

## **Inspection Report 2009/2010**

### **Bromley Road Hospital (previously Sovereign Health plc)**

**84-86 Bromley Road, Catford, London SE6 2UR**

#### ***Introduction***

Certain independent healthcare providers in England must be registered with the Care Quality Commission. Those that need to be registered are defined in the Care Standards Act (2000) and include Acute and Mental Health Hospitals, some private doctors and some smaller medical services that provide specialist medical services such as endoscopy. To register, they need to demonstrate compliance with the Act and associated regulations. The Care Quality Commission tests providers' compliance by assessing each registered establishment against a set of National Minimum Standards, which were published by the Government and set out the minimum standards for different types of independent health services.

In addition to this report, the establishment has been given further details about how we have arrived at their assessment. If you wish to see or discuss this additional information, you may ask the provider for this, at their discretion. The establishment's action plan, which sets out the steps it is taking in response to this assessment, may also be requested from the provider. You should contact the Registered Person at the establishment address at the top of this page regarding both the additional information and the action plan.

#### ***Background***

Bromley Road Hospital is a twenty four-bed mental health hospital. The name of the hospital has recently changed from Sovereign Health. The registered provider is Bromley Road Limited, previously Sovereign Health PLC.

The hospital two adjacent converted residential buildings connected by a covered passage way. The establishment is currently registered to accommodate up to twenty-four patients, who may be detained under the Mental Health Act. There are separate sleeping and bathing areas for male and female patients on one site. The second site accommodates female patients only. All patients have single rooms with handwash basins, but share toilet and bathing facilities.

The hospital is situated on a main road within a residential setting in Catford, Lewisham. Buses pass the front of the building, and it is a ten-minute walk to the nearest train station.

This inspection took place on 2 December 2009, and was announced.

#### ***Main findings***

At this inspection, a tour of the hospital was undertaken, and the inspector met with and talked to several members of staff, the registered manager and two patients. A range of documents were examined. All staff and patients were open and honest in discussion, and open about identifying areas of strength and weakness in the services at the hospital.

Patients are referred predominantly from Bromley and Lewisham, but at the time of this inspection there were also three patients referred from other boroughs. At the time of the inspection the hospital had 22 detained and two informal patients admitted. One patient was admitted in 2002 as

a detailed patient, but is now an informal patient. Although there are fortnightly meetings in place with the referring body, no suitable discharge plan or solution has been found to date for this patient. The registered manager advised in discussion that in the past the hospital has always run at slightly under full occupancy but that it has now been operating at full occupancy for approximately four months. He stated that he was confident that the clinical staff team was sufficient and competent for such full occupancy, but that the establishment will be recruiting a deputy manager soon to better facilitate administration and supervision processes.

The establishment employs two social inclusion workers, one full time and one four days per week to work with patients to empower and skill patients towards recovery and re-entry to the community. Two patients consented to discuss their experiences at the hospital, and both expressed their high regard for the staff in general, and for the social inclusion project and workers in particular. The social inclusion workers were said to be very accessible to patients and helped them to access internal and external services and facilities, such as joining a gym, taking up bank accounts and facilitating the resolution of minor issues and problems which patients were experiencing within the unit. Patient satisfaction with staffing is generally high, as evidenced by the results of a recent patient satisfaction survey.

The hospital was last inspected in January 2007. At that inspection patients also expressed positive views about the staff and the services being offered. However, requirements were made upon the hospital at that inspection including requirements relating to: reducing and managing environmental risks, including potential ligature points: reviewing and updating the restraint policy: the need to improve on the uptake of mandatory staff training, supervision and appraisal: reducing the the number of medication administration and recording errors: and improving on the documentation of patient money transactions.

The hospital was noted at this inspection to have made positive steps to address many of the environmental issues identified at the previous inspection. However, it was found that progress against maintaining the standards relating to reducing and managing potential ligature risk, reviewing and updating restraint policy, improving on the uptake of mandatory staff training, supervision and appraisal, reducing the the number of medication administration and recording errors and improving on the documentation of patient money transactions.had not been sustained, and requirements have again been made relating to these standards.

Further requirements have been made in relation to the disposal of unused medications, maintaining accurate and full patient records and notes, and reviewing the provision of independent advocacy and the arrangements in place for safeguarding referrals.

### **Registration Categories**

This registration is granted within the following categories only

Description	Service Category
Mental health establishments taking people liable to be detained	MH (D)

### **Conditions of registration**

This registration is subject to the following conditions. Each condition is inspected for compliance. The judgement is described as Met, Almost Met, Not Met or Not Inspected

Condition	Assessment
Male and female patients should be accommodated in separate areas in keeping with Department of Health guidelines on maintaining the safety, privacy and dignity of patients in mental health hospitals.	Met

Condition	Assessment
Patients are aged between 18 and 64 years.	Met
Only one patient outside the age range of 18 to 64 years who is identified in correspondence referenced S29341/SG/240806 may be treated.	Met

## Assessments

Prior to assessment, each establishment or agency is required to complete an assessment of their own performance against the National Minimum Standards. This is used along with other performance information held by the Commission to make a decision on the need for further assessment. Where overall assessment shows compliance with the standards, organisations may not be inspected each year.

The Care Quality Commission only carries out on site inspections to make assessments of standards where we do not have sufficient evidence that the required level of performance is being achieved. In some instances, we do not assess a standard. This is either because the standard was not applicable or because, following an assessment of the risks, no risks were identified and therefore it was decided that there was no need for the standard to be further checked through an inspection.

Our inspections are targeted to areas of potential risk. They focus on areas where previous inspections, the establishment's own data and inspectors' observations suggest potential risks. Further areas are also added as spot checks. In general, a smaller number of standards assessed at inspection reflects a strong ability in the establishment to demonstrate satisfactory performance. The Care Quality Commission is required to inspect establishments at least once every five years and this report reflects the assessment of the establishment or agency at a given point in time.

For each standard that we assess, we use a four point scale.

Standard met	Achieving the required levels of performance in all aspects of the standard
Standard almost met	Not achieving the required levels of performance in some aspects of the standard
Standard not met	Significant action is needed to achieve the required levels of performance
Not inspected	This is either because the standard was not applicable or because, following an assessment of the risks, no risks were identified and therefore it was decided that there was no need for the standard to be further checked through an inspection.

The assessments are grouped under the following headings:

- Safety - does the establishment provide treatment and care safely?
- Clinical and cost effectiveness - is the best possible treatment provided?
- Governance - is the establishment well run?
- Patient focus - does the establishment put the patient first?
- Accessible and responsive care - is care organised around patients' needs and wishes?
- Care environment and amenities - is the place where you are treated well designed and maintained?

## Types of Standards

Each standard number is prefixed by a letter denoting the type of standard it represents:

C	Core Standards
A	Acute Hospitals
M	Mental Health Establishments
H	Hospices
MC	Maternity Hospitals
TP	Termination of Pregnancy Establishments
P	Prescribed Techniques and Prescribed Technology – includes Lasers, Intense Pulsed Lights, Dialysis, Endoscopy, Hyperbaric Oxygen Treatment and In-Vitro Fertilisation
PD	Private Doctors

## Requirements

Following assessment, improvements are required for those standards, which are found to be judged either 'not met' or 'almost met' and do not comply with the Private and Voluntary Healthcare Regulations 2001. Improvement to comply with the requirements is the responsibility of the 'registered person' who may be either the registered manager or the registered provider. The Care Quality Commission will ask the provider for their plan of action to demonstrate how they are going to comply with the requirement(s) made. The Care Quality Commission will then agree and monitor the action plan but if necessary, will take enforcement action to ensure compliance with the regulations.

## Assessments and Requirements

### Safety

Number	Standard Topic	Assessment
C13	Child Protection Procedures	Not inspected
C18	Condition and Maintenance of Equipment and Supplies	Standard almost met
C20	Risk Management Policy	Standard almost met
C22	Medicines Management	Standard almost met
C23	Ordering and Storage of Medicines	Standard almost met
C24	Controlled Drugs	Not inspected
C25	Infection Control	Not inspected
C26	Medical Devices and Decontamination	Not inspected
M7	Risk assessment and management	Not inspected
M8	Suicide Prevention	Standard almost met
M9	Infection Control	Not inspected
M17	Administration of Medicines	Not inspected
M18	Self administration of Medicines	Not inspected
M30	Levels of Observation	Not inspected
M31	Managing Disturbed Behaviour	Not inspected
M32	Management of Serious/Untoward Incidents, Adverse Health Events and Near Misses	Standard met
M33	Unexpected Patient Death	Not inspected
M34	Patients Absconding	Not inspected
M35	Patient Restraint and Physical Interventions	Standard almost met
M36	Safeguarding Children in mental health settings	Not inspected

No	Standard	Regulation	Requirement	Time scale
1	C22	15 (5)	<p><b>Findings:</b> The most recent medicines management and pharmacy audit report evidenced a substantive improvement and significant drop in medications recording and omissions errors but also noted a number of non-compliances, including no British National Formulary (BNF) available to staff in one treatment room, clinic room equipment checks not undertaken/recorded and no evidence that MHRA drug alerts were being retained in the clinic room audit folder. No action plan was available to indicate that all the issues identified in the audit had been addressed.</p> <p><b>Action required:</b> The registered person must submit an action plan which demonstrates that all the issues identified in the pharmacy audit reports have been addressed, so as to demonstrate that measures are in place to ensure the safe management and secure handling of medicines.</p>	By 24 December 2009
2	C22	18 (2)	<p><b>Findings:</b> The administration of medicines policy requires all registered nurses who administer medicines to have demonstrates the necessary knowledge and competence. Evidence was available that only two members of staff had undertaken medication management update training in 2009. The registered manager stated that all RMN staff had to now undertake refresher training in medicines administration and that this would be completed by 31 January 2010. The registered manager was unable to confirm whether medicines administration competency would be assessed as part of this refresher training.</p> <p><b>Action required:</b> The registered person must submit evidence that appropriate medication administration and management training, including competency training, has been undertaken by all staff who administer medication at the hospital, so as to demonstrate that measures are in place to ensure the safe management and secure handling of medicines.</p>	By 1 February 2010

No	Standard	Regulation	Requirement	Time scale
3	C23	15 (5)	<p><b>Findings:</b> Loose, unlabelled or out of date medications are recorded in a disposal book and are then placed in a yellow sharps bin for collection and disposal by the hospital's contracted general clinical waste disposal firm. A yellow bin in the ward treatment room was designated for the disposal of unused medications: it was inappropriately labelled as the label was a scrap of paper stuck on with sticky tape, did not state the date that the bin was assembled, and had no signature on it. The label was easily removable and in addition, the medications seen within it could have been removed merely by tipping the bin upside down.</p> <p><b>Action required:</b> The registered provider must submit evidence to demonstrate that an appropriate and correctly labelled pharmaceutical waste bin for the disposal of unused medicines has been implemented in both wards, so as to ensure that all medicines are handled in a safe and secure manner.</p>	By 24 December 2009
4	C18	15 (2)(a)(b)	<p><b>Findings:</b> In one ward, there were no records available to demonstrate that the defibrillator or blood pressure monitoring equipment had been serviced or last replaced, and the registered manager stated that no contract was in place to do so.</p> <p><b>Action required:</b> The registered person must submit evidence that ward treatment rooms defibrillators and blood pressure monitoring equipment have been serviced or evidence of when they were last replaced, to ensure that patients receive equipment that is safe and in good condition.</p>	By 24 December 2009
5	M35	45 (b)(c)(d)	<p><b>Findings:</b> A summary record was available to evidence that only six incidents in 2008/09 and to date six in 2009/10 have required physical patient restraint. No summary record was available of incidents where medication restraint had been used. The registered manager stated that medication restraint was</p>	By 24 December 2009

No	Standard	Regulation	Requirement	Time scale
			<p>documented only in the patient notes and medication charts.</p> <p><b>Action required:</b> The registered person must implement a summary reporting system whereby all incidents of restraint, including medication restraint and rapid tranquillisation, are recorded. The procedures for incident and restraint recording should be updated accordingly and made available to all staff to ensure that all violent and untoward incidents are audited.</p>	
6	M8	9 (1)(e)	<p><b>Findings:</b> The hospital has an ongoing programme of patient and environmental risk assessment, including ligature risk assessment and risk minimisation. Ligature risk assessment summary action plans were presented which evidenced completed action points and key persons responsible to mitigate risk. However, the most recent action plan also noted that some ligature risks, such as an external light fitting and toilet holders, had not yet been replaced.</p> <p><b>Action required:</b> The registered person must submit evidence that all noted ligature risks have been addressed to ensure that patients are protected from self-harm.</p>	By 24 December 2009
7	C20	9 (1)(e)(g)	<p><b>Findings:</b> The registered manager described his understanding of the hospital's system for making safeguarding referrals. These did not fully correspond to the system described within the written vulnerable adult's policy. The policy makes no mention of the local authority safeguarding team in which the hospital is sited and no contact details for it are stated in the policy, these was no flow chart for POVA referrals available, the name of the safeguarding lead is not in the policy and the policy refers to the Healthcare Commission rather than to the Care Quality Commission.</p> <p><b>Action required:</b> The registered person must submit a reviewed and reissued vulnerable adult's policy which accurately</p>	By 24 December 2009

No	Standard	Regulation	Requirement	Time scale
			describes the procedures in place for making safeguarding reports and referrals, contains an easy reference guide for staff to follow, contact details for referrals, names the safeguarding lead and refers to the appropriate regulatory body. The policy should take into account the guidance given in the document, Department of Health: No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, Section 3.8. The policy and procedures must be made available to all staff, to ensure that any safeguarding risks are identified, reported and managed appropriately.	

## Clinical and cost effectiveness

Number	Standard	Assessment
C3	Management of Patient Conditions	Standard met
C4	Monitoring Quality	Standard almost met
M1	Working with the Mental Health National Service Framework	Not inspected
M4	Clinical Audit	Not inspected
M11	The Care Programme Approach/Care Management	Not inspected
M12	Admission and assessment	Not inspected
M15	Patients with Developmental Disabilities	Not inspected
M16	Electro-Convulsive Therapy (ECT)	Not inspected
M19	Treatment for Addictions	Not inspected
M20	Transfer of Patients	Not inspected
M21	Patient Discharge	Not inspected

No	Standard	Regulation	Requirement	Time scale
8	C4	17(1)(2)	<p><b>Findings:</b> An audit plan was available to review covering the 2009 calendar year but no full audit plan for 2010 was made available at this inspection. No full ward or patient bedroom infection control audits have been undertaken since 2008 and infection control audits were not included in the audit plan for 2009/10.</p> <p><b>Action Required:</b> The registered person must ensure that infection control audits are undertaken at suitable intervals, to ensure that the risk to patients, staff and visitors of acquiring an infection is minimised.</p>	By 1 February 2010

## Governance

Number	Standard	Assessment
C7	Policies and Procedures	Not inspected
C8	Role and Responsibilities of the Registered Manager	Not inspected
C9	Human Resources Policies and Procedures	Standard not met
C10	Practising Privileges	Standard almost met
C11	Compliance with Professional Codes of Conduct	Not inspected
C12	Health Care Workers and Blood Borne Viruses	Not inspected
C16	Worker's Concerns	Not inspected
C28	Contracts	Not inspected
C29	Records Management	Not inspected
C30	Completion of Health Records	Standard not met
C31	Information Management	Not inspected
C32	Research	Not inspected
M2	Communication Between Staff	Not inspected
M3	Patient Confidentiality	Not inspected
M5	Staff Numbers and Skill Mix	Not inspected
M6	Staff Training	Not inspected
M22	Patient's Records	Not inspected

No	Standard	Regulation	Requirement	Time scale
9	C30	21 (1)	<p><b>Findings:</b> A care plans audit had found that all patients had a care plan in place, but that the frequency of updating and evaluation in the plans was variable, the reason for missing patient signatures was not documented and that plans contained irrelevant and/or discontinued information. There was no significant improvement evidenced between the findings of the 2008 and the 2009 care plan audits. The most recent patient notes audit in November 2008 demonstrated notes well-below the hospital's minimum standard.</p> <p><b>Action required:</b> The registered person must submit evidence that patient care plans and patient notes are complete, up to date and include all relevant signatures or reasons for why these are missing, to ensure that all patient records are appropriately and full completed.</p>	By 1 February 2010
10	C9	18 (2)	<p><b>Findings:</b> Clinical supervision has not been undertaken in a systematic and regular manner at the hospital. Measures have been implemented to address this but no evidence was available that clinical supervision is taking place on a regular basis.</p> <p><b>Action required:</b></p>	By 1 February 2010

No	Standard	Regulation	Requirement	Time scale
			The registered person must submit evidence that all clinical staff now receive supervision in accordance with the hospital's policy on clinical supervision, to ensure that staff are appropriately supported and monitored in their giving of care to patients.	
11	C9	18 (2)	<p><b>Findings:</b> There were significant gaps in the numbers of staff who had undertaken recent POVA training and Mental Health Act and medication management training was also overdue. There was no record available to demonstrate that staff had undertaken COSSH training. It was also noted from training records that no member of staff had undertaken basic life support or first aid training in the past year, and all but five staff were found to be now due or overdue for this training.</p> <p><b>Action required:</b> The registered person must submit evidence that all staff have undertaken mandatory and statutory training, to ensure that patients receive care from appropriately trained and qualified staff.</p>	By 1 February 2010
12	C10	21(1)	<p><b>Findings:</b> Practising privileges files reviewed at the inspection did not contain all the required information, some information within both files was missing and/or was out of date.</p> <p><b>Action required:</b> The registered person must submit evidence that practising privileges files contain all the required information and are up to date to ensure that patients receive treatment from appropriately qualified, insured and trained health care professionals.</p>	By 24 December 2009

## Patient focus

Number	Standard	Assessment
C1	Information for Patients	Not inspected
C2	Patient Centred Care	Not inspected
C5	Care of the Dying	Not inspected
C14	Complaints Process	Standard met
C15	Information for Patients about Complaints	Not inspected
C19	Catering Services for Patients	Not inspected
C27	Resuscitation	Not inspected
M10	Resuscitation Procedures	Not inspected
M13	CPA Care Planning and Review	Not inspected
M14	Information for Patients on their treatment	Not inspected
M23	Empowerment	Standard almost met
M24	Arrangements for visiting	Not inspected
M25	Working with Carers and Family Members	Not inspected
M26	Anti-discriminatory Practice	Not inspected
M27	Quality of Life for Patients	Not inspected
M28	Patient's Money	Standard almost met
M29	Restrictions and Security for Patients	Not inspected
M41	Establishments in which Treatment is provided for Persons liable to be detained - Information for Staff	Not inspected
M42	The Rights of Patients under the Mental Health Act	Not inspected
M43	Seclusion of Patients	Not inspected
M44	Section 17 Leave	Not inspected
M45	Absent without Leave under Section 18	Not inspected
M46	Discharge of Detained Patients	Not inspected
M47	Staff Training on the Mental Health Act	Standard not met

No	Standard	Regulation	Requirement	Time scale
13	M23	16(1)	<p><b>Findings:</b> The majority of patients have access to advocacy services via their referring authorities/bodies but the hospital has ceased to employ independent advocacy services. The manager confirmed that that there were ongoing issues in making advocacy available for patients who were not from neighbouring boroughs. At the time of the inspection there were three such patients.</p> <p><b>Action required:</b> The registered person must submit evidence that a system has been implemented whereby all patients have equitable access to an independent advocacy service, to ensure that all patients are informed of and have access to independent advocacy.</p>	By 1 February 2010
14	M28	16 (2)	<p><b>Findings:</b> Written systems are in place to protect patient monies from abuse and systems are in place for ward staff to hold and</p>	By 24 December 2009

No	Standard	Regulation	Requirement	Time scale
			<p>dispense patient monies on an as required basis. Cash handovers should be undertaken twice daily, with two ward staff present, both of whom must sign to state the money recording is accurate. One patient's personal money purse was checked against the patient monies records; the accurate amount of money was found to be in the wallet. Recent cash handover entries were reviewed on one ward, and in five instances the check had been undertaken and recorded by staff only once on each day. There was no evidence at this inspection that independent auditor spot checks had been implemented as was recommended by a recent patient monies audit.</p> <p><b>Action required:</b> The registered person must ensure that all recommendations made by the recent patient monies audit are implemented, to ensure that all transactions are appropriately recorded and to ensure that patient financial interests are upheld.</p>	
15	M47	18 (1)(2)	<p><b>Findings:</b> Mental Health Act training for staff was overdue. The registered manager confirmed that this training had been booked for all staff to attend in January 2010.</p> <p><b>Action required:</b> The registered person must submit evidence that Mental Health Act update training has been undertaken by all staff,</p>	By 1 February 2010

### ***Accessible and responsive care***

Number	Standard Topic	Assessment
C6	Patient's Views	Standard almost met

No	Standard	Regulation	Requirement	Time scale
16	C6	17(1)	<p><b>Findings:</b> The most recent patient questionnaire results evidenced that although satisfaction with staffing achieved a score of 74%, satisfaction with nursing and care plans achieved only 51% (lower than the last audit by 15%), with only 20% of patients stating they had a copy of their own care plan, facilities scored 54%, therapies 63%, patient information only 13%, advocacy 49%, religion and cultural needs 27%.</p> <p><b>Action required:</b> The registered person must prepare and implement action plans to address those areas where patients have expressed dissatisfaction with the services they receive to ensure that patients' views are used to inform the provision of treatment and care at the establishment.</p>	By 24 December 2009

### ***Care environment and amenities***

Number	Standard Topic	Assessment
C17	Health Care Premises	Standard met
C21	Health and Safety Measures	Not inspected

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