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? | Inadequate |
| Are services effective? | Requires Improvement |
| Are services well-led? | Requires Improvement |

# Summary of findings

## Overall summary

**Long stay or rehabilitation mental health wards for working age adults.**

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 run.

We carried out this focused inspection since the comprehensive inspection in January 2023. We had concerns about the quality and safety of services. There were recurring themes on the safety of patients, and we were concerned there were risks and that serious incidents would occur.

We inspected Nelson House on 3 occasions since CQC introduced the rating approach of services. Nelson House was rated Requires Improvement in Safe on all inspections and in January 2023 we set requirement notices in care plans and risk assessments and medicines. We asked for the action plans to be submitted 14 days from the publication of the final inspection report dated January 2023. However, these were not provided until the visit in August 2023. The emerging oversight from our visits demonstrate continuous themes and slow to improve areas raised during previous inspections.

Following the inspection we issued a Warning Notice under Section 29A of the Health and Social Care Act 2008 due to our concerns that patients were not receiving safe care and treatment under regulations 12 and 17 of the Health and Social Care Act 2008 (regulated activities)

# 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 this service**<br>Our rating of this service stayed the same. We rated it as requires improvement because:<br>• The service was not fully providing safe care. Risks were not always well managed, they were not always identified, and action plans developed on how to remove or reduce them. There were ligature anchor points in bedrooms and communal space which were not identified in the ligature audit.<br>• Care plans were not informed by a comprehensive assessment. Care plans were not recovery-oriented and lacked detail on how staff were to meet the needs identified.<br>• There was a lack of activities and independent living training.<br>• The lack of documented guidance to staff in care plans and Positive Behaviour Support plans created inconsistencies between staff on how they de-escalated or managed situations where patients placed themselves and others at risk of harm.<br>• Governance processes were not effective. Shortfalls were not identified in audits and there were no actions on how standards will be met fully. Staff were not having regular line management supervision and compliance to mandatory training rates was below the target set by the organisation.<br>• Information on how to support patients was not easily accessible and shared with staff. The lack of substantive staff has meant patients' care and treatment was not consistent.<br>**However:**<br>• Although, managers ensured there were enough nursing and medical staff on duty, there were high numbers of agency and bank staff. This meant there was a lack of consistency in the care and treatment delivered. |

# Summary of findings

- There was low use of restrictive interventions. De-escalation was the main method of preventing behaviours that place people and others at risk of harm. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff morale was improving. There were better working relationships with staff.
- Staff engaged in clinical audit to evaluate the quality of care they provided.

# Summary of findings

## Contents

# Summary of this inspection

## Background to Nelson House

Nelson House registered with the Care Quality Commission on the 17th of 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**

Where patients were informal, they had no restriction placed on them and they were able to leave the hospital freely and staff may ask the anticipated time of return. One informal patient said they were able to "come and go as I please."

The complaints procedure was on display around the hospital. Patients commented they were confident to approach staff with concerns which were investigated. We joined the weekly community meetings where patients discussed concerns about leave as a group.

One patient said leave to visit family was granted. Other patients stayed in contact with family and friends by phone.

Patients were positive about staff, and they praised the regular staff.

One patient said there had been a lot of changes in decisions between staff. After reviewing comments from staff, it was evident that there were inconsistencies between staff. Some conditions were made more relaxed by some staff. During our visit a staff member told us a patient's relative was to be told about the possibility of them losing their forward moving placements. It was likely the relative will then discuss with the patient the consequences that led the decision to delay in their discharge.

# Summary of this inspection

Patient said they knew their advocate and the support they had from them. One patient said they were accompanied by their advocate to a multidisciplinary team (MDT) meeting. There was signage on the wards with details on how to contact the advocate that visit the hospital.

Patients said they felt safe at the hospital and staff gave them a feeling of safety. They said staffing had improved.

There were notices informing patients on the restricted items including lighters as there was no smoking at the hospital. There were lockers for patients to store any restricted items which they were given access when they were on leave.

One of the 7 patients we spoke with said there were too many "regulations" and too many rules. They said, "staff are too negative." Staff and patients said that situations were de-escalated, and restrain was minimal.

We observed that all bedrooms were single and en-suite. Some patients agreed for us to enter bedrooms and we saw personal toiletries and they said there was support with personal hygiene and keeping their clothes and bedrooms clean.

While activities were not meaningful and consistently happening across wards for patients, there was a recent group outing, 1 patient was in transition with a phased introduction to supported living and another patient was in full-time education. Comments from patients included "it's a bit boring," "can't do activities." "Go out for a walk," "reading, walking, listening to music and cooking sometimes." Staff also told us planned activities were not taking place consistently. We were told activities were to be reinstated once occupational therapist assistants (OTA) and an activities coordinator were in post.

## How we carried out this inspection

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

During the inspection, we;

Spoke with 7 patients and we attended the patients' community meeting.

Had a 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 4 care records and treatment records.

Interviewed the Hospital Director and Director of Clinical Services and also present was the Managing Director and Quality Improvement Lead

Spoke with 7 nursing staff including support workers and agency staff.

Spoke to the consultant psychiatrist, psychologist, and occupational therapist.

Spoke to the maintenance manager.

# Summary of this inspection

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Areas for improvement

**Action the service MUST take to improve**:

- The service must ensure fire risk assessment action plans are effective and include the risk along with the measures to reduce the risk of fire from patients smoking in bedroom when the service is non-smoking. Regulation 12 (a) and (b)
- Ligature risk assessments must include all anchor points and that actions are taken to ensure that the risk is reduced for patients that self-harm using ligatures. Regulation 12 (a) and (b)
- All risks to patients must be assessed, accurately scored and action plans are to be developed to reduce or remove the risk. Risk assessments for patients cared for under section of the MHA (Mental Health Act) must be completed before granting leave to ensure the conditions have not changed. Regulation 12 (a) and (b)
- The provider must ensure medical gas wall brackets and a medical gas grab bag are available on all wards. Blood sample bottles must be removed where they were not needed or were out of date. Regulation 12 (f) (g)
- The provider must ensure care plans are detailed, linked to risk assessments, recovery focussed and give staff guidance on how to meet the identified needs. Positive Behaviour Support Plans (PBS) must be detailed to list triggers and how staff were to respond to behaviours that placed the individual and others at risk of harm Regulation 12 (a), (b) and Regulation 9
- The provider must ensure governance arrangements are effective and systems and processes are embedded to develop better continuity of care to patients. Audits must identify the gaps in set standards to develop action plans on how to improve standards to ensure patients receive safe care. Regulation 17

**Action the service SHOULD take to improve:**

- The service should improve line management supervision for all staff.
- The service should improve the activities and independent living skills training for patients.
- The service should improve access to information for all staff.
- The service should ensure staff attend mandatory training.
- The provider should ensure the system for disposing medicines was implemented consistently.

# 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** | Inadequate | Requires Improvement | Not inspected | Not inspected | Requires Improvement | Requires Improvement |
| **Overall** | Inadequate | Requires Improvement | Not inspected | Not inspected | Requires Improvement | Requires Improvement |

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

| | |
|---|---|
| Safe | Inadequate |
| Effective | Requires Improvement |
| Well-led | Requires Improvement |

## Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate

**Safe and clean care environments**

**All wards were clean well equipped, well furnished, and well maintained.**

**Safety of the ward layout**

Risk assessments for the hospital were not detailed on the areas of risk or on the measures in place to remove or reduce any risks they identified. Some patients were smoking in bedrooms despite a clear non-smoking ban in the premises. This was a known risk, as evidenced by the risk register, however actions being taken as a result were not evident. The risk register had assessed smoking in bedrooms as high but in the Fire Risk Assessment the risk was medium. The key measures listed in the risk register were missing from the Fire Risk Assessment action plan which included lighters being banned items, performing room searches and the implementation of a smoking cessation programme. Staff were aware of the patients that smoked in bedrooms and during the site visit we noted signs of patients smoking. For example, strong odours of smoking in bedrooms, burn marks on windowsills and cigarette butts outside of windows. Individual risks were not assessed for patients known to smoke in their bedrooms.

Although there were few incidents of self-harm, there was the potential of self-harm by ligatures from new admissions. There were potential ligature anchor points found across all wards and the exterior of the property during the inspection site visit. We reviewed the service's Ligature Risk Assessment (LRA) dated 19 August 2022 because it was in date and the updated version was in progress and in the process of completion.

All possible ligature points in bedrooms and the exterior had not been listed, and the LRA had been completed by a senior recovery support worker and a nurse. For example, the actions to mitigate the risks were documented as "to manage risks" and there was no reference to the plastic corrugated structure in the vape garden and the cable trunking in bedrooms.

The hospital director responded to the concerns we escalated during the inspection and acknowledged there were no actions listed on the ligature audit for this period and there were concerns about the level of scrutiny given to the audit as there were areas missing from the audit. Since the inspection, a new framework will be implemented in August / Sept 2023 to include assurance through a Hospital Director sign-off process to ensure areas are not missed from the audit.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

An Environmental Ligature and Blind Spot Audit action plan 2023 provided since the inspection were for the wards, stair wells and vape garden. However, blind spots were the only identified ligature risks in the Vape Garden and actions were for angled mirrors on poles to be purchased to ensure clear sight of all areas.

Staff could observe patients in all parts of the wards. Mirrors were installed in ward in places where patients could not be observed from a distance. Close circuit television (CCTV) was used for the exterior of the property and patients could be observed when they were in the secure garden.

Staff had easy access to alarms and patients had easy access to nurse call systems.

**Maintenance, cleanliness, and infection control**

Housekeeping staff maintained the ward areas to a good standard and were adequately furnished.

Staff followed the service's infection control policy, including handwashing.

## Clinic room and equipment

Clinic rooms were fully equipped. However, some of blood sample tubes, and pathology sample kits kept in the downstairs clinic were out of date and some medical devices lacked or were past their calibration dates. Therefore, we were not assured that processes were effective in identifying out of date stock or the testing of medical equipmen.

Whilst each ward held a tamper evident emergency grab bag that was checked weekly, medical oxygen was only available on 1 ward of the 2 wards and in the clinical room on the ground floor. A medical gas wall bracket and a medical gas grab bag were only available on 1 ward and the clinical room on the ground floor.

Staff checked, maintained, and cleaned equipment.

**Safe staffing**

**The staffing levels were maintained with permanent, bank and agency staff. There were medical staff vacancies. Some inconsistencies in how staff managed situations were reported.**

**Nursing staff**

Leaders calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The registered manager was able to increase the staffing levels when the acuity on the wards increased.

Staffing levels were maintained with permanent, bank and agency staff. The staffing ratio across both wards were 2 nurses and 4 recovery support workers on each ward. While recruitment of staff was ongoing, there were vacancies across all levels of staff. For example, there was a vacancy for a ward manager working across 2 wards, deputy ward managers for each ward, 10 Full time Equivalent (FTE) nurses and 15 FTE recovery support workers.

Patients' care and treatment was delivered by mainly bank and agency staff. Staff gave feedback that there were high levels of agency staff covering vacant posts. The service has struggled to recruit and retain nursing and medical staff. Exit

interviews were conducted to assess the overall employee experience within the service and to identify opportunities to improve retention. Lack of permanent staff has meant that patients were not having continuity of care. For example, there was a lack of the recovery-focussed model to support patients with independent living skills. Lack of consistent staff has also meant inconsistencies on how staff managed situations.

There were handovers when shifts changed and where key information was to be shared to keep patients safe when handing over their care to others. However, staff told us there were inconsistencies between staff and all information was not always shared. For example, information was not easily accessible, or staff changed the decisions from one shift to another.

Regular bank and agency staff had a comprehensive induction and understood the service before starting their shift.

There were no documented records of escorted leave being cancelled although, the comments from staff indicated that escorted leave was sometimes cancelled and when activities were cancelled due to staff shortages.

**Medical staff**

There were medical staff vacancies. There was a transition period with the consultant psychiatrist and a locum consultant psychiatrist who covered until September when the permanent responsible clinician was in post. The occupational therapist assistant was absent and there was recruitment in progress for an activity's coordinator. We were told for this reason activities were not happening.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. There was a Hampshire rota for Out of Hours and evenings for medical cover.

**Mandatory training**

There was a mandatory training programme for substantive and bank staff. The training target was 95% but only 90% of staff had completed mandatory training which included basic life support, fire safety, safeguarding of adults and children and reducing restrictive intervention breakaway training. Seventy-six per cent of staff had attended all mandatory courses. Staff were reminded when they needed to update their training.

**Assessing and managing risk to patients and staff**

**Patients' individual risk were assessed but action plans were not always detailed or developed when they were identified. Some risks were not identified for action to reduce or remove the risk.**

**Assessment of patient risk**

Patients' individual level of risks was not always identified or actions to reduce them or to give staff detailed guidance on how to manage the risks including the potential of fire. Staff comments indicated that smoking in bedrooms was the highest level of risk. We also noted evidence of patient smoking in bedroom which included cigarette burn marks in windowsills and in one bedroom there was a strong odour of smoking.

Care plans lacked detail on how staff were to manage situations. For example, staff supervision was the only mitigating action for reducing the level of risk for some patients assessed as having violent, aggressive, intimidation and

inappropriate sexual behaviour. During discussion with staff, we were made aware that a specific member of staff was locked in the office when they were alone on the ward. The Hospital Director contradicted this comment and said the office door was closed and within policy. They said the rationale for the female staff using the office was because until they receive Restraint training (RRIT) they were not allowed to work in a ward area.

Care plans and risk assessments were not linked to the Positive Behaviour Support (PBS) plans and on Victory Ward, staff were not aware of where PBS plans were saved on the system. PBS plans reviewed during the inspection lacked detail on how staff were to reduce the likelihood of behaviours escalating and how to support patients to communicate their anxieties without placing others at risk of potential harm. The feedback from staff and from patients was that situations were de-escalated, and restraint was minimal. Staff told us about inconsistencies between staff on how they de-escalated situations which was due to the lack of guidance from care plans and Positive Behaviour Support plans.

The risk of patients on Section 17 leave (permission to leave the hospital) under the Mental Health Act were not fully assessed by a nurse to ensure the conditions of their leave had not changed. Leave authorised by a responsible clinician which should be granted by a nurse were instead being granted by recovery support workers and was being done without first assessing the risk of the detained patient leaving the ward. The recovery support worker told us that this was usual practice. Each episode of leave granted was not always at the discretion of nursing staff and a record of the assessment of risk was not documented which must include a discussion of destination, return time or assessment of mental state that was observed. A recovery support worker signed out a patient and completed the absence form, which included a description of the patient once they had left the ward. There was no documented discussion of destination, a return time or an assessment of mental state that was observed.

**Management of patient risk**

Staff were knowledgeable about patients' individual risks which included smoking in bedrooms, misuse of some substances and behaviours that place the patient and others at risk of harm. The staff were aware on the systems and procedures in place to reduce the risks to each patient. For example, de-escalation, room searches, smoke detectors in bedrooms and sniffer dogs. However, risk assessments lacked guidance on how staff were to manage situations which created inconsistencies between staff with changes in decision making.

Staff followed company policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patient consent was gained before searches of bedrooms took place.

**Use of restrictive interventions**

The lack of guidance to staff created inconsistencies on the de-escalation techniques to use because care plans and positive behaviour support plans lacked guidance to staff. A safety pod was available for staff to support safe patient care during times where de-escalation was considered.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Of all staff, 78% had attended reducing restrictive intervention breakaway training and only 3% of staff were overdue with this training. Staff said they had attended this training before starting work on the ward.

Staff followed National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

**Safeguarding**

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

**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 were knowledgeable on the signs of abuse and the actions they must take when abuse was suspected. Of all staff, 84% had attended safeguarding adults training while 87% had attended safeguarding children from abuse training.

A visitor's room was available on the ground floor where patients were able to meet with friends and families in private away from the ward.

A safeguarding lead was in post and staff knew how to make a safeguarding referral and who to inform if they had concerns.

**Staff access to essential information**

**Access to information was not always easily accessible to all staff.**

Patient information was not easily accessible by all staff. The service used an electronic patient records system, but information was not always easy to find. For example, 1 patient's leave was suspended following an incident the previous day, but the staff were not able to find the information when the patient requested leave. Staff said there were inconsistencies between staff and with decisions reached on patients because of this. Restrictions placed on patients were therefore not always followed by all staff.

**Medicines management**

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

Patients' medicines were regularly reviewed by staff, and they provided advice. Where appropriate, staff encouraged patients to become more independent via a self-administration of medicines programme.

Medicines records were accurate and kept up to date. However, staff had not identified the lack of additional information, when more than 1 'when required' medicine was prescribed to the same condition. The responsible clinician responded to our concerns and updated the 'when required' medicines protocols in line with good practice guidance.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely including controlled drugs and medical gases. Records showed that medicines were stored within their recommended temperatures. Lidded containers for pharmaceutical waste were available to staff but some lacked assembly details or had not been disposed of in a timely manner once full.

The service did not always ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Mental health medicines were prescribed for most patients within the limits described in their Mental Health Act (MHA) documentation kept with the prescription charts. However, for a few patients the doses of a few medicines were greater than described in the MHA documentation. A few patients were prescribed high dose antipsychotic therapy (HDAT); however, information was not available with the prescription charts to monitor the effects of HDAT.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. They reviewed the effects of each patient's medicines on their physical health according to NICE guidance. For example, when clozapine was prescribed bowel monitoring was also prescribed and reviewed on a regular basis.

**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.**

A Management Information System (Datix) was used by staff to gather and manage data on incidents and accidents to identify learning and implement improvement. The staff scored the level of harm and impact within the report, and most were low harm and minor impact.

Debriefs happened following incidents and monthly emails from the registered manager updated staff on learning from incidents. Datix showed the registered manager had investigated 2 incidents of inappropriate sexual behaviour by 2 patients towards one specific female staff.

The service had no never events on any wards.

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

## Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

**Assessment of needs and planning of care**

**Some care plans did not fully meet the needs of patients mental and physical health needs. Staff assessed the physical and mental health of all patients on admission. Care plans were not always reflective of patients' assessed needs or recovery oriented.**

Electronic Care plans were sectioned into Keeping Connected, Keeping Healthy, Keeping Safe and Keeping Well plans. Care plans were not developed where the needs identified did not fit into the 4 headings. Care plans lacked detail, and they were not linked to risk assessments. For example, for patients known to smoke in their bedrooms. Some care plans included conflicting information and lacked a plan of action on how to manage situations or deliver care. The hospital director acknowledged care plans were difficult for new staff and for agency staff to follow and they lacked guidance to staff on how to safely respond or care for patients.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients had their physical health assessed soon after admission. However, some care plans lacked guidance for patients with physical health care needs. For example, staff were to carry out physical health checks daily for a patient at risk of falls. The care plan was not developed on how staff were to support the patient with moving around the ward. Staff were also to monitor the patient's blood pressure weekly but lacked detail on the actions to take when the results were outside the safe range. A registered nurse and doctor were involved with patients' physical health and weekly checks were done by the recovery support workers.

Care plans were not recovery-focussed and lacked guidance on how patients were to gain independent living skills and on activities including discharge plans where appropriate. Positive behaviour care plans (PBS) lacked guidance to staff on how to support patients to communicate their anxieties without placing others at risk of potential harm.

**Best practice in treatment and care**

**Some treatment and care for patients was based on national guidance and best practice. This included access to psychological therapies.**

There were some therapies and activities organised for patients. Patients had access to psychological therapies from a psychologist and a psychology assistant. The service promoted a smoking cessation programme and a substance misuse group following patient meetings. The activities programme was limited while an occupational therapist assistant and activities coordinator was being recruited. Independent living skills training was limited while there were trips organised and a patient was in education.

There was some evidence that staff had delivered care in line with best practice and national guidance. For example, staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Good practice guidance for managing behaviours that placed patients and others at risk of harm and The Mental Health Act Code of practice were not being followed or adhered.

**Skilled staff to deliver care.**

**The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers provided an induction programme for new staff. Supervision was not regular.**

The service had followed recruitment procedures which ensured the suitability of staff they employed. The Hospital Director was alerted in July that an agency member of staff had an unsatisfactory DBS record following a HR audit. On investigation it became apparent that an email indicating their exemplary conduct whilst working at Nelson House had been sent to the agency they were employed by. However this reference was from a colleague and not from a line manager or supervisor. As a result of this, the Hospital Director reviewed the information in the DBS and discussed with the staff member. Following this they were risk assessed as being to eligible to continue working at Nelson House, however this was completed via email and not on an official form, however this was attached as an addition to his agency profile, which is kept on site.

New staff including bank staff had an induction to prepare them for the role when they were employed. Some training was completed before starting work and they worked supernumerary with more experienced staff to meet and gain insight into the needs of the patients.

Most staff said supervision was not regular.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

**Multi-disciplinary (MDT) 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.**

The staff that attended MDT meeting included the responsible clinician, lead nurse, occupational therapist, psychologists, and doctor. Care coordinators, commissioners and community placement agencies attended MDT meetings where there were planned discharges.

MDT meetings were weekly, and patients attended the full or part of the meetings depending on the number of staff at the MDT and the nature of the feedback to be shared. For example, a more sensitive approach was for the responsible clinician to share the delays with ongoing placements.

The registered manager, director of clinical services, medical staff and nurse in charge attended morning meetings. Information about patients, appointments, leave arrangements and support sought from external agencies were discussed at the morning meeting. Handovers were happening when shift changed, and staff shared information about patients and any changes in their care.

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

Patients knew the legal status of their stay. The staff read and explained to patients their Section 132 rights where they were cared under section of the MHA. Copies of patients' detention papers and associated records were stored correctly, and staff could access them when needed.

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 visited the service.

There were posters advising informal patients they were able to leave the hospital at any time.

**Good practice in applying the Mental Capacity Act**

**Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Most staff had attended training in Mental Capacity Act (MCA) and on Deprivations of Liberty Safeguards (DoLS). Staff we spoke with had a good understanding of at least the 5 principles. On review, 12% of MCA training for staff was overdue while 15% of DoLS training was overdue. Staff supported patients to make day to day living decisions such as meals and activities.

Patients consent to share information with health professionals and commissioner was sought and documented.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

## Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

**Leadership**

**Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.**

Patients and staff said the new hospital director and director of clinical services were visible on the wards and were approachable. Staff gave us examples on the benefits of having leaders visit wards daily.

The hospital director described the styles of management used to motivate and direct staff which included being approachable, building trust, having a presence on the wards, and working in collaboration with the team. A respectful manner was used when addressing practices that fell below expectations.

**Culture**

**Staff felt respected, supported, and valued. They said the company promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.**

Morale at the hospital had improved since the appointment of the hospital director and the director of clinical services. The hospital director ensured staff were kept up to date with organisational changes and had organised team building which included wellbeing events. Although there had been improvements, there was a lack of continuity due to the high levels of agency staff and not all structures were effective. For example, communications between staff were not always effective and decisions were changed depending on the staff on duty.

Previous leaders were not organised to support international nurses and since then mentors were assigned to improve the induction programme for future international nurses.

We observed patient-centred culture and how staff engaged with patients. Overall staff responded to tasks and always responded to patients when their attention was sought. Staff interaction was mostly neutral when they were sitting in the same area or passing through. We saw 2 staff members speaking to each other while there were patients sitting in the same area. There were times when staff stood up and without speaking left the area and walked up and down the ward corridor instead of suggesting some form of engagement or activity. There was 1 staff member who spoke to a patient when they entered the area where patients congregating. This member of staff was seen to say to patients “Good Morning. How is your day?” There was a pool table and we saw 2 patients playing pool with staff. We were not present on how this activity was organised.

**Governance**

The governance framework included monthly clinical governance meetings where the risk register was reviewed, and follow-up actions were tracked. Leaders such as the hospital director, director of clinical services, support service manager and locum doctor attended the clinical governance meetings. The minutes showed that at the clinical governance meeting, held in July 2023, patients experience, risk management, clinical effectiveness and continuous improvement was discussed.

Quality Walk Arounds across both wards took place in June 2023 where the notes of 2 patients were reviewed. The findings of the Quality Walk Arounds were inconsistent with the findings of the inspection. For example, identified as not meeting standards included patients' religion were not indicated, management of restricted items documentation and for individual patients their alcohol consumption and a day's entry was missing. The minutes of the Clinical Governance Committee meeting dated 21 August 2023 that happened since the inspection included the actions for meeting the shortfalls identified. However, we found risk assessments were not accurately scored and were missing known risks. Care plans lacked detail and were not linked other positive behaviour care plans where appropriate or risk assessments. They were not recovery-focussed, and medicine systems needed to improve such as out of date blood sample bottles. Since the inspection, the Director of Clinical Services carried out a Quality Walk Around, but the findings related to how documentation was saved on the system rather than the quality of information being recorded.

**Management of risk, issues, and performance**

The level of risk along with the actions to mitigate the risk was inconsistent. Smoking in the building was a high risk, despite being a no-smoking site, and the key measures to reduce the risk included a ban on lighters, room searches and a smoking cessation programme. The environment, lack of a physical health lead and lack of robust security processes were identified as medium risks.

Audits were used to assess processes and systems against standards to improve shortfalls. However, there were shortfalls in the following audits: ligature, care plans, risk assessments, medicine management and fire risk assessment action plans. For example, the ligature audits had not identified anchor points in bedrooms and vape garden, care plans and risk assessments were not linked and there were inconsistencies in implementation; fire risk assessment action plans had identified smoking in bedrooms as a medium risk while the same risk had been assessed as high in the risk register and actions were not shared across both to be acted upon.

**Information management**

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

Site improvement plans were developed to manage current and future performance. Action plans were developed from audits and visits. However, audits had not identified all shortfalls. Managers engaged actively with other local health and social care providers such as commissioners and external agencies that provided supported living arrangements.

The provider shared data securely with the Care Quality Commission and with local authorities in accordance with legislation.

**Engagement**

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

**Managers engaged actively with 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.**

Patients had contact with leaders and their views about the service had not been sought individually, but through community meetings and at MDT meetings. Leaders complimented the staff who delivered care and treatment.

**Learning, continuous improvement and innovation**

Leaders were visible on the wards. The Hospital Director had improved morale of the service, team building, and a recovery-focus model of care was to be introduced based on the concepts of education and support.

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 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• The service must ensure fire risk assessment action plans are effective and include the risk along with the measures to reduce the risk of fire from patients smoking in bedroom when the service is non-smoking. Regulation 12 (a) and (b)<br>• Ligature risk assessments must include all anchor points and the action taken ensure that the risk is reduced for patients that self-harm using ligatures. Regulation 12 (a) and (b)<br>• All risks to patients must be assessed, accurately scored and action plans are to be developed to reduce or remove the risk. Risk assessments for patients cared for under section of the MHA (Mental Health Act) must be completed before granting leave to ensure the conditions have not changed. Regulation 12 (a) and (b)<br>• The provider must ensure medical gas wall brackets and a medical gas grab bag are available on all wards. Blood sample bottles must be removed where they were not needed or were out of date. Regulation 12 (f) (g)<br>• The provider must ensure care plans are detailed, linked to risk assessments, recovery focussed and give staff guidance on how to meet the identified needs. Positive Behaviour Support Plans (PBS) must be detailed to list triggers and how staff were to respond to behaviours that placed the individual and others at risk of harm Regulation 12 (a), (b) and Regulation 9 |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Requirement notices

- The provider must ensure governance arrangements are effective and systems and processes are embedded to develop better continuity of care to patients. Audits must identify the gaps in set standards to develop action plans on how to improve standards to ensure patients receive safe care. Regulation 17

This section is primarily information for the provider

# Enforcement actions

## 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 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• All risks to patients were not always assessed, accurately scored and action plans developed to reduce or remove the risk. Risk assessments for patients cared for under section of the MHA (Mental Health Act) were not completed before granting leave to ensure the conditions had not changed. Regulation 12 (a) and (b)<br>• Ligature risk assessments did not detail all anchor points and the action taken ensure that the risk is reduced for patients that self-harm using ligatures. Regulation 12 (a) and (b) |