Brierley Court Independent Hospital

Quality Report

145 Church Lane
Moston
Manchester
M9 4LA
Tel:0161 205 2959
Website:www.partnershipsincare.co.uk

Date of inspection visit: 16 and 17 November 2015
Date of publication: 18/05/2016

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?	Inadequate
Are services caring?	Good
Are services responsive?	Requires improvement
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.

Summary of findings

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

Overall summary

We rated the service as **requires improvement** because:

Staff did not always assess or meet the physical healthcare needs of the patients. Staff did not undertake comprehensive risk assessments of the patients or develop plans to mitigate these risks.

Other areas for improvement included ensuring mandatory training was completed and that staff had an appraisal and regular supervision. Staff also needed training on how to support patients with diabetes.

The provider also needed to ensure the role of the service was clarified and there were clear measures in place to ensure patients were being supported with their rehabilitation. Plans were underway to complete this work.

Further engagement with patients and staff needed to be implemented such as patient and staff surveys.

However, at the time of the inspection a new provider, Partnerships in Care (PiC) had been managing the service for just over four months. It was evident that the provider had introduced many positive changes and yet there was more to do.

The feedback from patients, carers and external stakeholders was that the staff team were caring and supportive. Patients had a chance to give feedback about the service at community meetings and there were plans for further engagement going forward.

The provider was maintaining a safe environment and safe levels of staff who knew the patients well. Medicine management was done well. Staff knew how to report incidents and had opportunities to learn from incidents, which had taken place.

There was good multi-disciplinary working and effective communication with external agencies and care co-ordinators. Staff morale was good.

The provider had robust governance processes but these needed to be fully embedded in the service.

Summary of findings

Contents

Summary of this inspection

Page

Background to Brierley Court Independent Hospital 5

Our inspection team 5

Why we carried out this inspection 5

How we carried out this inspection 6

What people who use the service say 6

The five questions we ask about services and what we found 7

Detailed findings from this inspection

Mental Health Act responsibilities 11

Mental Capacity Act and Deprivation of Liberty Safeguards 11

Outstanding practice 19

Areas for improvement 19

Action we have told the provider to take 20

Requires improvement

Brierley Court

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Brierley Court Independent Hospital

Brierley Court is an independent hospital in Moston, Manchester. Partnerships in Care (PiC) is the service provider. It acquired Brierley Court in June 2015 and has been improving it since then. Improvement plans include spending £120,000 on refurbishment and appointing a full-time psychiatrist. Several action plans had been compiled to focus more on individual areas such as IT and mandatory training for staff.

The hospital manager is the registered manager and the controlled drugs accountable officer.

Brierley Court provides the following regulated activities:

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

Brierley Court provides care for up to 21 people, providing a step-down rehabilitation service for individuals with enduring mental health needs.

At the time of our inspection, the hospital had 14 patients, who were all detained under the Mental Health Act 1983.

We inspected Brierley Court under the previous provider in September 2013 and it was compliant with all the essential standards reviewed.

We undertook a Mental Health Act review in June 2015. During the visit the following issues were identified:

1. Privacy and dignity – the location of the phone allowed for little privacy. A phone hood had been installed.
2. Privacy and dignity - care plans and patients' files were not up to standard. These issues had been partially addressed.
3. Mental health care and treatment – inconsistent evidence that all patients were given a physical health assessment on admission. These issues were partially addressed.
4. Legal code of practice, section 17/18 – section 17 leave forms did not include records of whether a patient or other relevant parties were given copies of the authorisation and there was inconsistent evidence of consideration being given to risks related to periods of section 17 leave. This issue was addressed.

Legal code of practice – a patient requested an up-to-date copy of their care plan and review of their discharge plan. This issue was now addressed.

Our inspection team

Team leader: Sharon Watson, Mental Health Inspector, Care Quality Commission

The team that inspected the service consisted of two CQC inspectors, a rehabilitation nurse and a clinical psychologist.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

Summary of this inspection

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 these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with two relatives of patients who were using the service
- spoke with and obtained feedback from nine care co-ordinators who worked across four clinical commissioning groups
- spoke with the regional manager and clinical lead for the hospital
- spoke with 12 other staff members
- case tracked care records of four patients
- looked at medication charts for 14 patients
- carried out a specific check of the medication management on the ward
- looked at staff files to review how staff were recruited and supported by the provider
- looked at policies, procedures and other documents relating to the running of the service
- attended a patient community meeting
- attended a handover meeting at the change of a staff shift.

What people who use the service say

We spoke with eight patients individually. They said they felt their care and treatment was good, staff were kind to them and supportive. One patient told us there were times when the ward was short-staffed but it was not often and no activities or leave had been cancelled due to staff shortages.

Patients said there was a wide range of activities available and they felt safe. Staff checked their physical health every week and took blood samples to monitor their medication side effects. The food was really good and was all prepared freshly.

Patients said they saw their key worker regularly and were involved in the planning of their care. They had been given information about their care and treatment, including having their rights read to them every two months.

Patients told us they knew how to complain if they were unhappy. One patient told us their key worker had gone through the process with them on how to complain.

We spoke with two relatives of patients. They were happy with the service provided by Brierley Court. They felt the hospital was safe and homely.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Many staff had not undertaken training that the provider deemed to be mandatory.
- Staff had not ensured that all patients had comprehensive risk assessments in place.

However:

- The hospital complied with the Department of Health same sex accommodation requirements.
- The provider identified and adequately mitigated ligature point risks (risks that patients intent on self-harm might tie something to a place in the hospital to strangle themselves).
- Safe levels of staffing were maintained and there were low levels of sickness.
- Staff did not use restraint or rapid tranquillisation techniques; they used only verbal de-escalation techniques
- Medicines charts were up to date and clearly presented to show the treatment people had received, and the relevant legal authority for treatment had been given and were monitored by nursing staff. Medicines were stored safely and emergency medicines were available.
- Staff received debriefs following incidents of harm or risk of harm.
- Staff completed an environmental risk assessment every month.
- Staff knew how to report incidents of harm or risk of harm and learning from incidents was shared
- The hospital employed a maintenance worker who kept the building well-maintained and was responsible for the health and safety of the hospital.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Not all the patients had an up to date assessment and treatment plan for their physical health needs. Two patients were not having their needs met in terms of their diabetes and this had resulted in them requiring acute hospital treatment or was putting their long-term health at risk.
- Most staff had not had an annual appraisal and some staff were not yet receiving regular supervision.

Summary of this inspection

- The provider had not ensured that staff had received training in the care of patients with diabetes.
- The new electronic patient record system needed to be implemented so all staff could complete electronic instead of paper records.
- The service had not clarified the aims for the service in terms of how it would effectively rehabilitate patients.
- The provider had not ensured it followed up areas for improvement following external checks of medication.

However:

- The service had good access to a range of professionals, which included input from a psychiatrist, psychology, an occupational therapy and an assistant occupational therapist.
- The service adhered to the MHA and MHA Code of Practice and MHA documentation such as detention records and approved mental health professional reports were in place and up-to-date.
- The service used recovery star and health of the nation outcome scales (HoNOS) as part of their assessment tools to manage and support patients' mental health recovery needs.
- The psychologist was working towards implementing a comprehensive range of therapies to meet the needs of patients.

Are services caring?

Good

We rated caring as good because:

- We observed excellent interaction between staff and patients and found that staff were responsive, supportive, and appropriately discreet.
- Relatives described the staff and management as caring, supportive and respectful, and they felt welcome at the hospital.
- A patient representative from Brierley was part of the regional recovery group for PiC.
- There were plans for patients to be involved in induction and training of new staff.
- There were plans to improve the communication with carers and family members by introducing a newsletter and a carer survey.
- We observed a patient community meeting which took place on a weekly basis. Patients were being involved in decisions about the refurbishment of the hospital and activities.

However:

Summary of this inspection

- Some assessments had not been updated to include the views of patients and carers.

Are services responsive?

Requires improvement

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

- The hospital is not yet recovery focused with patients being actively discharged into more independent living.

However:

- The hospital contained a full range of facilities and equipment to support treatment and care including rooms for activities to take place.
- Staff worked with patients and relatives to understand the patients' preferences and help personalise their rooms.
- Staff informed the hospital's cook of the patients' dietary health requirements when they were admitted to the hospital.
- A large proportion of patients made their own meals but patients told us that the food prepared by the hospital's cook was of good quality and patients could have hot drinks and snacks at any time.
- Relatives and patients told us they knew how to complain.
- The hospital had a welcome pack, which was provided to patients on admission.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- A staff survey had not yet taken place. This was scheduled for December 2015 as part of the action plan.
- A patient survey had not yet taken place. This was scheduled for December 2015 as part of the action plan.
- The PiC visions and values had not yet been embedded.
- The risk register had not incorporated risks associated with the transition between providers.

However:

- PiC had a quality account which set out their performance, achievements and objectives.
- A transitional manager had been appointed to support the operational aspects of moving to the PiC group, this included management of the action plans.
- The service had a clear governance structure in place, with effective systems and processes for overseeing all aspects of care

Summary of this inspection

- There was very good morale among the staff and managers at the hospital, and the staff we spoke with expressed a strong commitment to the patients and the provider.

Detailed findings from this inspection

Mental Health Act responsibilities

- The service was adhering to the MHA and MHA Code of Practice. MHA documentation such as detention records and approved mental health professional reports were in place and up to date. All patients who required them had certificates authorising the administration of medication, certificates of consent to treatment (T2) and certificates of second opinion (T3), in place.
- Patients received their rights on a regular basis. We saw evidence in the patients' care records that their rights under section 132 of the mental health act were discussed with them monthly. The provider had developed an easy read format Mental Health Act rights leaflets and given them to patients.
- The provider employed a Mental Health Act regional manager across several sites with a local Mental Health Act administrator based at Brierley Court. The administrator oversaw all matters relating to the MHA, for example, patients' rights, detention, renewals, and section 17 leave.
- All staff had a good understanding of the MHA and MHA Code of Practice; this was despite not having completed mandatory training.
- We undertook a Mental Health Act review in June 2015. The areas of concern from this visit had now been completely or partially addressed.
- Patients had an up to date copy of their care plan.
- Patients had access to independent mental health advocates (IMHA) who attended CPA meetings.

Mental Capacity Act and Deprivation of Liberty Safeguards

- None of the patients were subject to a Deprivation of Liberty Safeguard (DoLS).
- Staff had a good understanding of the principles of the MCA, in particular, about the presumption of capacity and its decision-specific application. Staff knew they could consult with the mental health administrator or consultant for further advice and information.
- MCA/DoLS training was included in the mandatory training programme but at the time of our inspection, the compliance rate was low at 20%.
- Patients had access to independent mental capacity advocates who were invited to CPA meetings.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- The hospital layout did not allow staff to see all parts of the ward but staff presence throughout the hospital and the use of radio communication along with levels of observations for patients mitigated the risk adequately.
- The hospital complied with Department of Health same sex accommodation requirements by allocating separate wards for male and female patients. Patients shared the communal areas, such as the lounge and dining area, and there was a separate lounge available for female patients. There was also a separate women's garden area, which had recently been refurbished.
- All areas of the hospital were clutter free and were cleaned regularly but some areas still looked dirty because the hospital needed refurbishment. The new provider had started £120,000 worth of refurbishment work.
- The service had completed a ligature point risk assessment as part of the new ownership in August 2015. They mitigated the risks identified adequately.
- The service had completed an induction and risk assessments of the contractor staff working on the refurbishment. The service employed a dedicated maintenance worker for the unit, who ensured that all repairs were undertaken promptly and that health & safety was maintained. The maintenance worker also completed an environmental risk assessment monthly. The assessment included checking the maintenance of gas and electrical appliances.
- The service had completed a fire risk assessment in June 2015 and emergency evacuation procedures were in place.
- Each patient had a personal emergency evacuation plan.
- The emergency medication bag and equipment were routinely checked in line with the hospital policy.

Safe staffing

- The established staffing complement for the service was 37 whole time equivalent (WTE) staff. In the year to September 2015, the service reported 2.5% vacancies and a sickness absence rate of 2%. The sickness level was low in comparison to the national average of 4%. There was a turnover of 11%, with five leavers. The turnover appeared to be higher following the change in provider.
- Staff worked day shifts from 8am to 8.30pm and night shifts from 8pm to 8.30am. A usual shift staffing level for days was two qualified nurses and four support workers and the night shift was one qualified nurse with two support workers.
- Staff and relatives perceived there were sufficient staff to provide care, and escorted leave and activities were rarely cancelled because there were too few staff.
- The service shared staff between other local services, which helped improve access to experienced staff. Between 1 October 2014 and 30 September 2015, 29 shifts were filled by bank or agency staff. The use of bank or agency staff was low which meant patients are receiving continuity of care from familiar staff members.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The hospital had a contract for medical cover day and night, with arrangements for medical staff to attend quickly in an emergency. The consultant psychiatrist worked each Thursday as part of the multidisciplinary team and provided an on-call service as required. Following the transition to PiC, a full-time consultant psychiatrist had been appointed and was planning to join the team from December 2015.
- The service had a comprehensive mandatory training programme. It included induction and training on manual handling, safeguarding people from abuse, infection control, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the Mental Health Act Code of Practice, basic life support, intermediate life support, fire safety, conflict resolution, breakaway training, information governance, health and safety, moving and handling, suggestions, ideas and complaints, and food hygiene. However, staff were not up to date with all of their mandatory training. Training rates were less than the provider's target of 75% for basic life support (48%), intermediate life support (0%), conflict resolution (47%), moving and handling (64%), information governance (35%), health and safety (57%), food hygiene (38%), infection control (16%), safeguarding adults (43%), suggestions, ideas and complaints (51%), MHA (41%) and MCA/DoLS (20%). Training was booked for some of these areas, including basic adult resuscitation and MCA/DoLS. For example, only six out of 37 staff were up to date on infection control training and 15 out of 37 were up to date on Mental Health Act training. There was a training action plan to ensure all staff completed mandatory training and this was being monitored and reported on each month through the governance structure.

Assessing and managing risk to patients and staff

- The provider said they supported the patients without needing to use restraint. There were no seclusion facilities.
- We reviewed care records for four patients, which contained risk assessments that were up to date. Staff undertook an initial risk assessment of every patient on admission. The manager or the clinical lead attended the initial assessments for all new patients, and ensured full historical information was available. In records for patients who had been admitted under the previous owner there were limited risk assessments. There had been no full care record review or update on patients' records for all patients who were at the hospital prior to the transition, this meant that the records were not up to date.
- There were good policies and procedures in place for the use of observation to minimise risks to patients. Staff reviewed patients' risks on a daily basis during the handover meeting.
- Staff received training on safeguarding and knew how to raise safeguarding issues. Staff we spoke with gave examples of scenarios that would require a safeguarding alert. The service also had a local safeguarding lead which staff were aware of.
- We looked at 14 medicines charts. These were up-to-date and clearly presented to show the treatment people had received. All patients were registered with a local GP practice. The patients had the opportunity to meet with their doctor on the ward on a weekly basis.

We reviewed the provider's medication management practices. We found a system in place to ensure medication was ordered regularly and the medication was stored safely. Whilst practice was good there were no internal audits undertaken to assure themselves of stock levels, medication recording and dispensing. There was an arrangement in place for an external pharmacist from a local acute hospital to check the medicines management. This was undertaken every three weeks and notes of queries or errors were left for the consultant to review. It was not clear how this was followed up.

Track record on safety

- The service listed no reportable incidents under the serious incidents requiring investigation (SIRI) framework. The hospital had reported 21 incidents for the period August 2015 to 13 November 2015. Examples of incidents included patients smoking in their rooms.

Reporting incidents and learning from when things go wrong

- There was a standardised incident template being used to record incidents until the electronic system was implemented as part of the IT action plan.
- The hospital learnt from incidents and changed its practice, where necessary. For example, following an incident involving an agency member of staff, the service had reviewed its procedures and introduced an induction and identification validation process.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff confirmed they received debriefs following incidents. These took place at staff meetings, supervision sessions or during handover meetings.

.

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We reviewed care records for four patients and found there to be inconsistencies with the recording of care and treatment. For example a patient who had been admitted in November had comprehensive pre-admission assessments, risk assessments and holistic care plans. There was evidence of the patient being involved in the care planning, with goals and discharge planning being part of the care documentation from an early stage. In records for patients who had been admitted under the previous owners there were no clear care and treatment plans, which were recovery focused. One patient had been at the hospital for eight years.
- The service used recovery star and health of the nation outcome scales (HoNOS) as part of their assessment tools to manage and support patients' mental health recovery needs.
- Care records of recently admitted patients showed that they had physical health checks, which were supported by the national institute for health and care excellence (NICE) guidance on best practice. However, the physical health checks for patients who had been transferred from the previous provider had not been updated. The impact of this was that two patients who had diabetes were not receiving appropriate care. For example one patient with insulin controlled diabetes was able to purchase sugary drinks and chocolate whilst on escorted leave which presented a risk of hyperglycaemia. We raised this as a serious concern during the inspection and a best interests meeting took place after the inspection to review the leave arrangements. Another patient was not compliant with their medication for diabetes and had several emergency admissions to hospital due to the poor management of their diabetes.
- Care records were stored securely in the nursing office in lockable cabinets. All staff held keys to gain access to patient records.
- Care records were in two formats, paper and on the electronic patient administration system. Some night staff did not have access to the PiC network so they were unable to update the current electronic records. This meant they were writing their notes and someone else was updating the electronic system on their behalf. Within the IT action plan there was a comprehensive transition plan for Brierley Court to move to PiC electronic patient administration system. This meant following the migration to the PiC system all documentation would be on one system and easily accessible to all staff.

Best practice in treatment and care

- The provider had a process in place to disseminate national institute for health and care excellence (NICE) guidance information to all hospital locations by email. Each clinical lead reviewed the particular guidance to understand the care delivery and impact at that hospital. Information was then shared with the hospital staff through local meetings.
- Medication was prescribed and reviewed in line with NICE guidance. Staff monitored side effects and reported them at patients' reviews to ensure appropriate action was taken.
- We reviewed the provider's scheduled programme of audits. This included a wide range of audits that benchmarked practice against NICE guidance. This was not yet embedded into the service and was planned within the action plan as part of the transition management.
- The service did not have a clear statement explaining its admission criteria and how it would support patients with their rehabilitation. This meant it was hard to measure whether the hospital was achieving its goals in terms of the outcomes for patients. The provider had arranged an away day to make progress with developing the strategy for the service.

Skilled staff to deliver care

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- An occupational therapist and an occupational therapy assistant provided group activities and input into the multi-disciplinary team assessments for all patients.
- The service had access to a consultant psychiatrist who visited the hospital one day a week to review patients. A full time psychiatrist had been appointed but was not yet in post.
- The provider had a lead psychologist who supported the psychologist based at the hospital. The psychologist was working towards implementing a model of psychology, which incorporated a range of therapy approaches to meet the needs of the patients.
- Staff did not have specialist training to support patients with diabetes.
- We found supervision was not yet up to date for the staff based at the hospital. Under the new ownership PiC had implemented a supervision tree which outlined staff responsibilities for undertaking supervision. During our inspection we noted that staff supervision had improved and staff confirmed this when we spoke with them. This was being monitored.
- Information provided to us as part of the inspection process showed that only two out of 37 staff had received an appraisal within the previous 12 month period. The provider had an action plan to address this and progress was monitored at monthly governance meetings.
- There was an agency induction checklist in place which was clear and comprehensive. The checks included confirmation of identification and qualification or PIN number if the agency staff member was a nurse. The checklist was signed by both the agency staff member and the member of staff carrying out the induction.

Multidisciplinary and inter-agency team work

- Multidisciplinary team (MDT) meetings or ward rounds took place on a weekly basis and were well co-ordinated. They included as a minimum a psychiatrist, nursing staff and occupational therapist. Support workers did not usually attend the meetings but could do so if there was sufficient cover on the unit. Care programme approach (CPA) meetings took place on a minimum six-monthly basis. The MDT invited other disciplines when required
- Since the inspection we have been informed that the provider had scheduled a review of all patients by the newly appointed consultant. This would also take into consideration the service provision which PiC where reviewing and whether this was an appropriate service for each of the patients. Some of the patients had been identified as inappropriately placed and transfers to more suitable providers had been arranged. This meant that patients would have the correct care and treatment, which in turn would make the discharge process more effective.
- The service had good links with the local commissioners, the local mental health trust, and the local authorities safeguarding team. External stakeholders said they were kept up to date on patients' progress.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- The service was adhering to the MHA and MHA Code of Practice. MHA documentation such as detention records and approved mental health professional reports were in place and up to date. All patients who required them had certificates authorising the administration of medication, certificates of consent to treatment (T2) and certificates of second opinion (T3), in place.
- Patients received their rights on a regular basis. We saw evidence in the patients' care records that their rights under section 132 of the mental health act were discussed with them monthly. The provider had developed an easy read format Mental Health Act rights leaflets and given them to patients.
- The provider employed a Mental Health Act regional manager across several sites with a local Mental Health Act administrator based at Brierley Court. The administrator oversaw all matters relating to the MHA, for example, patients' rights, detention, renewals, and section 17 leave.
- All staff had a good understanding of the MHA and MHA Code of Practice; this was despite not having completed mandatory training.
- We undertook a Mental Health Act review in June 2015. The areas of concern from this visit had now been completely or partially addressed.
- Patients had an up to date copy of their care plan.
- Patients had access to independent mental health advocates (IMHA) who attended CPA meetings.

Good practice in applying the Mental Capacity Act (MCA)

- None of the patients were subject to a Deprivation of Liberty Safeguard (DoLS).

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff had a good understanding of the principles of the MCA, in particular, about the presumption of capacity and its decision-specific application. Staff knew they could consult with the mental health administrator or consultant for further advice and information.
- MCA/DoLS training was included in the mandatory training programme but at the time of our inspection, the compliance rate was low at 20%.
- Patients had access to independent mental capacity advocates who were invited to CPA meetings.

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

Good

Kindness, dignity, respect and support

- We observed excellent interaction between staff and patients. Staff were responsive, supportive, and discreet, when necessary. This was also confirmed in feedback from external stakeholders.
- Relatives gave good feedback about the staff and management. One relative told us they were involved in their family member's care planning. Another relative described the hospital as safe and homely. One relative spoke about the improvements since the transition to PiC had taken place.
- Staff showed a good understanding of each patient's needs and family circumstances. Staff showed a person-centred approach in their attitudes and behaviours towards patients. This included domestic staff.
- Staff had good working partnerships with families and carers, and were sensitive to their needs. For example, staff kept the family members up to date with care and treatment progress. Staff welcomed visits from relatives.
- Staff were very aware of the specific needs of their patients and were committed to ensuring the environment was safe, homely and welcoming.

The involvement of people in the care they receive

- Some patient records did not include the views of patients and carers and these needed to be updated. The planned admission process was thorough and informative, and involved the patient and relatives.
- Patients and relatives received a welcome pack prior to admission, which contained information about the service and contact details.
- Patient and relatives were actively involved in the whole care pathway from referral to discharge.
- Noticeboards held information about advocacy services available to patients and relatives.
- The service held a weekly patient community meeting.
- Improvement of communication between staff and families formed part of the action plan. This included the development of a newsletter and a carer survey. This had an implementation date of December 2015.
- The provider, PiC, held regional recovery groups and a representative from Brierley Court was part of that group from November 2015.

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

Requires improvement

Access and discharge

- At the time of our inspection there were 14 patients at the hospital.
- There had been one admission during November 2015 but prior to that there had not been any admissions for the previous 18 months.
- Patients were placed from four different clinical commissioning groups. There was only one patient who was out of area with the remainder being from the local area.
- There had been no reported delayed discharges within the last six months. We heard after the inspection that all the patients were being assessed to see if their needs should be met by the hospital and discharge plans put into place where needed.
- Patients had not yet been discharged or had active rehabilitation and discharge plans in place.
- The provider reported a mean bed occupancy of 71% over the last six months for the period June to September 2015.

The facilities promote recovery, comfort, dignity and confidentiality

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The hospital contained a full range of facilities and equipment to support treatment and care. There was a pleasant, recently refurbished garden area with a separate female only space within it. The accommodation was in need of refurbishment and the new provider had allocated a £120,000 budget to address this. The unit was warm and welcoming, and had a good atmosphere.
- Staff worked with patients and relatives to understand the patients' preferences and help to personalise their rooms.
- The unit employed its own cook, and the food was of good quality. Some patients were supported to undertake their own shopping and preparation of meals.
- The indoor and outdoor design and layout of the unit meant that patients could walk around freely and remain safe.
- Information was displayed on the hospital notice boards and included details of advocacy services, how to contact the CQC, PiC "talk to us" telephone numbers, how to complain, an activity planner and Mental Health Act code of practice 1983 in easy read format.
- There was a wide range of daily group activities available with regular day trips. Themed nights took place on Saturday evening, and a comedy night was planned for the week of our inspection.

Meeting the needs of all people who use the service

- Staff informed the on-site cook of patients' dietary health requirements when a patient was admitted to the hospital and following any changes. The cook prepared food taking into account guidance and preferences. Cultural dietary requirements could be met when required. Patients told us that the food was of a high quality.
- Staff supported patients with their spiritual needs and the local vicar attended the hospital site.
- Staff produced care plans in accessible formats. We saw care plans written in large font and pictorial format.
- Interpreters could be accessed when required to support patients' whose first language was not English.

Listening to and learning from concerns and complaints

- Patients and relatives told us they knew how to complain and said they would be confident in doing so. Details of how to complain was in the welcome pack for patients and displayed on notice boards around the hospital.
- The provider reported that they had not received any complaints within the last 12 months.

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

Requires improvement

Vision and values

- PiC had vision and values but these were not embedded within the service locally.
- Staff knew the structure of the provider organisation. Staff also knew who the senior managers were within PiC, and said the regional managers often visited the hospital.
- The hospital displayed information, which outlined how the service intended to meet the CQC inspection domains.

Good governance

- PiC had a staff guidance booklet explaining what governance entailed, how it was important to provide assurances of the quality of care being delivered, what the staff roles and responsibilities were and how the governance structure monitored the assurances through different meetings.
- The service had a clear governance structure, with effective systems and processes for overseeing all aspects of care. These included the national, regional and local governance forums scheduled for particular weeks of the month to enable the hospital managers to disseminate information to their teams at the same time throughout the organisation. The structure showed that the forums discussed issues, identified actions and monitored progress pertaining to the quality and safety of care. At the time of the inspection, this was in the initial stages of being embedded at Brierley Court.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The hospital's risk register did not reflect actual risks within the service. It included an assessment of the potential risks, likelihood, impact and risk rating. None of the risks associated with the transition between providers had been included on a risk register.
- The service had a planned clinical strategy away day scheduled for December 2015 to review the service provision, admission criteria and set clear objectives for Brierley Court.

Leadership, morale and staff engagement

- The staff we spoke with expressed strong commitment to the patients and the provider. Staff told us that they felt supported by colleagues and management. Staff spoke positively of the new provider and how they had a clearer understanding of their roles and the organisations future.
- We observed good team working and mutual support between staff of all grades. Unqualified staff, including domestic staff, reported feeling equal to all other staff and part of a bigger team.
- Staff said the new provider was supporting them to undertake training and development. For example, one staff member told us how they were being supported to complete the PiC leadership training course.
- Staff had the opportunity to give feedback on any aspect of the service during their supervision sessions or at staff meetings. Within the action plan for Brierley Court there was an action to establish a staff and patient health and safety group.
- Staff told us that the morale had improved since the transition to PiC.
- PiC had appointed a transition manager to support the operational aspects of the organisational change from one provider to PiC. This included policies, procedures, audits and benchmarking, electronic incident reporting system, electronic patient administration system and quality control. The action plans reflected realistic timescales and deadlines. The progress was being monitored at the governance structure meetings.

Commitment to quality improvement and innovation

- The hospital was not participating in any national quality improvements programmes and had no commissioner's quality incentives in place at the time of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that patients have an updated physical health assessment and their physical healthcare needs are met.
- The provider must ensure that risk assessments relating to the health, safety and welfare of the people using the service are completed and regularly reviewed by suitably qualified staff. Risk assessments must include plans for managing risks.
- The provider must ensure that staff receive the training required to perform their role, this includes mandatory and specialist training. Staff must have an appraisal.
- The provider should ensure there is a clear strategy for the service that supports the delivery of care and treatment to ensure the effective rehabilitation of patients using the service.
- The provider must ensure feedback is obtained from patients and staff to monitor and drive improvements.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should continue to embed the supervision process.
- The provider should continue to implement the electronic patient record system.
- The provider should ensure the areas for improvement identified in the review by the external pharmacist are implemented.
- The provider should ensure the risk register addresses the risks associated with the transition between providers.
- The provider should continue to embed the visions and values within the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for patients. Staff did not always assess and meet the physical health care needs of patients, especially those with diabetes. Individual risk assessments were not always up to date and being incorporated into care plans in order to mitigate those risks. This was a breach of regulation 12(2)

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 Systems and processes must be established and operated effectively to ensure feedback is sought and acted on from relevant persons. Patients and staff surveys needed to take place and the results used to improve the service. This was a breach of regulation (17)(2)(f)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed. Two out of 37 staff had not had an appraisal within the last 12 month period. Staff must complete their mandatory training. This was a breach of regulation 18(2)(a)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of patients must be appropriate to meet their needs. Patients must receive support to be actively rehabilitated. This was a breach of regulation 9(1)