

Partnerships in Care 1 Limited

Nelson House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

Nelson House is a purpose built 32-bedded independent hospital, operated by the Priory Group, that provides assessment and treatment for men within a locked rehabilitation setting.

The environment was recently re-designated to better meet the purpose of the service. Patients arriving at the service were admitted into Trafalgar ward and when they were on a discharge pathway moved into Victory ward for rehabilitation.

At the time of the inspection, the service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is ran.

We rated this service Requires Improvement because:

Governance Systems were not robust as audits had not identified all shortfalls to improve outcomes for patients.

Care plans were not devised for all identified areas of need. They lacked patients' preferences on how they wanted their care needs to be met and recovery plans were not aligned to the core care plans. There were inconsistencies from staff on their roles and responsibilities with supporting patients with rehabilitation which had created a disconnect between the Occupational Therapy team and support workers. This meant patients were not having person centred care

Medicines management systems were not always well managed. These included containers without lids for medicines no longer required, poor communication between the staff and the supplying pharmacist and internal guidance was not being followed for medicines with additional recording schedules.

There were blanket restrictions. There were smoking breaks known as “protective times” when patients were able to smoke despite a smoking cessation programme. There was an expectation that informal patients return to the hospital before 10pm.

Patient's consent was not gained to have their initials against comments and suggestions made in public documents.

The external environment was not maintained. Parts were overgrown, there was litter and cigarette stubs which increased the potential risk for the spread of infection.

There was poor visibility from the office into the wards. Staff were sitting in offices without having the light switch on due to the poor visibility from the office made worse by the panels of frosting on the glass panels.

However:

Staff felt valued and morale was improving where it was previously low. Internal training was due to be delivered to ensure staff knew their roles and responsibilities. There was to be team building to develop better ways of working between multidisciplinary teams.

The second floor environment was adapted to provide rehabilitation for patients on a discharge pathway.

Summary of findings

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly

Patients had access to a range of treatments suitable to the needs which included emotional and social support.

Staffing levels were maintained with permanent and regular agency staff.

Staff recognised and reported incidents appropriately

Patients felt confident to approach staff with complaints

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to Nelson House

Nelson House registered with the Care Quality Commission on the 17th October 2014. The hospital is registered to carry out three regulated activities;

- Assessment or medical treatment for persons detained under the Mental Health Act 1983,
- Diagnostic and screening procedures and
- Treatment of disease, disorder, or injury

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?

What people who use the service say

Patients felt safe with the staff and others at the service.

Patients knew the conditions of their stay and the leave they were able to have.

Patients knew how to access support. Some sought support from staff while others approached religious leaders, family members or advocate. Some patients praised individual nursing and agency staff for the support they offered.

There were patients that accessed support from external organisations such as AA and NA

Patients commented on the lack of activities or living skills training available at the service. There was praise to the housekeepers for the support with developing skills with laundry and keeping their space clean. However, most patients said they were bored. Suggestions to improve were made by patient which included having more group work and providing individual kitchen cabinets.

Patients said the staff were kind and they had daily conversations. They were encouraged to maintain relationships with relatives.

Patients made positive comments about their accommodation they also praised the quality of the food.

Summary of this inspection

How we carried out this inspection

This inspection was unannounced before the inspection visit. We reviewed information that we held about the service.

Spoke with 9 patients and we attended patient's community meeting

Tour of the environment and checked the clinic rooms

Looked at a range of policies and procedures related to the running of the service

Reviewed 16 care records and 10 treatment records

Interviewed the Quality Lead, Hospital Director and Director of Clinical Services

Spoke with 7 nursing staff including support workers and agency staff

Spoke to the consultant psychiatrist, psychologist, and Occupational Therapist

Spoke with the mental health administrator

Spoke with 1 housekeeper

Spoke to the maintenance lead and manager

Areas for improvement

Core service

The provider must ensure that medicines systems were well managed. Lidded containers must be provided for medicines no longer required. Recording of "nearly expired" medicines must be documented in the appropriating logbook. Regulation 12

Care plans must be person centred. Action plans must be developed from risks identified and linked to a care plan. Care plans must include patient's preferences on how their care needs will be met. Regulation 9

The provider must ensure where restrictions are imposed, they are individual to the patient and not blanket restrictions. For example, cigarette breaks, and the times informal patients return to the service

The provider must ensure that staff have good visibility from the offices into the wards.

The provider must ensure that staff attend mandatory training and receive supervision to ensure they are qualified and competent to ensure patient's receive safe care and treatment. Regulation 18.

SHOULD

Summary of this inspection

Core service

The provider should ensure that governance systems identify shortfalls to develop improvement plans to promote better patient outcomes

The provider should ensure that rehabilitation care plans are aligned to the organisations core care plans to develop more holistic documents.

The provider should ensure better communications between the staff and the supplying pharmacist and internal guidance is being followed for medicines with additional recording schedules.

The provider should ensure patient's consent is gained before having their initials added to comments and suggestions made in public documents.

The provider should ensure external environment was not maintained. Parts were overgrown, there was litter and cigarette stubs which increased the potential for the spread of infection

Our findings






Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

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

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The hospital complied with same sex guidance, offered male only accommodation and no mixed sex accommodation. The environment was recently re-designated to better meet the purpose of the service. Communal areas were on the ground floor and included the gym and meeting rooms while individual en-suite bedrooms along with communal space were on the first and second floors accessed by a lift. Patients arriving at the service were admitted into Trafalgar ward and when they were on a discharge pathway moved into Victory ward for rehabilitation

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. There were a few ligature anchor points on Victory ward and staff supervision was the measure in place to manage the risk. We raised with managers that Victory ward was not staffed during periods of the day which meant the risks of potential self-harm from ligatures were not reduced.

There was poor visibility into the wards from the offices and to improve lines of observations the staff were switching the lights off when they were in the office. The panels on windows were further obscuring their visibility and making it difficult to have a clear view into the ward. Mirrors were use in areas difficult to observe patients. For example, in corners of corridors and in bedrooms.

Staff had easy access to alarms and patients had easy access to nurse call systems. A nurse call system was installed for patients to gain attention from staff in the event of an emergency or at night.

Maintenance, cleanliness, and infection control

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Ward areas were clean, well maintained, well-furnished and fit for purpose. The staffing levels for housekeeping were adequate, and they were provided with the equipment and substances needed to prevent the spread of infection. We observed staff maintaining the environment to a good standard.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. There were hand sanitizers positioned around the wards and where appropriate staff wore gloves.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Physical health monitoring equipment was appropriately calibrated, and safety checked.

Staff checked, maintained, and cleaned equipment. Staff knew the location of where vital clinical equipment was stored. For example, ligature cutters were kept in the office and clinic rooms.

Signage helped direct staff to where equipment was stored that would be required in the event of an emergency.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Staffing levels had improved with the recruitment of permanent staff which has led to the reduction of agency staff. Recruitment of staff was successful for international staff which has led to a decrease in the use of agency staff. Regular agency nurses were used at night and from the organisation's approved agencies.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift. The staffing arrangements were for 16 patients and on duty there were 2 nurses and 3 support workers with 1 support worker covering Victory ward. Where necessary additional staff was rostered to escort patients in the community. At night there were 2 nurses, and 2 support workers rostered across both wards.

There were plans to increase staffing which will benefit patients in Victory ward as the additional staff were for this ward.

There was an expectation that agency staff complete an induction. The agency induction checklist reviewed did not demonstrate competencies. For example, checklists were missing for 1 agency nurse and registration details were missing for 2 agency nurses.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Verbal handovers and notes were available to staff on patient's current needs and there was access to electronic records for reference.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Medical staff

The service had enough daytime and night-time medical cover, and a doctor available to go to the ward quickly in an emergency. The medical team included 2 full time Consultants psychiatrists as well as a psychologist, and an Occupational therapist.

Mandatory training

A review of mandatory training set by the organisation was due to take place. Staff at the service were to attend internal training on Back-to-Basics training followed by Team building before re-introducing mandatory training.

The provider report dated 2022 showed 85% of staff had attended Basic Life Support, 55% Immediate life Support (ILS) and 75% safeguarding of adults. 91% across the organisation had attended Reducing Restrictive Intervention and Breakaway Training.

Staff giving feedback said they had attended eLearning and face to face training.

Assessing and managing risk to patients and staff

Some risks were assessed. Staff used de-escalating and breakaway techniques when they managed behaviours that placed patients and others at risk of harm which meant that restraint was rarely used. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Risks relating to Keeping Well, Keeping Healthy, Keeping Safe and Keeping Connected were assessed during the admission process. Where risks were assessed, they were reviewed and updated following discussions at MDT (multidisciplinary team) meetings. Some risks were identified but a care plan was not developed or updated on how to reduce the risk. For example, the support needed from staff with finances.

Patient's physical health was regularly checked by staff, and NHS community services were accessible and included optician, chiropody, and dentists. The physical health lead supported staff as a point of specialist information and carried out monthly audits to ensure patients ongoing physical health was monitored.

Management of patient risk

Staff showed insight into individual risks and how to manage them. Observation levels were set at the individual's level of acuity on the ward and staffing levels can be increased based on complexities of need along with staffing and the needs of the ward. Mirrors were positioned in places where observations of patients were not easily possible at a distance.

Posters on prohibited items were displayed around the hospital. There were searches when patients returned from unescorted leave and where appropriate random bedroom searches. Patients agreed to random screening following unescorted leave and room searches for substances likely to be misused.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

We saw examples of blanket restrictive practices which included smoking times known as “Protected” times and the times that informal patients must return to the hospital. We raised restrictive practices with senior managers who gave us assurances that protected times were to be removed. They explained the process for informal patients wishing to leave the hospital. There was an expectation that staff complete risk assessments before informal patients left the hospital and not on the set times for returning. Senior manager said the process would be reinforced with staff.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Care plans were not detailed on how staff were to manage behaviours that place the patient and others at risk of harm. Positive support plans were not detailed on how staff were to manage triggers exhibited when the patients show signs of frustration and anxiety. They lacked detailed guidance on how staff prevent situations from escalating.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff attended safeguarding training appropriate to their role and kept up to date with this training. They knew the types of abuse and their expectations on reporting concerns.

Staff followed clear procedures to keep children visiting the ward safe.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Records were stored securely, and staff had easy access to notes. Staff updated patient's electronic notes daily and paper notes such as observations and leave.

There were verbal handovers whenever staff changes took place. For example, significant events, new risks, and changes in leave. Handover notes were accessible to staff and gave them current information on patient's needs.

Medicines management

The service used systems and processes to safely prescribe, administer, and record medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

There were safe systems for prescribing and administering medicines. Staff regularly checked systems and processes to prescribe and administer medicines safely.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The pharmaceutical waste container in the second-floor clinic room was unlidded. The contents of the container could be accessed easily by any one with authority to enter the room. For example, out of date and unused medicines. Lidded bins were provided once we escalated our concerns to the clinical lead and the Hospital Director

Medicines disposal procedures were not followed. The medicine fridge in the clinical room contained medications of a patient discharged in October 2022 and discontinued medicines.

Documentation was not always logged securely. Staff were listing medicines about expire on a blank piece of paper instead of documenting the information in the logbook provided. The list of soon to be expired medicines was left in the stock cupboard which meant the information could be easily misplaced.

Staff were not following their own processes for some classified medicines although the policy had change it was not in writing. We acknowledge there was no legal requirement to follow additional recording measures.

The pharmacist audits dated 10 October and 31 December 2022 stated that 40% of queries and interventions made by them was not acknowledged.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The Hospital Director assessed incidents to identify trends and themes. The providers' report dated May to October 2022 listed the incidents along with the themes. There were 35 incidents in October 2022 which focused on medicine management, patients not returning from leave, use of drugs open to misuse and heating systems. While the learning from incidents were identified within the report it was difficult to establish the effectiveness of some learning. We noted that medication compliance for expired medicines was not included. There were restrictive practice although the plan was for staff to understanding their effects on patients.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were not recovery oriented, reflective of all assessed needs, and lacked patient's preferences.

Managers recognised that care plans met a clinical model, but they were not always person centred or supported patients with developing independent living skills.

Patient's needs were assessed during the admission process. Electronic care plans that focused on patient's physical health care needs were comprehensive and reviewed regularly. Care plans were not developed where the identified needs did not fit into the format standards of Keeping Well, Keeping Healthy, Keeping Safe and Keeping Connected. Action plans were not always developed for all assessed needs. For example, finances.

The organisation re-introduced a rehabilitation model of care. Some staff said support workers were not fully engaged with motivating patients to develop skills. There was some confusion between staff on the expectations of the model. Occupational therapists (OT) developed Individuals core care plans based on the 4 format standards. However, these plans were not person centred or linked to the electronic care plans.

Victory ward was recently re-established as a rehabilitation ward for patients moving towards discharge. The OT described the plan to support patients with developing their independent living. A member of the housekeeping staff was working closely with OTs (Occupational Therapist) to support patients to develop independent living skills. For example, laundry and how to maintain their bedrooms cleanliness. One patient on Victory ward was independent while other patients needed input with improving their skills such as cooking. Support workers commented that patients on Victory ward needed minimal support because they were independent, and the rehabilitation programme was lacking and there were inconsistencies.

Best practice in treatment and care

The service was introducing a range of treatment and care for patients based on national guidance and best practice. Patients had access to psychological therapies, support for self-care and the development of everyday living skills. Staff supported patients with their physical health. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking, and quality improvement initiatives.

Staff were not always delivering care in line with best practice and national guidance. NICE (National Institute of Clinical Excellence) guidelines for medicines no longer required were not fully followed.

The service was moving away from a clinical model of care towards a rehabilitation model.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff used recognised rating scales such as NEWS2 to assess and record the severity of patients' conditions and care and treatment outcomes.

Skilled staff to deliver care

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

New staff attend a corporate induction completed over a 6-month period which included eLearning, face to face training and onsite experience. The checklist was signed by the mentor and new staff to show competence.

Staff attended mandatory training and were sent reminders when their refresher training was due. Eighty-two percent of staff had attended Basic Life Support, Immediate Life Support and Safeguarding face to face in November 2022. Ninety percent of staff across the organisation had attended mandatory training in Reduction of Restrictive practice. While a review of mandatory training was undertaken to include learning disabilities and autistic people, mental health training was not part of mandatory training.

Training on risk assessments, observations, and capacity assessments was due to be delivered for therapists and medical staff. Internal training to all staff was arranged on care planning, risk assessments and Back to Basics which focuses on the values of the organisation and the principles of care such as privacy and dignity. *Rehabilitation and Recovery training was an action arising from the inspection to embed the model and raise staff's understating of their roles and responsibilities*

All staff had clinical and management supervision as appropriate in November 2022 but 50% of staff had management supervision in September and October 2022 and less than 50% for the rest of the year. Clinical supervision was above 50% except for October and December 2022 when it was less than 50%.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Patients attended their MDT meetings with their advocate if appropriate. They were able to discuss and reach agreements on care plan outcomes, discharge goals, relationships, and section 17 leave.

The consultant psychiatrists, psychologist, Occupational therapist (OT), care coordinator and ward managers were present at the MDT meetings which the psychologist chaired.

There was comprehensive feedback prior to the meeting about the patient. For example, physical health, leave, incidents and discharge plans.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



Staff received and kept up to date with training on the Mental Health Act and approached the Mental Health Act administrator for support and guidance.

Notice board giving patients information on their rights, and advocacy were displayed around the hospital. The posters gave additional guidance on the process for advocacy referral and the name and photograph of the advocate who visits.

The Mental Health Act administrator explained part of their role was to ensure where patients were detained the correct documentation was in place. The electronic system listed when patients had their 132 rights read, dates of tribunals and consent to care and treatment under the relevant and authorised legal frameworks.

Fifteen of the 17 patients admitted were detained under the MHA (Mental Health Act). Section 17 leave (permission to leave the hospital) was documented when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff had documented when leave was taken. Patients were able to have escorted leave and unescorted leave in the community. Patients mainly used their “ground” leave for smoking breaks.

Posters advising informal patients they were able to leave at any time were displayed in the hospital. The minutes of the community meeting gave conflicting information to informal patients. Informal patients were to return by 10pm. Managers gave reassurances that staff were to be reminded to complete the risk assessment before informal patients left the hospital and not to restrict their leave.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves.

Patients were supported by staff to make day to day decisions. Patients consent to share information with nearest relatives was gathered and documented.

Mental capacity assessments were not always completed, and some were missing details where they had been completed. For example, a mental capacity assessment was not in place for 1 patient on managing finance and another mental capacity assessment for medicines was missing detail on how the decision was reached that the patient had capacity.

Patients consent was not sought to have their initials against their comments and suggestions disclosed on the displayed Community Meetings minutes. Managers responded to our concerns and only included the initials of patients who attended community meetings and removed from the minute's initials from their comments and suggestions.

Is the service caring?

Good



Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Patients said the staff were kind and spent time with them. Nursing staff ensured staff were allocated time to spend with patients. Staff on Trafalgar spent time engaging with patients. For example, playing pool.

Staff raised concerns about the lack of activities and rehabilitation for patients which impacted on their outcomes.

Staff followed policy to keep patient information confidential.

Involvement in care

Patients were invited to their multidisciplinary meeting and if they attended their treatment plans were explained. Some patients were involved in their care plans and risk assessment. The care plans and risk assessments reviewed did not reflect patients input.

Patients had access to independent advocates.

Patient Council Meetings were held and were attended by the Hospital Director, advocate, and director of clinical services. An agenda was followed, safeguarding and leave were standing items for discussion. At the most recent meeting, staff shared information and patients gave feedback about their experiences and raised suggestions for improvement. Their feedback was part of Clinical Governance meetings.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Patients were invited to their multi-disciplinary meetings and staff used these meeting to explain the treatment the patient was receiving and any changes that were needed.

Patients could give feedback on the service and their treatment and staff supported them to do this. For example, there was a “you said we did” board to demonstrate any changes that were made following patient suggestions.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Patients said they were encouraged to maintain relationships and develop contact with relatives.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer’s assessment where there was consent.

Is the service responsive?

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. There were delays in discharges for a few patients.

The organisation agreed to maintain occupancy at 19 patients and 17 patients were currently accommodated. There were 6 discharged in 2022 and 2 were delayed between 28 and 31 months.

Patients moved to the rehabilitation wards when they were on the discharge pathways. Managers said this move was positive and reinforced to other patients that rehabilitation of skills including independent living was the pathway to discharges.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. These delays were over 30 months for 2 patients.

The discharge dates set during the admission were not always meaningful and not adhered to. Patient discharges were discussed during MDT meetings which care coordinators joined. At a recent MDT meeting gradual transitions were discussed for 1 patient which included introductory visits to new placements, registration for NHS facilities and legal status.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Parts of the hospital's communal spaces were bare or not inviting for patients to spend time socialising or relaxing. An action plan was to be developed for patient to have a better environment and to seek accreditation from the Royal College of Psychiatry.

Each patient had their own bedroom, which they could personalise. Lockers were available for patients to store their possessions securely.

The service offered a range of rooms and equipment on the ground floor to support treatment and care. Patients had access to quiet rooms, a gym and instructor, a family room for visits and large lounge for group meetings.

There were phones on the wards for outgoing calls which patients used although some patients had their own mobiles.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The service had an outside space that patients could access easily. Patients were able to access the gardens between 06.00hrs and 24.00hrs which was used for smoking. These areas were poorly maintained. For example, the grass was overgrown in the BBQ garden, overflowing bins with litter and cigarette butts on the floor. We raised our concerns with managers and bigger bins were sourced. They told us about the smoking cessation programme in progress.

Patients had free access to the kitchens located on each floor. There were hot and cold refreshment making facilities in patient areas. The kitchen in Victory ward was a more sociable space with sofas, dining areas and TV. Additional cupboards were due to be provided for all patients in Victory ward to have secure storage of their food items.

The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education, and family relationships.

Personal plans were being introduced by the Occupational therapy (OT) team which included swimming, joining walking groups and cooking.

There was an expectation that patients attend daily planning meetings to organise the activities for that day, Weekly activities included Mindfulness, arts groups, and reflection. AA and NA were other external groups patients were able to access.

Patients were supported to maintain relationships with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

There was level access to the hospital with lifts to upper floors. Corridors were wide and bedrooms allowed patients to move around the space easily.

Notice boards placed around wards gave patients information on safeguarding of adults, their rights and advocacy. There were Easy to Read notice boards on smoking cessation and how to gain support. The complaints procedure was also displayed within the hospital

Patients had access to spiritual, religious, and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles and they had a good understanding of the services they managed. While patients and staff knew the Hospital Director they approached the Director of Clinical Services for support and was more visible in the service.

The Hospital Director had management support from senior managers. The Hospital Director was working across two sites which meant their presence at Nelson House was 2 to 3 days per week and virtual at all other times. The Director of Clinical Services was supported by the Hospital Director, and they worked well together. However, the Director of Clinical Services covered when the Hospital Director was not at Nelson House which meant they covered multiple roles and there was heavy reliance from staff.

The Hospital Director used the leadership skills of openness, transparency and sharing information to promote person centred care. Being contactable to staff and sharing information to both staff and patients were important to develop the values of the organisation.

Ward manager's meetings were to be held to cascade policy changes and to discuss quality improvement plans.

Staff and patients were positive about the Hospital Director. They were known to patients, and they had a presence on the wards but said they approached the Director of Clinical Services in the first instance.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The most recent success was to specify the purpose of each ward and to adapt Victory ward to provide an environment for patients to develop their independent living skills. Patients moving into Victory ward were on a discharge pathway and were having support to move into the community. Other patients were able to aspire to be transferred into Victory ward as a positive direction for discharge.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

The recruitment of international nurses was to provide a consistent approach and reduce the use of agency staff.

Culture

Staff felt respected, supported, and valued. They could raise any concerns without fear.

Morale at the service was improving as previously staff gave feedback that it was low. They spoke about their pride at how team works. Overall staff said morale was variable, but they felt valued by the local leadership team. Staff raised concerns about the rehabilitation model, the heating system and about staff vacancies. We raised with managers the concerns that staff raised before and during the inspection. Managers were responsive to the concerns and explained the actions they were taking to improve morale for staff. For example, training on the roles and responsibilities of the rehabilitation and recovery pathway was to be provided, heating temperatures were being taken daily to ensure a consistent temperature and new staff were progressing through their induction.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

There had been changes on the expectations on the reports from leads to be discussed at team level governance meetings which were submitted and discussed at board level. The minutes of the Clinical Governance meeting listed the topics discussed and the action plan. For example, emergency action scenario training.

Clinical Governance meetings at team level were chaired by the Hospital Director and focussed on feedback received from the leads such as the Mental Health Act administrator, outcomes of audits, accidents and incidents, lesson learnt and issues of concerns.

Quality Walk Arouns were completed by nursing staff on specific areas and reports were submitted for discussion at Clinical governance meetings. For example, the quality walk around in December 2022 was based on physical health. Staff complete the walk around checklist on the topics covered, documentation reviewed and patient feedback. Comments on how to meet shortfalls were made against the standard identified for improving.

There was an internal compliance visit that took place in August 2022 and except for governance all previously made recommendations were actioned. We found areas met at the visit were inconsistent with our findings. For example, care planning.

Patients were smoking in the outdoor areas although a smoking cessation programme was in progress. Areas where patients were smoking were poorly maintained. For example, there was litter and cigarette stubs which had a potential for the spread of infection.

Management of risk, issues, and performance.

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

There were effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. An audit system to assess and monitor the standards of care was in place and action was taken where shortfalls were identified.

The risk register listed the risk, the level, and the actions to reduce the risk. Risks included patients smoking in their bedrooms, the recent resignation of the Hospital Director and the heating system which were rated along with the actions to reduce the level of risk. Ligature audits were not robust because the actions did not lower the risk. Staff presence was the actions to lower the risk, but staff were not always on duty in Victory ward. We observed during the inspection when staff were not present on the ward.

While there were clear performance measures the outcomes from the audits were inconsistent with our findings. There were inconsistencies from staff on their roles and responsibilities with supporting patients with rehabilitation. Although staff said patients in Victory ward were independent the feedback from the Occupational Therapists (OT) was that patients needed staff's input with independent living skills before they were ready for discharge. There was recognition from the Hospital Director that there was a disconnect between the OT team and support workers.

Internal audits had assessed the care plans to meet the required standard for the organisation. However, risks identified during admissions were not part of the care planning format. Care plans were not devised for all identified areas of need. They lacked patients' preferences on how they wanted their care needs to be met and recovery plans were not aligned to the electronic care plans. This meant care plans were not holistic.

Medicines audits had not assessed containers for medicines no longer required with missing lids. There was poor communication between the staff and the supplying pharmacist and staff not following their own guidance for medicines with additional recording schedules.

Audits had not identified restrictive practices. There were smoking breaks known as protective times when patients were able to smoke despite a smoking cessation programme, there was an expectation that patients return to the hospital before 10pm and patient's consent was not gained to have their initials against comments and suggestions made against public documents.

Internal walk arounds had not identified that staff were sitting in offices with the lights switched off due to poor visibility into wards which made it difficult for staff to have clear lines of observations into the office.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Improvement plans were developed to manage current and future performance. Action plans were developed from audits and visits. However, audits had not identified shortfalls in medicine management, care plans were not person centred or recovery orientated.

Managers engaged actively with other local health and social care providers. The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation.

Engagement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The Hospital Director engaged with external commissioners. They joined weekly meetings where discharges and referrals for admission were discussed. There was contact with other external agencies such as colleges, advocate services and vocational networks.

Learning, continuous improvement and innovation

The Hospital Director responded to incidents. They were investigated and there was learning from incidents. There was openness and transparency to ensure the lessons shared was embedded.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure that medicines systems were well managed. Recording of “nearly expired” medicines must be documented in the appropriating logbook

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure where restrictions are imposed, they are individual to the patient and not blanket restrictions. For example, cigarette breaks, and the times informal patients return to the service

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Care plans must be person centred. Action plans must be developed from risks identified and linked to a care plan. Care plans must include patient's preferences on how their care needs will be met.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The provider must ensure that staff have good visibility from the offices into the wards.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 18 CQC (Registration) Regulations 2009
Notification of other incidents

The provider must ensure that staff attend mandatory training and receive supervision to ensure they are qualified and competent to ensure patient's receive safe care and treatment