a social worker.

We saw evidence of liaison with patients' home care co-ordinator to ensure that professionals were informed of key events and reviews of patients' care.

Systems were in place for staff to regularly meet with local commissioners funding patients' care.

We observed a multi-disciplinary meeting and a handover. There was comprehensive information on each patient to ensure that all members of the nursing and multi-disciplinary team were kept up to date on current issues and to inform decisions about future holistic care needs. There was good rapport between the staff and patients.

Adherence to the MHA and the MHA Code of Practice

We carried out a routine Mental Health Act monitoring visit in September 2014. We found issues in relation to leave recording, access to the IMHA service, discharge planning, cleanliness and individual episodes of rights not being given and route of medication not being recorded. Managers of Deepdene Care provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice. On this inspection we saw that many of the issues raised had been addressed. For example patients now had access to an IMHA service and we saw that cleanliness had improved. A staff member told our expert by experience the independent mental health advocate (IMHA) visited the hospital twice a week. Despite

this patients that lived at Brook House told us IMHA support was inconsistent. This may be expected as the new IMHA service had only recently started visiting Brook House.

The hospital had a Mental Health Act administrator who ensured that the responsibilities of the Mental Health Act were met. This role was part–time but there were systems in place to manage the receipt of MHA paperwork. As this was an independent hospital, admissions were planned so the MHA administrator could ensure that they checked the paperwork before patients were transferred into Brook House. There were good systems in place to support adherence to the Mental Health Act and MHA Code of Practice. The records we saw relating to the Act were generally well kept. The main exception was around the recording of section 17 leave. There were several examples of section 17 leave forms being amended numerous times, rather than a new form being rewritten. This meant that, at times, it was not fully clear what the conditions of section 17 leave were from looking at the form due to the amendments. The parameters of section 17 leave were also frequently recorded on specific days of the week which did not permit flexibility for patients on a rehabilitation unit. The recording of section 17 leave needs to improve to ensure that parameters of leave are clearly recorded and ensure there is an appropriate balance between prescribing conditions of leave whilst permitting flexibility.

We noted in a patient's review records a reference to how section 17 leave had been managed. The reference described how patients had to adhere to attend social and therapeutic activities leave over a period of four weeks and comply with taking medication and abstinence for drugs and alcohol. We spoke with two staff at the time of reading this reference, one of which was a registered nurse. They said if the patient achieved four weeks of compliance they would be given their section 17 leave. If the patient was not compliant in any week the four week period started again and would not get leave until they were four weeks compliant. This use of section 17 leave was no longer in use.

Some patients raised the use of section 17 leave with our expert by experience. Patients complained about the frequency of section 17 leave. One person told us section 17 leave was less frequent at Brook House than they had experienced in other places they had been accommodated at. One patient told us his parents "Dislike my visits with escorted leave; they find it intrusive, and impersonal. Staff sit in their lounge for four hours on a Sunday".

We found that the statutory systems were in place for planned admissions and the records seen showed us that patients had been informed of their rights of appeal against their detention. We found systems in place for staff to produce statutory reports where patients had appealed against their detention to first tier tribunals and hospital managers' hearings. However through looking at records and speaking with the MHA administrator, there were no proper arrangements for the independent medical scrutiny of MHA applications and renewals. Medical scrutiny should occur in a timely manner to ensure that the medical reasons for detention or continued detention appear sufficient to support the conclusions stated in them.

We found that staff at this location was aware of their duties under the Mental Health Act (1983). Staff had received the relevant mandatory training.

Records we saw showed that patients were informed of their rights.

We reviewed the information provision available to the informal patient regarding their rights to leave and saw that satisfactory arrangements were in place

Good practice in applying the MCA

We saw that the provider had systems in place to assess and record patients' mental capacity to make decisions and develop care plans for any needs. Most staff demonstrated awareness of the Mental Capacity Act (MCA).

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

All but one of the patients at Brook House was detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were therefore made under the legal framework of the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues. The one

informal patient on the unit had consented to stay on the hospital and was living in the annexe. This person had a high degree of autonomy, including being able to leave the hospital without any significant restrictions.

Deepdene Care had a policy and a checklist for the consideration of Deprivation of Liberty Safeguards. The checklist supported staff to consider whether a person was being deprived of their liberty – managers may wish to review this checklist in light of the recent case law (for example, the Cheshire West case) to ensure that if considerations were made about deprivation that staff were using the correct legal test.

Is the service caring?

Our findings

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and understanding manner. The patients we spoke with were complimentary about staff attitude and engagement.

There was a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care.

Patient's relatives we saw were complimentary about the respectful care their loved ones received. One relative did comment that they were not informed about a change in ward round times which led to a 'wasted' trip to the hospital. They were going to raise this with the manager. One relative of a newly admitted patient stated that their relative had made noticeable improvement since moving to Brook House.

The involvement of patients in the care they receive

Most patients told our expert by experience they did not understand the term 'care plan' and only one of the eight patients said they had access to a care plan. Patients said they wanted to be more involved in their care planning and set goals for discharge planning to help them progress further. Patients told us they were not aware of their rights or consent to treatment and did not have sufficient information about the medication they were prescribed. However records showed that people were being regularly informed of their rights and MDT meetings evidenced discussions around medication.

Advance decisions were not always being considered or recorded to support patients when they were in crisis. Patients said this would help staff support them better when they were in crisis a staff would have information on how they wanted to be supported.

Patients told us that care was planned and reviewed with them. However in some cases this was not always evidenced in the care notes. We saw active involvement and participation from both staff and patients at the ward round meeting.

Community meetings were held regularly and minuted. Issues regularly discussed were food, environment, activities, events, advocacy, complaints and other issues. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible. For example following several comments from patients about the quality of the food, consultation meetings took place around new menus and new menus were being introduced.

When we visited in September 2014 on a MHA monitoring visit, patients did not have regular access to advocacy, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). IMHAs are specially trained advocates who support people who are detained under the Mental Health Act to understand their rights and the restrictions placed on them. Deepdene Care had recently worked with and commissioned a local IMHA provider to secure an appropriate service for IMHA patients. Posters were displayed throughout the hospital informing patients about the availability of the IMHAs. Some patients we spoke with were aware of the IMHA service; others stated that they were not aware but this may be expected as a new IMHA service had only recently started visiting Brook House. We spoke with a representative from the IMHA service who told us they were going to visit weekly to support patients particularly at ward round and told us that the provider was very enthusiastic about setting up the service. This meant that people received support to safeguard their rights under the Mental Health Act.

Is the service responsive?

Our findings

Access, discharge, and bed management

We saw that the hospital staff carried out assessments of people who were usually already in another hospital to consider the appropriateness of admission to this hospital. We saw that the hospital worked with NHS staff to coordinate the transfer of people into this hospital, including transferring patients who were already detained under the Mental Health Act. As Brook House was an independent hospital, before patients were admitted, the hospital needed the agreement of the relevant clinical commissioning groups who contracted the hospital to provide a bed for particular patients in their area. The hospital had a draft care pathway that clearly determined their admission criteria.

We saw records of meetings occurring about patients' care and treatment that included the attendance of members of the person's family community psychiatric nurse. This meant that when decisions had to be made the right people were involved in the decision and the hospital was cooperating with other providers where care and treatment was shared.

We saw records of regular contact and communication with mental health professionals from relevant local mental health NHS Trusts, such as invites and attendance at ward rounds and other multi-disciplinary meetings. We also saw evidence of the hospital working with others to co-ordinate information and reports when people had a mental health tribunal. The hospital's social worker ensured that appropriate liaison occurred with local mental health services.

The responsible clinician (RC) for the hospital told us that four patients had been discharged over the last six months. Patients on the CPA process were reviewed every three months and local care coordinators were invited and attended these meetings. They told us eight of the 12 current patients had been in the service for over one year and four patients between one to two years. They said two of the patients would need to be at the hospital on a longer term basis due to their complexity of their need.

The hospital had an annexe to which patients who were moving toward discharge could move into to prepare for more independent living. This service was not being fully used at the time of the inspection.

The ward environment optimises recovery, comfort and dignity

Patients had their own individual bedrooms with shared communal areas. The bedrooms had en suite sink facilities and patients were able to have their own personal items and furniture in their rooms if they wanted. The hospital was clean and organised. The communal areas were comfortable and there was a range of activities that patients could participate in. There were identified areas for patients to have visits with family, friends or professionals for privacy.

Patients could make telephone calls in privacy. Patients had access to mobile phones and told us they had regular contact with family/friends.

Patients were encouraged to complete their weekly activity plans and indicate what therapeutic groups they were attending inside and out of the hospital. The responsible clinician told us leave was decided in advance at the MDT meetings. From our discussions with the RC, manager and social worker we concluded the responsive requests for leave outside of the MDT were not routinely accommodated.

Information on advocacy, the complaints process and Mental Health Act (MHA) rights was available to read on noticeboards.

Patients could access hot and cold drinks when required. Patients at Brook House had direct and unlimited access to a garden. These were well maintained and provided seating as well as a smoking shelter for patients to use. Patients said access to an outside area to smoke was flexible including for them to have a smoke at night.

Ward policies and procedures minimise restrictions

We saw that patients could personalise their bedrooms. For example, patients had posters on their walls and photographs in their rooms.

Patients who were not detained under the Act had signed agreements/contracts stating they would abide by the rules of the hospital, such as not bringing or consuming drugs/alcohol on site, telling staff where they were going on leave and returning by a specified time. We saw the patients had access to significant periods of leave as part of managing their transition from hospital to community.

Is the service responsive?

Patients were given autonomy to decide on many aspects of their daily lives. Patients had access to their bedrooms during the day. Patients said there were some rules in the hospital they did not necessarily agree with. Examples given were patients reporting being discouraged from leaving their bedroom between midnight and six o clock in the morning as well as only being allowed one towel a week for their personal hygiene. The managers of the hospital agreed to look at these patient concerns.

Meeting the needs of all people who use the service

The provider had timetables to offer patients a weekly activity and for tracking attendance. The OT told us that patients had an individualised activity timetable for the week. The OT told us that patients were given a copy of the range of activities available and then chose what they wanted to attend. Activities were provided by the multi-disciplinary team. Patients were supported as appropriate to access local amenities such as public transport, library or gym.

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. Patients had access to a community arts day service in Old Trafford which included group sessions targeted towards Black and African Caribbean backgrounds run by the local mental health NHS trust.

Some patients told us the food was good. Food was prepared on site and patients could choose from a menu. The provider had systems to assess and monitor the quality of the hospital and gain feedback. A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the multi-cultural nature of the communities the trust serves.

There was information on different faiths and their holy days displayed in patient areas; there was also information displayed from Black and Minority Ethnic Groups such as voluntary and faith organisations for patients from Pakistani backgrounds and African Caribbean Mental Health groups.

Listening to and learning from concerns and complaints

Information about how to make a complaint was clearly displayed on the noticeboards for patients to read. Patients told us that they felt well supported by staff in making complaints. Patients were reminded of the complaints procedure at community meetings.

We saw that there were a small number of complaints received. We saw that there were appropriate investigations and attempts to resolve these.

Complaints and concerns raised were audited to ensure that actions were completed and responses and feedback sent to patients in a timely manner.

Patients told us that changes to the menu had been made following their comments about the lack of choice and availability of fresh fruit and vegetables. Patients said there had been some changes to the menu choice but overall the food served was generally the same.

Is the service well-led?

Our findings

Vision and values

The hospital managers had a finalised document which shaped how the service should run which included the philosophy and ethos of Brook House. This was entitled a draft care pathway but it encompassed more than the care pathway as it included the philosophy and ethos of Brook House the models of care, admission criteria, patient involvement processes, rehabilitation and recovery interventions and evaluation. This identified that the team at Brook House have the objective to treat patients with respect and offer patients greater choice and assistance to gain greater control and autonomy of hteir lives. It also identified the important core values of the Brook House team. These were:

- Passion about patients

- Innovation; trying new ways at all times to improve care.

- Performance; continually striving to do their best

- Professionalism; grounded in training and quality provision

The document highlighted the vision towards working with patients to become independent with milestones within their care. This document was in a finalised draft form and had not been fully adopted or shared with the full staff team but the managers were looking to adopt and implement this in the near future.

Staff reported contact with senior managers in the organisation and that these managers have visited the ward areas. Quarterly staff briefing meetings were held with the hospital director.

Good governance

We found that there were governance systems and meetings at the hospital to review and report for example on incidents, audits and complaints and develop plans for actions needed.

There were a range of regular audits carried out by various levels of staff within the organisation. These included medication, care file audits which included aspects of clinical care, food temperature checks, health and safety checks, audits of personnel and supervision checks and MHA audits. Whilst the audits themselves were of a good standard and issues identified within audits were usually addressed to improve the quality of services for patients, many of these audits overlapped or duplicated areas to be considered. Audits were also routinely repeated without proper consideration of improving and stretching the indicators so that continuous improvement was evidenced, for example when an audit result was routinely achieving near 100% the audit was repeated without amending the audit process. As the audits had been developed on an incremental basis a number of audits duplicated each other and there was no clear sense of how audits were co-ordinated into a robust and streamlined clinical governance assurance framework. The provider should consider reviewing the audits into a co-ordinated clinical governance framework.

Staff told us that they felt supported in reporting incidents and that lessons learnt were discussed in team meetings and at handovers.

There were resources available from the provider to deliver training on site and via 'e learning'. Staff reported receiving appraisals. However the allied professional staff did not have access to peer supervision on site and had to source this outside of the hospital.

There were opportunities for staff to undertake mandatory and specialist training as relevant for their work such as the prevention and management of aggression.

Some staff told us that they considered that there was too much paperwork introduced to monitor security and this impacted on the staff and their ability to work with patients, due to the time constraints.

Leadership, morale and staff engagement

Most staff reported receiving support from the managers within the organisation and peers. Comments from staff included, "I like the team work, we work well together" and "The good thing about working here is the staff who work with the patients, they support one another and the standards of care are great".

Staff undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Most staff reported the manager was approachable and the provider senior managers were effective leaders.

Is the service well-led?

We saw evidence of regular individual supervision meetings and team meetings for staff. Staff told us that they felt their individual supervision meetings were valuable and staff generally felt well supported.

Morale was reported to be good. Staff reported that they had been able to raise concerns with managers. Staff were aware of the whistleblowing policy and told us that they knew how to raise any issues through this process or anonymously. Where staff had concerns this was mainly around uncertainty for the rationale for some of the rules within the hospital. This was summed up by one staff member who described the manager as, "Running a tight ship and she knows the legal aspects of running a secure service, but this is not a secure service". The managers of the hospital need to clearly articulate the rationale for any local rule or restriction within the locked rehabilitation environment to both staff and patients through information and policy development, ensuring that the least restrictive principles are met.

Commitment to quality improvement and innovation

The hospital director of quality and governance received regular reports on the quality of the services provided. Key events were reported and used to monitor and improve the hospital for example reporting on staffing issues, safeguarding, incidents, complaints and absence without leave (AWOL) incidents. Information was analysed and action taken to maintain and sustain quality services.

The hospital had identified a number of next steps to improve the service – these largely related to specific identified areas such as improving patient involvement and to reach out more to the local community rather than innovation being embedded within a co-ordinated clinical governance framework. There were no immediate plans for the hospital to be accredited with the Royal College of Psychiatry. The draft care pathway document identified key expected milestones working towards rehabilitation and discharge. These milestones would provide a basis for identifying and improving quality through key performance indicators within a co-ordinated clinical governance framework.