Nelson House

Quality Report

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Date of inspection visit: 12 - 13 January 2016
Date of publication: 07/06/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

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

Summary of findings

Overall summary

We rated Nelson House as requires improvement because:

- We rated effective as inadequate. Care plans completed by staff were not personalised and did not capture patients' views. Appropriate information to provide care for patients was not contained in the care plans. Care coordinators confirmed that there had been a lack of meaningful activity focussed on patient recovery. The provider had identified this and had started a new activity programme the week before the inspection.
- Staff had not received regular clinical supervision to review their work and their approach towards it. Staff had not had annual appraisals to discuss their progress and identify training needs and career aspirations.
- Staff did not follow the ligature point (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) management plans consistently. Staff had developed these plans for patients identified as at risk of self-harm using a ligature. The hospital's audit of ligature points was incomplete; however, there were very few ligature points due to the hospital's modern design.
- Staff did not document patients' risks consistently using recognised risk assessment tools.
- The hospital placed unnecessary restrictions on all patients. These included patients not being able to access the hospital garden for fresh air or to smoke when they wished. Patients without a personal mobile phone could not make private phone calls.
- Patient records were inconsistent and staff could not always find documents relating to patient care.
- In an emergency staff could not access emergency equipment, including a defibrillator, in a timely manner as they had to run down several flights of steps or take a lift to collect these.

However:

- Staff interactions with patients we witnessed were respectful and polite. Staff demonstrated knowledge of patients' histories and holistic needs.
- Staff were very positive about the developments and changes that had been made since the change of ownership. They told us they felt safer and that a more structured approach had improved relationships with the patients.
- There were good governance structures for incident reporting and evidence of staff learning from incidents.

Summary of findings

Contents

Requires improvement

Nelson House

Services we looked at

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

Summary of this inspection

Background to Nelson House

Nelson House is a purpose built 32-bedded hospital that provides assessment and treatment for men and women within a locked rehabilitation setting. The patients have severe and enduring mental health problems, including schizophrenia and personality disorders. There are two 14-bedded wards (Trafalgar for men, Victory for women). The service has four bedrooms on the ground floor which it is planning to use as a pre-discharge unit once changes have been made to the environment. Patients who struggle within the ward environments were able to use the bedrooms on the ground floor at the time of inspection.

Partnerships in Care took over the service in July 2015. In order to ensure the hospital met Partnerships in Care standards it created a transformation team.

The last inspection by CQC was in October 2014 when we judged it compliant with the Health and Social Care Act 2008.

This was the first comprehensive inspection of Nelson House since the change of ownership.

Our inspection team

The team that inspected Nelson House comprised of Colin Jarratt (Inspection Lead) an Inspection Manager, a further inspector and a Mental Health Act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit the inspection team:

- spoke with 18 members of staff including: managers, nursing staff, a psychologist, an occupational therapist, a psychiatrist, a social worker and other hospital workers
- spoke with one carer of a patient
- spoke to seven patients and reviewed five comment cards left by patients
- attended a therapy group
- arranged one staff focus group
- attended two multidisciplinary team meetings
- reviewed a number of the organisation's policies, procedures and other documentation
- reviewed seven care records

Summary of this inspection

- looked at the environment in which the provider was delivering services.

What people who use the service say

We spoke with seven patients at Nelson House. They had mixed opinions about the care they received. They were positive about the new group and therapy programme that had started on the week of the inspection. They did not like the recent restrictions put in place around their smoking and leave but understood why some of the restrictions were in place. We spoke with one family member who was positive about the care provided by Nelson House. They stated that there was good communication and that they received invitations to attend meetings and reviews.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The audit of hospital ligature points (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) was incomplete although there were few ligature points due to the hospitals modern design; staff were not consistently following the management plans for specific ligature risks identified.
- Staff had not used a recognised risk assessment tool to identify and manage risk.
- There was one emergency bag and defibrillator in the hospital, kept in the clinic room on the ground floor; staff working on the wards had to run down flights of stairs or use the lift to collect the bag in an emergency.
- To manage concerns around security and safety the hospital had put in place a number of blanket rules that did not always take into account individual patients' needs. The provider planned to review this now there was a stronger focus on safety and security.
- Staff had not calibrated or cleaned equipment in the clinic room; electrical equipment in the hospital had not been subject to safety testing in the previous 12 months.
- Fifty per cent of staff had completed mandatory training; however, the provider's target was 85%.

However:

- Managers and staff met every morning to discuss risks and incidents on the ward; there was a clear system of governance regarding incidents and evidence of lessons learnt leading to changes in practice.
- Staff received training in verbal de-escalation to reduce the need for physical restraint when dealing with violence or aggression.
- There were robust medication management processes in place.
- Staffing levels changed dependant on the risk and needs of the patients. Regular agency staff acted as named nurses for patients to ensure consistency of care.
- The hospital had design features to keep the patients safe. There were alarm buttons at floor level in bathrooms in case a patient had a fall.

Summary of this inspection

Are services effective?

Inadequate

We rated effective as inadequate because:

- The change over to a new computerised system for patient care records had caused some difficulties leading to important patient information being lost or not recorded.
- Care plans we examined were not always personalised and did not capture the patient's views.
- Care plan goals were not linked to assessment tools the service used that measured patient improvement.
- Clinical staff had not received regular one to one clinical supervision or annual appraisals; however, managers had developed a new supervision structure and allocated responsibility for completion of staff appraisals.
- Care coordinators had raised concerns about the effectiveness of the service, citing the lack of meaningful activity available. The provider had recognised this and commenced an activity programme on the week of the inspection.
- Lack of permanent occupational therapy staff meant they were not able to be involved in individualised patient care or assessments.

However:

- The provider had introduced an activity programme on the week of the inspection and patients were positive about this.
- The service provided a wide range of psychological therapies including group and individual sessions.
- There were good relations with the local GP who provided physical healthcare.
- Staff management and performance issues identified following incidents were dealt with promptly and appropriately.
- Staff demonstrated knowledge of the Mental Capacity Act and how they supported patients to make their own decisions including how to manage their dietary intake.

Are services caring?

Good

We rated caring as good because:

- Interactions we saw between staff and patients were always respectful.
- We saw staff taking time to discuss issues with patients; this enabled the patient to make an informed choice about how to proceed.
- Staff displayed detailed knowledge of patients' individual needs and history.

Summary of this inspection

- Patients attended ward rounds and were able to make requests. Changes to care plans were made with the patient present.
- Staff respected patient confidentiality
- An advocacy service was available for patients.
- There were regular community meetings.

However:

- Staff had not considered the effect on a patient's dignity when providing one-to-one support near a busy communal area.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patients who used the bedrooms on the ground floor as they could not cope in the wards upstairs had more restrictions than those on the main wards. However the provider was going to review these as part of a review of their service when they opened a pre-discharge unit on the ground floor.
- Access to open space and fresh air in the hospital garden was restricted and only happened during smoking breaks. The provider planned to review this now there was a stronger focus on safety and security.
- Patients without a personal mobile phone were not able to make a private telephone call.
- Complaints regarding cold water in patients' showers had not been responded to even though ward staff confirmed they were aware of the issue.
- There were limited facilities for children visiting patients in the hospital as there was no dedicated visitors room.

However:

- Bedrooms were furnished to a high standard and could be personalised.
- Food was of good quality and tailored to patient requirements by a chef who supported them to make healthy choices.
- The service supported patients to practice their faith, either at places of worship in the community or by arranging visitors to the ward.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Clinical staff had not received regular clinical supervision, completion of mandatory training was poor and staff generally had not received annual appraisals.

Summary of this inspection

- The provider had created procedures to support staff but these were not fully in place at the time of inspection.

However:

- Managers had created a comprehensive action plan that identified issues that they needed to address and set target dates for completion.
- Staff reported that morale had improved following changes implemented by Partnerships in Care; they felt safer and that the service had improved.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The inspection of Nelson House included a formal Mental Health Act monitoring visit.

Nelson House had a dedicated Mental Health Act (MHA) administrator who had access to administrative support and legal advice on implementation of the MHA and its Code of Practice from within the organisation.

Correct completion and appropriate storage of legal paperwork was the sole responsibility of the administrator. Clinical staff were not involved in this.

There was evidence that patients were prescribed medication under Section 58 of the MHA. T2 forms were in place as per section 58 (3) (a) of the MHA as a certificate of consent to treatment. T3 forms were in place as per section 58 (3) b of the MHA where a certificate from a second opinion doctor is required. These were kept with the patients' drug charts apart from in two cases.

Staff attempted to read patients their rights monthly and this was recorded in their notes.

Information was available to patients as to how access an Independent Mental Health Advocacy (IMHA) service. An IMHA visited the hospital once a week.

Mental Capacity Act and Deprivation of Liberty Safeguards

Clinicians clearly considered mental capacity when making decisions regarding treatment options for patients. Staff advised us that when considering capacity they started with a presumption of capacity and then consider if the patients could retain the information to make an informed choice. Staff would offer information in an appropriate way and change the approach if needed.

We saw detailed discussions regarding a patient's ability to make decisions that was then carefully discussed with them. The staff also discussed working with outside agencies whose view of a patient's capacity might be different.

A company policy was in place regarding the Mental Capacity Act (MCA). This gave clear guidance regarding the Act and Deprivation of Liberty Safeguards (DoLS).

Partnerships in Care had included training in the MCA as part of the corporate induction package.

All patients were detained under the Mental Health Act so there were no DoLS authorisations in place at the time of inspection.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- The management of ligature risks on the ward was inconsistent. Managers had reviewed the ligature point (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) audit in December 2015 and identified the majority of risks. There were very few ligature risks due to the modern design; however the bathrooms were not fitted with ligature proof taps. The reduction of other risks was inconsistent. For example, staff removed a curtain rail in the female lounge, but an identical rail in the male lounge was still in place. In the female lounge, there was a variety of equipment to help with relaxation. This included strings of fairy lights and fibre optics, all with electrical wires. There was no log of the equipment so staff were unable to check if anything was missing. The managers had marked the majority of actions to reduce known risks as "to be locally managed". However, staff were not aware of the risk assessment or the management plans. Staff were meant to lock the bathroom and laundry when not in use. During our inspection these rooms were unlocked.
- There were blind spots in the corridors, so staff could not see the entrance to all the bedrooms from the nurse's station.
- All bedrooms were en-suite and there were separate male and female wards that ensured compliance with same sex guidance.
- The clinic room was on the ground floor. It was clean and tidy and appropriately equipped except there was no examination couch. Staff said this was on order. Staff had not calibrated or serviced the equipment in the clinic. There was an emergency bag and defibrillator kept in the room. We were concerned that these were the only ones in the hospital. Staff on the second floor ward had to use the lift or go down several flights of stairs to retrieve them in an emergency. Managers had introduced checks of the emergency equipment and other items in the clinic room in December 2015.
- The hospital was clean with designated cleaning staff.
- Electrical equipment had not been safety tested in the hospital. The new provider had identified this as a concern. The unit maintenance worker was due to receive training to conduct the tests.
- There was a personal alarm system for staff. Patients had call alarms in their rooms, including call alarms at floor level in the en-suite bathrooms in case of falls.

Safe staffing

- The establishment number for qualified nurses at the time of inspection was eight. Only two qualified staff were in post. Agency staff filled the remaining qualified staff vacancies. Managers and other staff told us that they block booked regular agency nurses to fill the available shifts. This helped ensure consistency in the care provided. They also acted as named nurses for allocated patients. The established figure for support workers was 17 and there were two vacancies.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The provider had calculated the number of staff needed per shift. This fluctuated depending on the number of patients admitted to the hospital. The hospital had a matrix that they used to calculate how many staff were required depending on patient levels. Rotas showed that staff numbers increased to meet clinical need. Managers discussed concerns with ward staff during morning meetings and staffing levels changed accordingly. Managers could authorise extra staff out of hours if required.
- During the previous three months, there were ten shifts where staffing levels were short of one member of staff. Four of those shifts were short of a qualified nurse on one of the wards. However, there was always a qualified nurse within the hospital. As there was only one qualified member of staff on each ward, they were not always in the communal areas.
- Patients had a weekly one-to-one session with a named member of staff. Records and talking to staff and patients indicated that this was happening.
- Patients made leave requests during a daily meeting. Extra staff worked when there were a high number of leaves requested. Staff prioritised appointments and assessments.
- Sixty per cent of staff had attended training for management of violence and aggression. The hospital target was 85%. Staff from other Partnerships in Care units would assist during situations that required restraint if necessary. Staff reported that this had happened on one occasion.
- A consultant psychiatrist was available for consultations and advice during working hours. Doctors from local Partnerships in Care hospitals shared the out-of-hours rota to provide medical cover. The regional medical director was also available for support. A doctor could be at the unit within half an hour, 24 hours a day.
- The completion of mandatory training until November 2015 had been minimal. At the time of inspection, two groups of staff had undertaken the corporate induction programme. Only four subjects had completion rates of above 50%, safeguarding, security, conflict resolution and management of violence and aggression. The provider target was 85%
- There was no purpose built facilities to manage aggressive patients. If a patient became too unwell to care for safely, staff transferred them to a psychiatric intensive care unit.
- In the previous six months, there had been four episodes of restraint. Three were supine restraint (where the patient is on their back). One was in a prone position (where the patient was on their front).
- We examined seven patient care records. Patients had risk assessment care plans in place. However, the nurses had not consistently written them based on the recognised risk assessment tools the service used. In the seven notes we examined one had a formal risk assessment in place. Staff had not received training to complete the risk assessments.
- A number of blanket restrictions (rules applied to all patients rather than based on the individual's needs or circumstances) existed to manage and reduce risks. This was in response to specific issues around security, patient safety and possible exploitation of vulnerable patients by others. Access to open space and locked areas of the hospital was restricted and staff were responsible for patients' tobacco. Garden access and unescorted leave had been restricted following problems involving legal highs, including patients collapsing. Patients could only access the garden at set times whilst escorted by two staff members. Patients reported that they had been able to use unescorted leave more frequently before the changes. When patients were going for scheduled fresh air/smoking breaks staff distributed their tobacco from a locked trolley.
- Managers advised us that the security of the hospital and structures in place to manage it were more robust than when Partnerships in Care (PIC) took over. They stated that the stability this provided, along with a new permanent consultant, meant they were in a position to review the blanket restrictions. However, no date had been set for this review.
- Four levels of observation were available to staff to maintain patient safety and the security of the hospital. They ranged from hourly checks to having a member of staff with a patient constantly. There was a search policy in place. Staff searched patients after they returned from

Assessing and managing risk to patients and staff

unescorted leave or leave with family members. This included a "pat down" search of the patient's body (avoiding intimate areas) and a search of their belongings.

- Staff received training in verbal de-escalation, an approach to defusing or talking down a volatile situation. Company policy was that staff used verbal de-escalation before using management of violence and aggression (MVA) techniques requiring physical interventions. Records indicated that this had been the case.
- There was a policy for the use of rapid tranquilisation (the use of medication to calm/lightly sedate the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression). The policy included each medication's maximum dose and the physical health monitoring that must occur afterwards. The policy covered medication given orally or by injection.
- Safeguarding training was not up to date. Managers were ensuring that all staff completed the Partnerships in Care mandatory training programme to rectify this. Staff we spoke with were able to identify issues that they would report as safeguarding; this included physical and verbal abuse, exploitation or neglect. Staff explained how and to whom they would report safeguarding issues. The hospital social worker was the point of contact for local safeguarding teams. Staff discussed any potential safeguarding concerns they had with them. The multi-disciplinary team would discuss incidents or situations where there may be safeguarding concerns that were not immediately clear. Expectations were that staff would report all incidents of physical contact between patients with the victim given the opportunity to contact the police.
- There were good medicine management practices in place. We checked twelve medication charts. The responsible clinician had reviewed the charts. All prescriptions were correct. Nurses had signed for administration of medication. There had been no recent administration of medication for rapid tranquilisation. A local pharmacist had started doing monthly audits. Nurses were responsible for completing weekly medication audits. The clinic was tidy but there were storage issues as all patients were receiving individually named medication. The pharmacist and senior nurse had created an action plan to address this. The plan included moving to stock medication to reduce the amount stored on site. The clinic room was on the ground floor and patients had to come down from the wards at medication times.

Track record on safety

- Nelson House reported three serious incidents in the previous 12 months. One involved a patient on patient assault. The other two involved patients collapsing after using legal highs. We saw clear evidence that staff had learnt from these incidents. Managers made changes to the hospital environment and policies to improve security and prevent the reoccurrence of incidents involving legal highs. Contingency plans were in place to move patients to a more secure environment if their mental state deteriorated and they needed higher levels of care.

Reporting incidents and learning from when things go wrong

- Staff demonstrated they understood how to report incidents. Staff stated that the incident reporting system was changing from paper to computerised records. They were positive about this change as they would be able to record more information about incidents.
- Staff were reporting a wide range of incidents, forms we saw demonstrated this. However, the information collection was inconsistent with fluctuations in the amount and quality of data provided.
- Staff demonstrated knowledge of the principles of the duty of candour. They recognised the need to be open and honest with people who used the service and their carers (where appropriate) when things went wrong.
- There was a clear governance structure around the management of incidents. The nurse responsible for management of risk would sign off the incident forms. Staff discussed incidents during the hospital management meeting that occurred every morning. Managers would discuss incidents with wider implications at the regional governance meetings. Staff would discuss lessons learnt from these incidents at staff meetings and would receive information in an email to their personal account.
- There was evidence of change within the service after incidents occurred. There had been a change in the

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

management of security and risk following incidents involving consumption and distribution of legal highs. An example of this was the installation of privacy fencing to prevent passers-by from giving patients illicit substances.

- After serious incidents, staff and patients were debriefed. We saw evidence of this documented on incident form

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We looked at seven care records and noted that staff completed physical health observations on admission. The service completed the Malnutrition Universal Screening Tool (MUST) assessment tool (to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese). It included management guidelines, which staff used to develop a care plan. The screening tool advised staff to complete it weekly for each patient but the service was completing the tool monthly. Therefore, the service may not identify when a patient needs in this area increase.
- Staff were not always able to access the information they needed and information was not always stored securely One completed assessment recommended that the staff recorded the patient's food and fluid intake. There was limited information about the patient's food and fluid intake in the daily notes. Staff told us this was because they were completing a paper food and fluid chart. Staff were unable to find this chart. They told us that all recording should be on the electronic care record, but staff continued to use paper records, as they had not completed their training. Staff had not reviewed the patient's MUST assessment for three weeks, their score recommended weekly reviews.
- One care record identified that a patient required to be cared for in a sterile environment. There was no record of the discussions about why this was the best option; any considered alternatives, why it should continue or when it would be appropriate for this intervention to finish.
- We examined twelve care plans. The care plans we examined were not personalised and did not effectively record the patients' views. They did not contain appropriate information needed to provide care to the patient. We saw discrepancies between care plans and recording sheets. For example, two care plans advised staff to record physical observations monthly but the recording sheet advised staff to record it weekly. A care plan for dealing with inappropriate behaviour did not identify what this behaviour was or how staff should respond.
- Staff reported that having three forms of patient record (one paper file, the previous computerised record and the new care notes system) caused confusion at times. Staff highlighted problems in ensuring consistency across all the records. This meant staff could miss important information. Staff kept all computer records and files in locked offices. Staff were receiving training to use the new care notes system. Staff told us there were issues getting agency staff access to the system to make entries in the patients' care records.

Best practice in treatment and care

- The responsible clinician advised us that they followed National Institute for Health and Care Excellence (NICE) guidance in relation to antipsychotic medication. This guidance for clinicians included the monitoring of doses, avoiding prescription of multiple antipsychotic medication, clozapine and lithium. Staff told us that if prescribing outside of this guidance was required a second opinion appointed doctor would need to approve this.
- The service offered a range of psychological therapies including cognitive behaviour therapy, acceptance and commitment therapy and mindfulness. The service ran group psychology sessions, individual work and drop in sessions. Staff told us they tailor therapy sessions to meet the needs of the people attending the groups. The service was providing input around drugs and alcohol and anger management at the time of our visit.
- We observed the first session of a therapy group. The session allowed patients to identify the name of the

group, set their own rules and to adjust starting times to meet the needs of the patients wishing to attend. Staff told us groups were informal and gently encouraged patients to engage as they found this approach was more successful. Recovery support workers attended the group and engaged appropriately with the patients.

- There was a close working relationship between the hospital and the local GP surgery for patients to receive physical care there. Patients were being taken there for routine blood tests and other physical health interventions and testing. The consultant psychiatrist checked patients' results.
- The clinical team used encouragement and positive reinforcement on self-esteem to work with patients to improve their nutritional intake. They used a variety of care plans and approaches, including the unit's chef speaking with the patients. They had enabled one patient to reduce the number of takeaways they ate to reduce from daily to two or three a week. Staff wanted to support the patient to reduce it further.
- We did not see evidence of care plan goals agreed or measured by assessment tools the service used that can measure patient outcomes. The service used health of the nation outcome scores (HONOS) and the recovery star (a key-working tool that enables staff to support individuals they worked with to understand their recovery and plot their progress. As an outcomes tool it enables organisations to measure and assess the effectiveness of the services they deliver). Psychology also used individual psychology measures to plot patients' progress.
- Staff completed clinical audits regarding medication administration and management. There was also an audit by the mental health act administrator of paperwork relevant to the mental health act.

Skilled staff to deliver care

- There was a range of disciplines within the staff team. The team included occupational therapists, a psychologist, a social worker, a consultant psychiatrist and nursing staff.
- Occupational therapy (OT) staff worked with the team to help them provide activities for patients. The therapists were not permanent hospital staff. They were working on a locum basis or were coming in from other PIC units. Plans were in place to employ at least one permanent occupational therapist at the hospital. Once permanent OT staff were in post, the intention was for them to be involved in the assessment of patients and work on a one-to-one basis with them. This would enable them to work with the service users to develop skills they would need for entering the community. Staff had supported a patient to start volunteering at a local nursing home and wanted to support more patients to access opportunities like this. A recovery support worker had expressed an interest in changing roles and was working as an activity coordinator to support the occupational therapists.
- A permanent psychologist worked in the hospital and had agreed to increase their hours from February 2016. This would ensure more access to psychology input for the patients. A social worker was in place that assisted patients with issues such as benefits. They also acted as a point of contact for care coordinators in the community. The social worker contacted patients' families if any problems arose. Staff told us that if other services were needed for patient care that they would be able to refer to outside agencies.
- Hospital managers told us that they were in the process of ensuring that all staff had completed the PIC induction programme that included mandatory training. Two groups of staff had attended this training prior to the inspection. Managers planned to review support worker competencies in January 2016. This would identify any training needs. The managers stated that mandatory training rates before the new programme were not acceptable. Managers had placed mandatory training on their action plan.
- Staff members confirmed that staff meetings occurred regularly. They were on hold whilst the new hospital manager settled into post. They occurred monthly and the last one had been in December.
- Management confirmed that there had been a poor culture of supervision within the hospital. The supervision log showed no one- to- one supervision had occurred since May 2015. The majority of staff had received no supervision since 2013. We found supervision records dated after May 2015. These records were of poor quality and did not relate to the majority of staff. Two senior nurses in the transformation team were due to take over clinical supervision from January 2016.

This followed the departure of the previous hospital manager in December 2015. Staff showed us the new clinical supervision structure that included regular agency staff. The new hospital manager would provide management supervision.

- There had been no appraisals completed for staff within the hospital. PIC policy was that these should occur annually. The new hospital manager was due to address this issue as part of the hospital improvement plan that we saw. A date for completion of all staff appraisals had been set for end of February 2016
- We saw evidence of prompt and effective management of staff performance issues. Interventions used were dependant on the nature and seriousness of the problem identified or the incident reported. Managers had access to a corporate human resources department for advice and guidance around personnel issues.

Multi-disciplinary and inter-agency team work

- The hospital had a daily handover meeting attended by senior staff. This included the hospital manager, senior nurses, psychiatrist, social worker, psychologist and security. The meeting followed a set agenda that included a general discussion of patients including observation reviews and incidents. Staffing levels, section 17 leave, new admissions, security issues and visitors to the unit were also included. There were good interactions between the senior team interspersed with humour. The team took appropriate action to resolve issues raised during the meeting.
- The format of the ward round meeting had changed following the permanent appointment of the consultant psychiatrist. The psychiatrist had previously worked at the hospital part time before accepting the permanent position. The psychiatrist built a consensus with the clinicians and social worker to agree how the meeting would work. This was to ensure they met the aims of a rehabilitation service including clear goal setting and focus on outcomes for patients. Other members of the multidisciplinary team commented that it was refreshing that the consultant valued their disciplines. Staff felt there was now stability following four different registered clinicians in a short period.
- The multi-disciplinary team held a clinical discussion followed by the patient being invited in for a further discussion. The team worked well together in identifying needs and agreeing possible actions that they then discussed with the patient.
- The social worker at the hospital ensured there was regular contact with care coordinators. Discussion with a number of them confirmed this. There were inconsistencies in how effective the care coordinators felt the relationship was. Two described concerns that the hospital did not seem to know what type of service it was delivering. They described a lack of meaningful activity for their service users and that plans agreed during meetings had not being acted on.
- The social worker confirmed there was a good working relationship with the local safeguarding teams. They were keen to make contact with a specific liaison person rather than using a central reporting line. They felt that this would make the safeguarding process more effective.

Adherence to the MHA and the MHA Code of Practice

- Twenty eight per cent of staff had received training about the mental health act as part of their mandatory training. More staff were due to complete this training in February 2016.
- All patients were receiving medication covered by a current certificate of consent to treatment (T2) or certificate from a second opinion doctor (T3). We found these certificates were not with the medical charts in two cases. Second opinion appointed doctors (SOAD) had reviewed all patients at some point, although in some case this was prior to their admission to Nelson House. The responsible clinician had been undertaking reviews of treatment and reporting these to the CQC according to Section 61 of the MHA.
- We saw records of attempts staff made to discuss rights under section 132 with every patient on a monthly basis. This reflected that staff made patients aware of their rights as a matter of routine. We saw no evidence that staff discussed rights with patients at other points in their admission. For example, when their section was renewed as directed by the code of practice.
- The Mental Health Act (MHA) administrator ensured detention paperwork was completed correctly, up to

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

date and stored appropriately. The administrator received legal advice and administrative support from within the organisation. The administrator undertook regular audits of detention paperwork. There was no evidence of sharing the results of these audits with the clinical team. Clinicians did not check the MHA paperwork and were at risk of giving treatment not covered by the Act. Staff told us that patients had access to an independent mental health advocate (IMHA). They visited the ward once a week and there were posters on the wall showing information on how to access this service.

Good practice in applying the MCA

- The clinical team considered capacity carefully with no blanket assessment of an individual's ability. Whilst discussing an individual's care there was lots of discussion about their strengths. Staff felt that the patient would not have the ability to make appropriate decisions regarding their food intake or understand the link to their illness. There was detailed discussion as to how to work with the patient on this. Staff then carefully addressed the issues with the patient. The team also discussed how to work with outside agencies that had a different view of patients' level of capacity than they did.
- A company policy was in place regarding the Mental Capacity Act (MCA). This gave clear guidance regarding the act and Deprivation of Liberty Safeguards (DoLS)
- Staff told us that the service had provided MCA training on an ad hoc basis. The service wanted the training to be case specific, so staff got a good understanding of how the MCA affects the patient's care. There was also a more structured training programme put in place by the new provider which covered MCA. At the time of inspection, 28% of staff had completed this training.
- Staff told us that when considering the patients mental capacity they started with a presumption of capacity and then considered if they could retain the information and use it to make a choice. The staff would offer information in an appropriate way to the patient and change the approach if needed.

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

Good

Kindness, dignity, respect and support

- In all interactions with patients, there was clear respect with staff using positive reinforcement. Staff maintained this with patients who were mentally unwell. Staff interactions enabled these patients to express themselves.
- When a patient requested an increase in the level of a fizzy, sugary drink they could have, the clinical team considered the request. They discussed with the patient the benefits to their health that the patient had observed since reducing their intake of fizzy drinks. This approach led to the patient agreeing that the increase would not be good for them.
- Staff displayed detailed knowledge of individual patients' needs and history. This informed their practice and approach to individuals.
- Patient views of staff varied. Most felt that the staff treated them politely and with respect and cared about them and their wellbeing. Others felt that the staff were not interested in them, one confirmed that staff used to show them their care plans but they did not anymore.
- Staff respected patient's confidentiality. In the ward round, the consultant psychiatrist asked each patient whether he or she would allow our inspector to observe.
- At the time of inspection, one patient was receiving one-to- one care with a member of staff observing them at all times. The patient was in a room adjacent to the main communal area outside of the nursing office. Other patients were able to see into their room which compromised their privacy and dignity. Ward staff had not recognised that this was an issue. We brought this to the attention of the hospital manager and they arranged for the patient to move to a more suitable room.

The involvement of people in the care they receive

- Patients attended ward rounds if they wished to. They discussed their care and were able to make requests for changes to their care plans or treatment. Staff fed back their clinical discussions and recommendations and agreed with the patient changes to their care plans. Staff

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

then amended the care plans, with the patient present, on the electronic record system using a big screen in the meeting room. The patients told us that they did not normally get copies of their care plans.

- Patients requested leave during the morning meeting on the ward. We had concerns about patients discussing their needs in a public meeting rather than in private
- An advocate attended the hospital once a week to hold a surgery where patients could discuss concerns. Posters about this service were on the walls in the ward.
- Family members could be involved in the patients care if the patients gave consent. The relative we spoke with confirmed that they received updates from the hospital. They received invites to meetings but could not always attend.
- Regular community meetings had occurred for patients where staff kept them informed of changes. Patients gave feedback at these meetings. However there was no evidence of staff acting on concerns raised during the last three meetings.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- The average bed occupancy since July had been 53 %. To allow quality improvement changes to become embedded the provider had decided to restrict new admissions. At the time of the inspection, there was no clear procedure for management of admissions. However, discussion in the ward round showed the clinical team were working together to develop an admission pathway. This was to ensure a coordinated clinical team approach to the assessment and admission of new patients. Managers confirmed that they had recently declined to admit patients they did not feel were suitable.
- Staff advised us that patient discharge would only occur following discussions with care coordinators. They would work together, along with the patient to identify an appropriate care pathway. This meant patient discharge would occur at appropriate times in the day.
- Staff advised us of a situation where a patient had been transferred to a psychiatric intensive care unit due to a deterioration in their mental state. Partnerships in Care had facilities available so were able to manage them within the company structure. This may not always be close enough to relatives so that they could visit the patient.
- There were records of one delayed discharge at the service. Funding had been in place for some time but there was a difference of opinion in how to proceed. The medical and nursing team were working to promote discharge but felt that the patient needed more time. A plan including input from occupational therapy staff to prepare the patient with skills they would need in the community was in place.

The facilities promote recovery, comfort and dignity and confidentiality

- Patients who were unable to cope with a ward environment used the bedrooms on the ground floor. These were comfortable and well-furnished. Staff kept the lounge locked. Its main use was for groups and activities. It was cold and the furnishings were not as comfortable as the wards upstairs. Staff also locked the kitchen. It was fully equipped and occupational therapy staff used it to do assessments and for patients to cook. The patients on the ground floor had to access the male ward on the second floor to make hot drinks or sit in comfort. The service planned to review the restrictions on the patients on the ground floor when it opened as a pre-discharge unit after changes had been made to the environment.
- The garden area was small and poorly designed. It had a very small bit of patio with a smoking shed and a strip of land between the building and the fence next to a main road. There was nowhere for patients to sit if they were not smoking. Access to the garden was restricted and patients and staff viewed it as limited to smoking times only. Managers confirmed that patients could access the garden at other times if they requested. This was not explicitly stated anywhere on the wards. There were a

large number of cigarette butts and signs saying "garden not a toilet or a dump: no urinating, no spitting" with accompanying graphics. Staff removed these immediately when inspectors raised this with them. There was another, more pleasant garden area to the side accessed through the locked Mary Rose lounge, which patients did not use.

- An activity programme had only started in the last week as part of the process of improvement. Before this, there was very little organised activity. The head occupational therapist (OT) from another PIC unit had created the new programme. Staff asked patients for ideas as to what they wished to do. The OT staff were able to provide activities on four days a week. Training was available to interested recovery support workers so they could facilitate additional groups and activities. The head OT was clear that this was going to be a fluid process to give it the best chance of succeeding. She recognised that they needed to keep the patients engaged if they were going to keep doing activities. She described a process of constant review of which groups worked and which did not so they could give the patients what they wanted. She planned to employ at least one permanent OT so there would always be therapy staff available. Her aim was to put in place a comprehensive activities programme such as the one at her own hospital base. This would provide activities seven days a week.
- We saw patients encouraged to take some responsibility. When a patient asked to go the cinema to see a popular film staff agreed with them that they should speak to other patients to see if they would like to go too.
- The hospital clinic was on the ground floor and all patients had to go there for medication. Staff and patients had identified concerns regarding confidentiality due to having so many people there at one time. To resolve this, managers had ordered a drugs trolley to take medication to the wards for administering, with stock drugs to remain in the clinic. The trolley had arrived on the day of inspection so this process had not yet started.
- Water temperature in patient's bedrooms was variable. On one side of the building it was lukewarm and, sometimes, cold in the sinks and the shower. Senior staff were not aware of this. Patients confirmed that they had been raising it as a complaint for some time. We found no record of this complaint, but support workers confirmed patients had raised it as an issue on a number of occasions.
- There were care plans in place for patients to access their mobile phones dependent on their mental state. There was no dedicated patient phone, but staff would facilitate calls in the occupational therapy office. However due to this containing confidential materials, staff always supervised the calls meaning patients never had privacy.
- The service did not have a separate visiting area. Visits occurred in either the formal boardroom or the lounge area on Mary Rose. There were no activities or toys available for visiting children to interact with their relatives. Staff said they encouraged family visits to take place in the community where possible.
- Bedrooms were of a high standard with a double bed and fitted furniture, a TV provided and a safe to secure valuables. Patients were able to personalise their bedrooms and have their own belongings. The hospital search policy stipulated that staff should be able to search a room in 20 minutes. Due to this, patients were limited to how much property they could retain in their room. Excess property was stored in locked rooms on the ward. There was no robust method in place to document and monitor patients' property.
- The hospital had well-furnished and comfortable lounges on both the male and female wards. Kitchenettes were available for making drinks and snacks. However, patients on both wards did not use the lounges preferring to sit in the large open area outside the nurses' station.
- Air conditioning within the building was very loud as was environmental noise from a local factory at times. Staff and patients however said they were used to it and did not notice it until someone brought it to their attention.
- Patients confirmed that the food was of good quality and there was a varied choice. Patients were able to have hot drinks and make snacks when they liked. We saw a good variety of fruit provided in the kitchen areas on the ward. Patients told us that this had only started on the week of the inspection.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Meeting the needs of all people who use the service

- Staff confirmed that the ward areas were accessible to all as they had a lift to all floors. They had received a new hoist on the day of inspection so that they were able to work with people who needed assistance with mobilising.
- All service users within the hospital spoke English. Staff could obtain leaflets in foreign languages from the provider if patients required them. The social worker arranged for a signer or interpreter to be available if a patient needed one. This could be for any occasion, including ward rounds or Mental Health Act tribunals.
- There were information leaflets available on the wards. These included details regarding treatment available, how to complain and how to access advocacy services.
- The chef at the hospital was able to tailor meals to the requirements of the patients. This could be on the grounds of religion, ethnicity or dietary requirements. He also worked in conjunction with staff to support patients to make healthy choices to improve their nutritional intake.
- The service supported patients to practice their faith in local places of worship. Staff confirmed that they encouraged patients to attend services as part of their integration back into the community. Where this was not possible, the hospital would arrange for people to visit the patients to provide spiritual support. Staff gave an example of one patient who had weekly visitors who ran a bible study group. Other patients were able to attend this group if they wished to.

Listening to and learning from concerns and complaints

- The hospital followed the complaints procedure introduced by PIC. We saw evidence of three informal complaints recorded after this policy was in place. Staff followed procedure and dealt with the complaints accordingly. We saw evidence that staff had followed the complaints procedure following a formal complaint from a patient's relative. They had responded within the timeframe and had organised an investigating officer from outside of the hospital.
- There was still some confusion amongst ward based staff about how to manage complaints. Staff were unclear as to how to manage informal complaints. Staff told us that patients could make complaints via the comments boxes if they wanted to remain anonymous. At times patients made comments that staff had not escalated to managers.
- We saw patient information posters on how to complain when we inspected the wards.
- Staff told us that the service provided them with feedback following complaints through staff handover or at team meetings.

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

Requires improvement

Vision and values:

- Hospital staff were able to discuss the company's vision and values in general terms. They indicated that this was a "work in progress" following the recent change in ownership of the hospital. They were very positive about the changes that had occurred since July 2015. The management team were more able to discuss the vision of the organisation and the values this encompasses.
- The team objectives reflected the organisations values. They felt that improvements made since July supported them in providing appropriate care to the patients. They felt empowered by the management team to be able to do this.
- Senior managers from board level had visited the hospital and met with the managers and member of the transformation team to provide support.

Good governance

- Managers had put new governance structures in place. Local governance meetings passed information up to the regional governance meetings giving the provider an overview of the service. They created a comprehensive action plan which identified a large number of areas for improvement and set target dates to address these. They had created new structures to manage staff

supervision, appraisals and mandatory training. These structures were not fully in place at the time of inspection. Plans were for staff to complete more audits to monitor compliance with standards.

- Managers told us that the hospital did not use key performance indicators (KPIs) to monitor the performance of the team at the time of inspection.
- Managers were able to submit items to the Partnerships in Care (PIC) risk register.

Leadership, morale and staff engagement

- When Partnerships in Care took over the hospital it identified that the leadership of the hospital needed to change to ensure improvements could be made. This had taken some time. A new hospital director had commenced in post two days prior to our inspection. She was confident that she had sufficient authority and would receive appropriate support to achieve the outcomes identified on the action plan developed to bring in the new developments.
- The new managers stated that a number of changes had to happen before they increased patient numbers. They were keen to ensure that operational structures in place were robust before this occurred. They stated that they planned to increase patient numbers slowly.
- Sickness rate was 36% of all staff having at least one period of sickness in the period between 16 September 2015 and 15 November 2015 To help manage sickness and absence PIC had introduced a new centralised telephone line for staff to contact if they were unable to attend work. Some staff still contacted the hospital direct to report illness. Managers had sent letters to staff reminding them of the new procedure.
- The hospital offered a number of incentives to encourage qualified nurses to work there. These included paying professional registration fees and offering additional training opportunities.
- There were no reported cases of bullying or harassment.
- Staff were aware of the whistle blowing process. PIC had a confidential telephone number for staff to contact if they had concerns that they could not raise with their line manager.
- Staff reported that since the changes at Nelson House they felt more confident to raise concerns.
- Staff told us that the new provider had come in and challenged existing working practices. Staff told us that the changes had improved the service, risk management was more structured and they felt safer. Patient leave had a greater focus on recovery. They were pleased that more activities were starting to happen and that this would help patients move on. It also meant the patients spent more time in therapy and less time smoking. Staff stated that communication between managers and the wards had improved following the start of the morning meetings. Boundaries and expectations for the patients were now more clear which helped improve concordance with their treatment programmes. Staff were positive about the training they received. More options for training were available and managers allocated them time to complete on line learning.
- Partnerships in Care provided opportunities for leadership development and managers at Nelson House had attended this.
- Staff stated that team working had improved. The multi-disciplinary team had experienced recent changes. This had resulted in improvements in communication. Psychology and occupational therapy staff were supportive of the recovery support workers in the hospital who wanted to take part in groups. Staff were positive about the level of support they both gave and received from the members of the hospital team.
- There were regular team meetings where staff could raise concerns and give feedback regarding services and ideas on how to make improvements to the care they delivered.

Commitment to quality improvement and innovation

- The service is currently not working towards a quality accreditation scheme. However, the action plan has identified the Accreditation in Mental Health Services (AIMS) as a future target.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve the long stay/rehabilitation wards for working age adults:

- The provider must ensure that risk assessments in care records are comprehensive and use a recognised risk assessment tool.
- The provider must ensure that the environment at Nelson House is safe for patients by reviewing the ligature point (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) audit to ensure all risks are documented. Managers must make staff aware of the plans for the management of specific ligature risks and ensure that they follow them.
- The provider must ensure that patients assessed as ready for more independence and on the pre-discharge ward are not subjected to blanket restrictive practices and that their care is person centred to promote recovery.
- The provider must ensure that they undertake a review of blanket restrictions in place for patients on Victory and Trafalgar wards, including access to fresh air and the hospital garden, and make care and risk management patient centred.
- The provider must ensure that records are complete, up-to-date and consistently completed during the transition to the new computerised notes system.
- The provider must ensure there is regular 1-1 clinical supervision and appraisals for staff.
- The provider must ensure that all care plans are personalised and include the patient's views.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve the long stay/rehabilitation wards for working age adults:

- The provider should ensure that emergency equipment and a defibrillator is accessible to all staff without the need to run down flights of steps or use a lift to get them.
- The provider should ensure that patients have the facility to make private phone calls.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person centred care was not being provided to patients in the Mary Rose unit due to the enforcement of blanket restrictive practices contradictory to their recovery pathway. Person centred care was not being provided to patients in Nelson House due to the enforcement of blanket restrictive practices that had not been reviewed. These affected access to tobacco, fresh air and locked areas of the hospital. Person centred care was not being provided to patients in Nelson House due to care plans not being person centred or capturing patients views. This is a breach of regulation 9 (3) (a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were no appropriate arrangements in place to protect patient from the risk of inappropriate care and treatment due to a lack of robust, documented, accurate, individual risk assessments. There were no appropriate arrangements in place to protect patients from harm due to a lack of robust action in implementing a ligature risk assessment and ensuring that staff were aware of management plans to reduce risk.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 12(2)(a)(b) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were not being kept accurately due to staff using three different forms of notes resulting in information being lost, mislaid or not recorded. This is a breach of regulation 17 (2) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive regular clinical supervision or appraisals. This is a breach of regulation 18 (2) (a)