We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Broadmoor Hospital

Broadmoor Hospital,  Crowthorne,  RG45 7EG

Tel: 02083548055

Date of Inspections:  26 June 2013
25 June 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

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## Details about this location

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 June 2013 and 26 June 2013, observed how people were being cared for and spoke with one or more advocates for people who use services. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, talked with local groups of people in the community or voluntary sector, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The visits to Broadmoor Hospital took place over two days. We provided the Trust with 24 hours notice of the inspection visit. During the inspection we visited nine wards, the Primary Health Centre, Newbury Therapy Centre and the Education Centre.

We spoke with approximately 25 people who use the service and six relatives/representatives of people who were using the service. We spoke with a minimum of 43 staff of different disciplines. During the inspection we met with members of the independent advocacy service for the hospital. We also met with the social work manager.

The majority of feedback we received from people who use the service was positive. One person said "I feel that I am respected" and "staff do their best". All the relatives and representatives of people commented that they were pleased with the care people received.

There were a number of staffing vacancies within the hospital, which the Trust was aware of and was taking action to address.

We did identify that whilst staff had a good awareness of safeguarding issues, they were
not always aware of how to raise issues with external statutory bodies.

We also found a few examples where the use of seclusion for nursing people might not have fully complied with the Mental Health Act Code of Practice.

The Trust had systems in place to regularly assess and monitor the quality of service that people received.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Respecting and involving people who use services  
Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and treatment. We observed staff treating people with respect and in a courteous and professional manner. The staff listened to and spoke with people sensitively, even in challenging and hostile situations. The majority of people who use the service spoke positively about the staff and how they supported them to take a lead role in their own care. Some people told us how they led their own Care Programme Approach (CPA) (the approach used to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with mental health services) meeting and took responsibility of their rehabilitation plan.

One person explained how they were involved in their treatment. They said they learnt to understand their behaviour and recognised when they might not be in control and the actions they could take so they were in control of their behaviour. Similarly, another person told us that "I took the lead in my own treatment and chose my own objectives", whilst another commented that "I have a care plan, I know what's in it and I get the care I need." Some people spoke about the medicines they took as part of their treatment, and that their feedback in relation to side effects they experienced was listened to and changes made to the medicines they were prescribed.

The care records we viewed demonstrated that people were involved in discussions about their care and treatment. On the high dependency or admission wards where people were acutely unwell, some chose to sign their care plans and others refused. However, they were given opportunities to contribute to their care and treatment through attending their CPA meetings. In some cases people's solicitors or relatives attended these meetings and could contribute to the way people's needs were being met. Three of the relatives we spoke with said they were always invited to and involved in their relative's CPA. The advocacy service told us that they often attended CPA meetings, particularly where a person did not have any representative, and had requested support.
People we spoke with valued the advocacy service and said they were able to access them easily through their regular visits to the ward or over the telephone. The advocates we met with said that they aimed to meet newly admitted people within their first five days and they had allocated wards that they visited every one to two weeks. Information on how to contact advocacy services was displayed on notice boards on the hospital wards. Information on how to contact the CQC and Mental Health Act Commissioner was also displayed. Two people we spoke with told us that they had contacted the MHA Commissioner to raise concerns regarding their detention. Some people who use the service had also contacted the CQC, by letter and telephone. This showed that the CQC contact details were readily available to people, so we know the information is readily available to people. We also saw telephones on the ward that people could use.

People who use the service understood the care and treatment choices available to them, within the restrictions that were imposed on them as a result of staying in a high secure hospital. Staff told us that due to the nature of the service they reinforced boundaries to make sure that people's safety was maintained. One person who uses the service told us "the rules are applied, you know where you stand", whilst a number of people spoke of knowing what they needed to do to progress and move on from the service.

People's diversity, values and human rights were respected. We saw that people's care records included information about their cultural and religion or faith needs. People told us that representatives from different faiths visited the hospital to lead religious services and to support them with their spiritual needs. For example representatives from the Roman Catholic, Church of England and Muslim faith visited people regularly. Staff told us that people were able to visit the mosque and chapel within the hospital grounds. The care records for one person showed they were provided with Halal meals and had access to interpreters to enable them to speak with relatives during visiting times. This meant that people's cultural and faith needs were known to staff and action was taken to meet these.

However, the advocates we spoke with highlighted that the hospital had not taken enough action to protect people from discrimination because of their sexual orientation. This was reiterated by some healthcare professionals that we spoke with during our visit. The social work manager told us that this had been acknowledged and they were in the process of starting a diversity forum, whereby they would run focus groups for the each different strand of diversity.

People were supported in promoting their independence and community involvement. We attended a community meeting on one of the wards and viewed the minutes of these on some of the other wards we visited. We saw that people who use the service were encouraged to speak up about any concerns they had about the service. Where people wanted to talk about their individual conditions staff dealt with this sensitively so that people's individual privacy and dignity were maintained. People also told us that each ward had a patient representative who attended the patient forum. This enabled people to provide feedback on the service and make suggestions about improvements, such as the provision of meals, activities and staff attitudes.
Care and welfare of people who use services

Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. On admission to the hospital the multi-disciplinary team considered previous reports about people's needs and carried out their own needs assessment which included mental health, physical, psychological and social needs. The staff told us that people spent an initial period of at least three months on an admission ward. During this time assessments of the person's care needs and possible risks to themselves or other people were carried out. We saw that throughout this process care and treatment plans were developed and these were kept under regular review. The care records showed that a more in depth review of people needs and care planning took place with the multi-disciplinary team during CPA meetings. This ensured that people's needs were regularly assessed and the care and treatment they received was adjusted to meet their changing needs.

The care plans addressed people's mental health and physical healthcare needs. Staff told us they referred people to the healthcare centre when people were not physically well. There was evidence of input from healthcare professionals, including the GP, chiropodist, dentist and optician in people's care. Where people's physical conditions needed to be monitored, we found that this was evidenced as being addressed in the care records. For example people with diabetes had regular blood tests to monitor their blood sugar levels. However, the provider may find it useful to note that a person who had a significant weight loss was not weighed monthly according to their care records. The weight loss had not been planned. There was also evidence that they were consuming a limited diet, and we did not see measures in place to monitor the person's nutritional intake to ensure their wellbeing and safety.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. All the staff we spoke with told us risk management and the safety of people and others was central to the work they carried out. In the care records we saw that risk assessments had been carried out and risk management plans were in place to address foreseeable risks, based on the information they had about the person. There were risk management plans for areas such as self-harm, violence, suicide and absconding. This meant that staff had considered the potential risks for each person and taken action to manage these. The risk management plans were reviewed at regular
Where people were nursed in seclusion, plans were in place that detailed how people were cared for to ensure their safety. The care interventions included regular checks according to the level of observation people needed. However, the provider may find it useful to note that some of our findings highlighted that seclusion might have been used pre-emptively as a way of managing the ward environment rather than as a response to the violent or disturbed behaviour of individuals.

An example of this was that we were told by staff that a person would not stay in seclusion long, but after a review by the doctor during which time the person refused to acknowledge their behaviour earlier in the day, the decision was made to continue seclusion. We were unable to clarify with the staff what the person needed to do before their seclusion could be terminated. Similarly, another person told us they had been in seclusion for not taking their medicine. We checked the care records and found that these appeared to support the person's version of events, and it was not clear what 'severely disturbed behaviour' had triggered the episode of seclusion. This is because the Mental Health Act Code of Practice, Paragraph 15.43, states: "Its [seclusion] sole aim is to contain severely disturbed behaviour which is likely to cause harm to others."

The hospital operated night time confinement practices from 9.15pm to 7.15am. Feedback from advocates and people who use the service was that people were used to this practice and that they had no objections. People spoke about it helping to regulate their sleep pattern, and some said that they looked forward to it, as it meant they could spend time on their own and relax without other people being around. On one ward we saw that due to medical risks a person was not confined to their bedroom, but was nursed with the door open, this was so that staff on the ward could monitor the person's health needs.

People were engaged in activities to ensure they led as fulfilling a life as possible. The care records showed that people had an occupational assessment to identify the activities they enjoyed doing and their functional and physical ability to engage in these activities. Some people were engaged in woodwork, gardening or mechanics. People said they enjoyed doing these activities and it gave them something interesting and meaningful to do. The wards kept activity records for people so we could see that people were involved in stimulating activities. However, we found that the records of two people we looked at showed they were not regularly involved in activities and there were no care plans in place despite this being identified in their CPA plans on how the people could be supported to be more involved in activities.

During our inspection we visited the Newbury Therapy Centre. We found that they provided a full weekly programme of psychological therapies, such as cognitive behavioural therapy and helping people to understand their mental health. A number of people who use the service told us they enjoyed the group therapy work as it enabled them to engage with other people outside of the ward and gave them a sense of community involvement.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others. The care records we viewed demonstrated positive information sharing upon admission, and where people needed treatment outside the hospital, such as in an acute hospital. The care records included information from other agencies, including health services, social services and legal services. People told us they were able to meet with their legal representatives, and they were aware of the various healthcare professionals involved in their care. Similarly, there was evidence of appropriate communication with the Ministry of Justice and the criminal justice system. We were also made aware of positive links with other High Secure Hospitals, in the transferring of people, and the occasions where people needed to be accommodated in the short term, whilst needing to attend Court proceedings in the area.

People's records showed that staff from the hospital worked with other agencies to manage their discharge from the hospital. This included MAPPA (Multi-Agency Public Protection Arrangements) as part of the pre-discharge programme, and planning with the host authority. People told us they felt supported by staff on the ward but delays with their moving on were often caused by other agencies. People said this had been explained to them by staff and they were kept informed about their move.

Staff within the Education Centre told us that the centre was registered as an examination centre to enable people to undertake formal exams and other qualifications. We saw that some people had completed qualification training in IT skills while others were studying Open University courses.

The MHA Commissioners found during recent visits to different wards within the hospital that the physical health care provision on the wards was good. The care records also showed that people had at least an annual physical examination, and more frequently where they had been newly admitted to the hospital.

Within the hospital there was a Primary Health Centre, which we visited as part of the inspection. The service is led by a GP and supported by a full time nurse practitioner, three
nurses and a full-time dietician. The service also accommodated external professionals, such as a physiotherapist, podiatrist, dentist and diabetes specialist when they visited to treat people who use the service. We saw evidence of positive and effective relationships with external health and emergency care/treatment providers, and the hospital had processes in place to respond to emergency, urgent and routine physical health situations. For example, during the inspection we found that the appropriate process was followed when a person needed to attend the emergency department of a local hospital in response to a change in their needs.
Safeguarding people who use services from abuse  ✔ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. All staff who spoke with us said they received training in safeguarding adults and children and understood issues about safeguarding. We saw the training records which indicated that the majority of staff had received safeguarding training. However, the provider may find it useful to note that staff received significantly more safeguarding children training (one and half day) than safeguarding adults training (two and half hours) although the hospital accommodates adults only.

The majority of staff we spoke with were not aware that it was the local authority safeguarding team that led on safeguarding adults cases, or that they could contact the safeguarding team directly if they were concerned that someone was being abused. This information was not detailed in the training information or safeguarding policy for the hospital. As a result staff were not given all the necessary information about how to raise a safeguarding alert if they had concerns about the safety of people.

However, staff knew they should report suspicions and incidents of possible abuse to their manager. They told us the process they would follow to escalate any safeguarding concerns within the hospital management structure. One member of staff explained how they reported an incident between two people to their manager and completed the necessary incident form. The manager told us the incident was discussed with the social work team to decide whether to invoke the safeguarding adults' process to ensure the safety of the people.

There was a social workers team that was based at the hospital. We met with the social work manager who explained that their team ensured safeguarding concerns were appropriately dealt with to protect people from the risk of harm. The social workers who worked within the hospital were employed by the London Borough of Ealing. This enabled them to take an independent view of safeguarding issues. The social work manager also explained how they contributed to and worked alongside the local council's (Bracknell Forest) safeguarding team to ensure allegations of abuse were appropriately investigated and to prepare suitable protection plans for people at risk of abuse, where this was
The hospital had an established Safeguarding Adults panel that met every two months to review and sanction new case referrals, amend or discuss on-going cases and close cases. This ensured that safeguarding issues and the responses to these were monitored and risks to people minimised.

People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. Staff spoke about the training they had received in restraint and physical interventions, and we saw evidence of staff having been trained in the prevention and management of violence and aggression (PMVA). This enabled them to have the skills and knowledge to ensure that people were managed safely. They told us this was renewed regularly and where they had concerns regarding the restraint of individual people they had access to a PMVA advisor at all times. Staff spoke about the support they had to work with people whose behaviour was often unpredictable. One member of staff said "it's a good team, we work well together." Staff spoke about ‘de-briefing’ sessions following each incident, to review the incident as a team, so that learning took place and to provide support to each other.

During the inspection we saw staff managing the challenging behaviours of a number of people using the service. Staff worked well together to minimise the risk of harm to people using the service, to themselves and others. One person we spoke with told us they had been restrained when they were moving onto the ward. They told us that on reflection the staff had no choice but to use restraint as there was a high risk of violence. Findings from two recent visits by MHA Commissioners was that the people they spoke with felt the staff were quick and responded appropriately to any incidents that occurred on the ward. On two wards we looked at the use of emergency medicines for some of the people who use the service. Use of these had been appropriately recorded, in accordance with the requirements of the Mental Health Act, and our findings showed that in these instances, unlawful restraint by the use of medication was not being used.

The staff gave us examples of circumstances when they would use restraint and showed us how these were recorded. They told us that all incidents were recorded and discussed at the ward meeting. This meant that the provider had systems in place to monitor and review incidents for lessons to be learnt to prevent recurrence of similar incidents. We looked at a ward’s incident reports for the period April – June 2013. We saw that two incidents had been appropriately recorded and no restraint was used on either occasion. As the result of one incident, one person using the service had a vulnerable adult’s protection plan to make sure they were cared for safely on the ward. Staff on other wards showed us examples of other protection plans that had been developed in response to any safeguarding concerns, to minimise risk to the vulnerable person, and the perpetrator, where required. Risk management plans were in place for people that presented with a behaviour that challenged to reduce the risk of self-harm and to protect staff and others against the risk of violence.
**Staffing**

| Met this standard |

There should be enough members of staff to keep people safe and meet their health and welfare needs

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**Our judgement**

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

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**Reasons for our judgement**

Findings from two recent MHA Commissioner's visits to two wards at the hospital identified that, at times, staff felt there were inadequate levels of staffing on the wards. During our inspection we followed this up and spoke with people who use the service. The feedback we received was that they felt there were sufficient numbers of staff to meet their needs. Similarly, the majority of staff we spoke with told us they felt there were enough staff on duty at all times and additional staff could be provided, if required. During the inspection we saw that, following an incident, an additional member of staff was provided to a ward to increase the number of staff for the remainder of the shift.

There were staff vacancies on a number of the wards we visited and we noted that the Trust had taken action and had advertised to recruit for those vacancies. Bank staff were used to cover shortages of staff. This meant that people received care and treatment from staff who were familiar with the hospital and understood their care needs.

The Clinical Nurse Managers we spoke with said the staffing of the wards was flexible. They told us they assessed the staffing levels of the ward each day and decided how many staff they required. The request was routed through to the site management team and the wards were staffed as appropriate. They said they always considered the safety of staff and people using the service when making decisions about staffing levels, and that these varied according to people's needs. Where there were a number of people being nursed in seclusion or in long term segregation we saw that the staffing levels were higher than normal to reflect the needs of the people on the ward. Each ward submitted to management a twenty four hour report which included the details of the numbers of staff on duty and the changing needs of the people who use the service. This meant that hospital management had an overview of the staffing levels across the hospital and that they were taking steps to ensure that enough staff were available to meet people’s individual needs. This meant that the hospital provided enough qualified, skilled and experienced staff to meet people's needs.

On one ward we viewed the duty rotas that had been planned in advance for July 2013. We saw that occasions where additional staff were required had been identified so appropriate arrangements could be made to have the required number of staff on duty. For example, where people who use the service were required to attend Court additional staff were on duty to ensure that appropriate escort arrangements were in place. Similarly, in
the Education Centre we were informed that staffing levels were risk assessed for each session, depending on the number of people using the centre. Education staff worked with individuals or groups of people using the service and ward staff were available for support and supervision, as well as providing continuity of care to people.

All of the staff we spoke with said they felt supported by their managers and that there was good teamwork. Staff told us they received regular supervision and could access reflective practice meetings that were held weekly on each ward. The hospital also had arrangements to monitor the professional registration of staff to ensure they remained registered with their professionals body and fit to practice. This ensured that people were supported by appropriately qualified staff.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

The provider took account of complaints and comments to improve the service. Contacts to the Complaints and Patient Advice and Liaison (PAL's) were monitored as well as the responses to these and the actions that were taken as a result. Trust wide areas of development were identified and plans put in place to address these.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. There was a carer's forum for the friends and relatives of people who use the service, which was attended by senior management staff from the hospital. On some wards we saw that feedback from people who use the service was obtained through the Meridian feedback system that was in place at the hospital. This entailed people completing a satisfaction questionnaire on an electronic tablet. As a result people were able to provide immediate feedback about their care.

We were shown collated results of feedback and actions that were taken to improve the service, where this was identified. People were also able to give feedback via their ward patient representative who attended the regular patient's forum. These were also attended by senior management staff from the hospital. This ensured that people's views were heard by those who could take action. We spoke with a number of ward patient representatives. They told us that they felt listened to in the forum, and changes were generally made as a result of feedback they gave. One representative told us how they had asked for improvements to be made to the 'all weather football pitch' so it could be used. The person told us that a plan had now been implemented to repair the pitch, and we saw meeting minutes to confirm this.

We found that the results of a recent patient survey of the Primary Health Centre showed high levels of satisfaction with the service that people received. All staff and patients we spoke with about the primary care service were grateful and positive about the service they received. We found that the Primary Health Centre operated to national standards. This meant that reporting took place in accordance within the quality and activity targets contained with the Quality and Outcomes Framework (QOF), which included reporting on areas such as clinical care, organisation and patient satisfaction. All QOF data was
reported internally to the Trust Board and an independent professional external review was conducted annually to the same standards as community GP primary care services.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. Incidents and accidents were recorded electronically and enabled senior managers and staff working within the Trust governance team to access the data easily. They could analyse any incidents and accidents, check the action being taken locally by staff and identify trends and patterns so action could be taken to prevent similar incidents and accidents from recurring. All incidents were investigated and the directorate managers developed action plans to minimise the risk of similar incidents occurring elsewhere in the hospital. However, the provider might find it useful to note that we found an occasion where the necessary learning had not taken place following the investigation into an incident. At the time of the inspection we noted that a similar incident had occurred and an investigation was being carried out. Managers told us they would investigate this matter to identify why recommendations from the previous investigation report had not been acted upon to prevent recurrence of similar incidents.

We asked West London Mental Health Trust how they monitored the quality of service provided at Broadmoor Hospital. We were provided with evidence of monitoring that took place at Trust level. This included monthly monitoring reports from each directorate within the hospital. A quarterly performance meeting took place of the hospital, which looked at issues such as staff performance and management issues, training and staff vacancies. Recent MHA Commissioner findings were discussed and actions taken to address issues raised, as well as issues regarding the people who use the service, such as seclusion, waiting times and incidents.

The Trust also carried out an annual 'Learning from Experience' audit, which looked at issues across the clinical service units, and high secure service, throughout each month and quarter of the year. This included the monitoring of patient safety incidents, such as abuse and assaults, security issues and where people self-harmed. We viewed meeting minutes and reports that had been submitted to the Trust Board about incidents and actions taken to prevent recurrence. This ensured that learning from incidents took place and appropriate changes were implemented to improve the service people received.

There were a number of indicators that were reported at ward and directorate level to assess the quality of service being provided on each ward. For example the frequency of staff supervision, staff training, one to one meetings between people using the service, risk reports and patient activity reporting. All of the reporting required actions being set and there were plans in place to address the shortfalls. Ward managers said they had to provide responses to their line managers when their monitoring and audits did not match agreed targets. This demonstrated that the service delivery of each ward was being monitored closely.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

- **Met this standard**
  This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

- **Action needed**
  This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

- **Enforcement action taken**
  If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
### Glossary of terms we use in this report

#### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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#### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.