Nelson House

Quality Report

14 Rowner Road
Gosport, Hampshire
PO13 0EW
Tel:02392513882
Website: www.priorygroup.com

Date of inspection visit: 17 and 18 July 2018
Date of publication: 24/09/2018

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	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

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 Hospital as good because:

- The staff carried out checks of the hospital to ensure it was safe and the hospital was in a good state of repair. There was a good incident reporting culture and staff learnt from incidents to help prevent them happening again.
- There was a multidisciplinary team working at the hospital and they offered a full therapeutic programme to meet the needs of the patients. The hospital followed National Institute of Health and Care Excellence guidance and completed comprehensive assessments of patients on admission to meet their needs. Staff completed and updated risk assessments for each patient and used these to understand and manage risk.
- The staff understood their responsibilities under both the Mental Health Act and Mental Capacity Act.
- Patients and carers reported that staff treated them with respect and that the care given was good. Staff actively encouraged patients to give feedback to help develop the service. Care focused on increasing independence.
- Patients were involved in discharge planning.
- Staff planned activities based on patients' likes and needs. There were activities both on and off the wards seven days per week.
- The service had an open culture when dealing with complaints.
- Local managerial and clinical leadership was strong. The service used the providers visions and values to plan the future of the service. There were governance structures in place that helped drive improvements.

However:

- The senior management team had not identified that a wide range of blanket restrictions where being used to manage risk to all patients in the hospital. The staff team were using blanket restrictions rather than undertaking individual risk assessments, managing risks in accordance with those risk assessments and only using blanket restriction where absolutely necessary.
- Not all bedroom doors had observation panels that staff could lock to ensure individuals privacy could be maintained.
- The staff did not provide patients with care plans in an easy to understand format. Staff did not agree advanced directives with patients about their care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good 	

Summary of findings

Contents

Good

Location name here

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 independent hospital, operated by the Priory Group, that provides assessment and treatment for men 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 and Victory) and a four-bedded ward (Mary Rose). At our last inspection in 2017, Nelson House Hospital provided services for women but during our inspection in July 18 the provider informed us that going forward it only planned to deliver a service to men. The provider intended Mary Rose ward to be a pre-discharge ward. However, the manager told us patients who did not settle on the main wards could use the bedrooms on Mary Rose ward.

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

Nelson House registered with the Care Quality Commission on the 17th October 2014. The hospital is registered to carry out three regulated activities; (1) assessment or medical treatment for persons detained under the Mental Health Act 1983, (2) Diagnostic and screening procedures and (3) treatment of disease, disorder, or injury.

This was our third inspection of Nelson House. Our last inspection was on the 7 and 8 February 2017,

when we rated Nelson House as requires improvement overall.

We rated the service as requires improvement for safe, effective, responsive and well led and good for caring.

Following the February 2017 inspection, we issued four requirement notices for breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014:

We told the provider it must take the following actions to improve Nelson House:

- The provider must ensure that the environment at Nelson House is safe for patients by reviewing the ligature point 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 have effective systems and processes to assess, monitor and improve the quality and safety of the service. Including appropriate policies, regular audits and systems to monitor progress against plans to improve the quality and safety of services.
- The provider must ensure that regular health and safety risk assessments of the premises (including grounds) and equipment are undertaken. The provider must carry out legionella testing to prevent and ensure that premises and equipment are clean and control the spread of infection. The provider must ensure that equipment is effectively maintained and timely action is taken when improvements are required, such as the temperature of the showers.
- The provider must ensure all staff receive mandatory training, regular 1-1 clinical supervision and appraisals.
- The manager must ensure there is a robust induction and training programme that prepares staff for their role and is updated on a regular basis to ensure they can meet the needs of the patients. Staff competence to do their job should also be assessed both during and following induction and periodically and the manager must ensure all staff are competent to carry out the roles required of them.
- The provider must make sure that medicines are supplied in sufficient quantities, managed safely and

administered appropriately to make sure people are safe.

Overall, during the July 2018 inspection, we concluded that the service had made the required improvements to meet the requirement notices. However, we found that the provider needed to make improvements to ensure patients were not restricted by the use of blanket restrictions for all patients.

Summary of this inspection

Our inspection team

The team comprised three CQC inspectors and one specialist advisor, who was a nurse with experience in long stay/rehabilitation mental health wards for adults of a working age.

Why we carried out this inspection

We inspected this service as part of our ongoing 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 the location.

During the inspection visit, the inspection team:

- visited the two wards open to admission at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with six patients who were using the service;
- spoke with the registered manager and managers for each of the wards;
- spoke with ten other staff members; including doctors, nurses, an occupational therapist and a psychologist;
- attended and observed one multi-disciplinary meetings, one multi-disciplinary handover meeting and team daily flash meeting;
- looked at nine care and treatment records of patients:
- carried out a specific check of the medicine management on two wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with six patients at Nelson House. The overall opinions of patients at Nelson House were positive and they were happy with the care they received. They told us that staff were good at managing any incidents or disagreements on the wards and keeping them safe.

All the patients were positive about the therapy programme on the wards and the activities available.

Patients told us that the food was good and that there was plenty of choice on the menu.

Patients were unhappy about access to the garden on Mary-Rose ward. Patients told us that the environment in the garden was nice but that they did not get to access this often, as staff needed to supervise them.

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 staff team were using blanket restrictions rather than undertaking individual risk assessments, managing risks in accordance with those risk assessments and only using blanket restriction where absolutely necessary.
- The restrictive practices were depriving some patients of their liberties, treating all patients as though they had the same level of risk and were preventing some patients from gaining skills they would need following discharge from the hospital.
- The hospital did not have a programme for reducing restrictive practice an meetings to discuss this had been cancelled.

However:

- There were regular environmental checks to find and address any risks. The environment was clean and in a good state of repair.
- Staff knew what to report as an incident and took action following incidents to keep patients safe.
- Staff followed good hygiene to avoid the spread of infections.

Are services effective?

Good

We rated effective as **good** because:

- All patients received an assessment that covered both mental and physical health needs. There were care plans in place to help patients meet their needs.
- The hospital team followed National Institute of Health and Care Excellence guidance and actively reduced the use of high does and the prescribing of multiple anti-psychotic medicine.
- There was a therapeutic programme available for patients that staff reviewed and updated to meet patients' needs.
- There was a full multi-disciplinary team at the hospital who met daily to review patients' care.
- The staff team had working links with other services and involved families in the patients care.
- The staff team followed the Mental Health Act, made sure patients knew their rights and arranged tribunals and second opinion appointed doctors as needed. Staff audited patients' consent to treatment in the care records.
- Staff received regular supervision and a yearly appraisal.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- Patients reported that staff treated them with respect and were friendly. Carers told us they were involved in meetings, always welcome at the hospital and felt their relatives received good care.
- Staff encouraged patients to give feedback about the service through meetings, suggestion boxes and patient surveys.
- There was a patient forum and a patient representative who attended the hospital's clinical governance meeting.
- Care plans focused on developing independence and staff involved patients in planning their care. Patients could have a copy of their care plan.
- Staff gave patients a welcome pack and a tour of the hospital on admission.

However:

- Staff had not given care plans to patients in a simplified easy to read format.

Are services responsive?

Good

We rated responsive as **good** because:

- Patients could remain in the same bedroom throughout their stay at Nelson House and staff only moved patients for clinical reasons or if the patient wanted to.
- Staff worked together with patients to plan their discharge and patients could decline a placement if they did not think it was right for them.
- There were several rooms and seating areas available to patients on the wards.
- Patients could use their mobile phones to make private calls and the hospital provided a phone to patients that did not have one.
- Patients reported that the food was good.
- There were activities on the ward and in the community seven days per week.
- The staff team were open and honest with patients following complaints and identified learning to improve the service.

However:

- Patients could not access the garden on Mary Rose ward without staff and the garden they could access without staff was not a relaxing environment.

Are services well-led?

Good

We rated well-led as **good** because:

Summary of this inspection

- There was strong local leadership from the hospital's senior management team. Staff reported the local managers were approachable and responded to concerns.
- The management team used the providers' vison and values to develop the service.
- The hospital management team had robust governance systems in place to monitor the service and help drive improvements.
- The management team checked staff morale regularly and could show it was good.
- The hospital was working toward a nationally recognised accreditation scheme.

However:

- The management team had not identified and reviewed the use of all the blanket restrictions in the hospital. The hospital did not have a programme for reducing restrictive practice and meetings to discuss this had been cancelled.

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.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. One out of nine medicine records did not have the correct medicine listed on the attached section 62(2) form.

Patients had their rights explained to them and could appeal against their sections at managers meetings and mental health review tribunals. There was an independent mental health advocate available to the patients.

Patients had section 17 leave and staff recorded when patients used their leave and completed an assessment of patients before going on leave. Staff recorded this in the patient record.

The consultant psychiatrist applied for a second opinion appointed doctor when needed.

There was a Mental Health Act administrator available to give staff advice about the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly.

Staff completed audits of capacity assessments in the patients' files. Staff attached the correct paper work to medicine records to show a patient did or did not have capacity. If staff felt a patient had lost capacity they reassessed the patient and took the necessary action needed for the patient to continue treatment.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

Staff regularly assessed environmental risks across the hospital. Staff completed weekly environmental walk around audits and annual local blind spot and ligature point audits (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). Staff had recently completed the ligature audit for all wards. Staff completing ligature audits had identified risks and put in place appropriate interventions to reduce risks. All staff completed an anti-ligature workbook which included information about what a ligature was, how to report it and the location of ligature cutters. All emergency 'grab bags' and nurses' stations contained ligature cutters and staff were able to tell us this. We found one corner at the end of the corridor on Trafalgar ward where staff had identified a blind spot. Staff had installed a convex mirror to allow them better visibility of the corner. However, it did not give enough visibility unless staff were very close to it. Estates staff told us that that they would re-position the mirror to give better visibility of the corner. Staff could see patients in their rooms through viewing panel in the doors.

Patients and staff could call for help easily in an emergency. There was a nurse call system throughout the hospital for patients to alert staff that they needed help. All staff carried personal alarms which they could activate to signal they needed help from other staff in an emergency.

All ward areas were clean and tidy. Housekeeping staff worked throughout the day to keep all areas of the hospital clean and cleaning schedules were in place. Furniture was in good condition on all wards. However, the walls and skirting boards had scuffs and paint and plaster missing and needed attention.

Staff followed infection control principles. There were posters above basins reminding staff how to wash their hands effectively and how to rub their hands with hand gel. Hand gels and soaps were available to staff and patients. There were 'catch it, kill it, bin it' posters around the building to help reduce flu infections. All staff completed an infection control workbook. Environmental health had awarded the hospital a food hygiene rating of five.

The clinic room on Mary Rose ward was fully equipped. There were two clinic rooms; one large clinic room on Mary Rose ward and one small clinic room on Trafalgar ward. The clinic room on Trafalgar ward was only big enough for one to two people and had a medicine cupboard for the patients on Trafalgar ward. The clinic room on Mary Rose ward had an examination couch, a range of cupboards and shelves for medicine and physical health monitoring equipment and a medicine fridge. Equipment available included; a glucometer, an electrocardiogram machine, a suction machine, an oximeter and a defibrillator. The provider kept all equipment well maintained and calibrated. Staff used a spread sheet to check when each piece of equipment needed calibration. All cupboards and the fridge were tidy, in order and kept locked. There was a controlled drug cabinet locked and secured within the medicine cabinet but there were no controlled drugs at the time of our inspection.

Safe staffing

Long stay/rehabilitation mental health wards for working age adults

Good

There were enough staff with the right skills to give safe care at Nelson House. The provider used the Priory nursing ladder to identify how many staff should be on duty. The current staffing numbers were two registered nursing staff and three non-registered staff between 7am and 7:30pm and two registered nurses and two non-registered staff between 7pm and 7:30am. There were two occupational therapy staff on duty during the day Monday to Friday. The ward manager was in addition to these number four days a week. The ward manager told us they could increase staffing levels to meet the changing needs of patients.

At the time of our inspection there were five vacancies for qualified nursing staff and one vacancy for unqualified staff. The provider covered shifts that could not be filled by substantive staff with bank and agency staff. The provider used agency staff on longer contracts so that they were familiar with the patients and ward policies and procedures. Records showed the provider was using the same agency staff on the rotas. Over the past four months there had only been one shift that management were unable to provide the core staffing numbers and that shift was one member of staff short.

Staff sickness was low. In the 12 months before our visit, clinical staff sickness was at 3% while the national NHS average is 4%. This was an improvement from our visit in February 2017 when sickness was at 6%.

Nurses told us that if they had to cancel leave they would rearranged it for the same day and patients told us staff never cancelled their leave. Records showed there was always registered staff on the wards and there were enough staff available to offer patients one to one time and use physical interventions, if needed.

The hospital had an on-call rota. The responsible clinician provided cover on an evening and weekend with support from their clinical colleagues.

At the time of our inspection 94% of staff had completed all their mandatory training which was above the provider target of 90%. This was an improvement from our last inspection when staff had completed less than 75% of the mandatory training. The Priory also had a service level agreement with all agencies, who provided staff to the hospital, to ensure they had completed 100% of their mandatory training. However, there was no up to date training matrix for agency staff held at the hospital. The ward manager told us that the agencies would tell them if staff did not have the agreed training and not send them to the hospital. The ward manager would also periodically email the agencies to check a sample of staff were up to date with training and we saw emails to confirm this.

Assessing and managing risk to patients and staff

The hospital did not have a seclusion room and there had been no incidents of seclusion (the supervised confinement of a person alone in a room, which may be locked, for the protection of others from significant harm) in the past 12 months. There had been 13 incidents of physical interventions in the past 12 months. There had been no incidents of prone (face down) restraints. We saw that patients had care plans in place that showed how to de-escalate them without using physical interventions.

All patients had a comprehensive risk assessment in place. Staff told us that they started completing the risk assessment before admitting patients. We reviewed nine patient records which all had a risk assessment completed using the risk assessment tool on the electronic record system. All identified risks had a risk management plan to address the risk. We saw that staff updated risk assessments following incidents and the multi-disciplinary team reviewed risk daily (Monday to Friday) during their morning meeting.

Staff were using restrictive practices within the hospital instead of individually risk assessing this. The Mental Health Act Code of Practice says that providers should avoid blanket restrictions, when used there should be a clear justification for that ward or group of patients and they should be subject to review by the provider's governance systems. There was an agenda item to discuss restrictive practice at the hospital's governance meeting but the team had not recognised or reviewed all the blanket bans in place. Restrictive practices included staff keeping all patients' cigarettes and lighters, we spoke to staff about this and they told us it was to reduce the risk of patients smoking on the wards. At mealtimes, staff issued cutlery to patients individually counting it out at the beginning of the mealtime and counting it back in at the end. Patients had access to two gardens, one secure garden with an anti-climb fence that patients could access freely. The second garden was not secure and staff had to supervise patients in it. This was the case regardless of whether they were informal patients or had unescorted community leave. All patients had to open personal mail in front of staff to ensure there were no dangerous or

Long stay/rehabilitation mental health wards for working age adults

Good

contraband items in them. Staff kept restricted items in a security cupboard. Staff did not keep a record of what was in the cupboard and patients accessed the cupboard with staff to collect items for leave or to use on the ward, the hospital director told us they would rectify this during the inspection. However, staff no longer searched patients returning from escorted leave.

There was signage to tell informal patients they could leave the hospital if they wanted to.

The hospital had policies and procedures relating to the observation of patients. The ward manager ensured that all staff working on the ward, including agency staff, had completed the ward observation check list. We checked five agency staff records and saw that staff had completed the checklist. We reviewed the observation records during our visit and staff had completed them correctly.

There had been no incidents of rapid tranquilisation used at the hospital (when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need). There was a policy in place to safely administer and monitor the effects of rapid tranquilisation and rapid tranquilisation flow charts in each of the clinic rooms.

All staff received safeguarding adults and children training. All staff we spoke to could explain how to make a safeguarding referral and what type of incident would trigger a safeguarding alert. The staff team had displayed the contact details for the local safeguarding teams in the ward office.

Staff mostly followed good practice in medicines management. We reviewed 12 medicine records, all 12 were of a good standard. Staff had administered medicine in line with the prescription and British National Formulary guidelines. There were no gaps and where patients had not received their medicine, there were explanations for this. Nurses disposed of medicine correctly and documented this in the disposal book. Patients had their own named medicine and there was also stock medicine available. There were no patients receiving high dose anti-psychotics and the consultant kept the use of sedating medicine to a minimum. However, we found two boxes of medicine and six blood taking vials that were out of date. We informed the provider of this at the time.

Children could visit the ward. Staff organised visits from children in one of the meeting rooms down stairs which they could access without entering patient areas. The hospital provided books and toys for children.

Track record on safety

There had been 84 incidents during the last six months, 12 of which needed further investigation and an action plan to prevent them happening again. We reviewed an incident where a patient was almost able to access keys to the building. A senior manager investigated this and found that there were issues with the secure storage of keys after the receptionist had finished work. Management had put a new process in place and told staff via email and in the daily flash meetings of the new process.

Reporting incidents and learning from when things go wrong

Staff knew what incidents they needed to report and how to report them. We reviewed nine incident records, staff had taken appropriate actions including making referrals to the local safeguarding team. Mangers gave staff de-briefs following incidents and informed them about any learning through a hospital newsletter, team meetings and minutes from clinical governance meetings. Staff used reflective practise during debriefs to see why things had gone wrong, what had caused an incident and how to prevent the same thing happening again.

Staff understood their responsibility to be honest with patients when things had gone wrong, sometimes called duty of candour. We reviewed a letter to a patient that explained why something had gone wrong and what the staff team were doing to stop it happening again.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed nine patients' files and saw that they all had a comprehensive assessment of their needs. Staff helped all patients at Nelson House Hospital to register with a local

GP and booked a new patient appointment. Staff took physical health observations including weight, pulse and blood pressure, weekly and more often if needed. Staff would care plan and monitor any identified physical health needs such as asthma or diabetes.

All care plans we reviewed were comprehensive, recovery focused and included the patient's views. Staff recorded patients' views in the first person and they showed that patients had been involved in developing the care plan.

Staff kept all the information they needed to provide care for patients in the electronic patient record. There were enough computers on the wards to ensure staff could access information when they needed it. Staff issued temporary logins to agency staff so they could access the patient information as soon as they started working on the wards. The temporary logins expired after a limited time to help keep information secure. Staff could reset the temporary logins for staff still working on the wards.

Best practice in treatment and care

We saw evidence that staff followed National Institute of Health and Care Excellence (NICE) guidance on prescribing medicine. The consultant psychiatrist was a member of the Priory Drugs and Therapeutics Committee, they discussed NICE guidance at meetings and reviewed and challenged the prescribing of multiple and high doses of antipsychotic medicines. There was a service level agreement in place with a pharmacy group who audited medicine and sent national and local reports to the provider.

The service offered psychological therapies, this included groups and individual work in substance misuse, positive behaviour support, art and sand therapy. Patients had a 12-week programme of therapeutic interventions, staff then reviewed and developed input to meet individual patients' needs.

Patients had good access to physical health care from the local GP practice. Staff referred patients to access health support groups provided by the local GP practice such as the weight management group. Staff also supported patients to access specialist services at the local general hospitals. Staff reviewed patients' physical health needs during the daily meeting.

Staff assessed and planned to meet patients' needs related to food and drink. Records showed that when there were concerns staff would monitor and record patients' food and drink input and staff reviewed these records at ward rounds and the daily meeting.

The hospital used the Camberwell Assessment of Need Short Appraisal Schedule, a life skills assessment and a patient satisfaction survey to measure the outcome of patients' treatment.

The hospital followed the Priory national audit schedule and had recently completed the National Clinical Audit of Psychosis (NCAP) and were preparing for an audit of psychological therapies. The service also completed local audits around ligature points, medicine, supervision and the recording of consent in patient records.

Skilled staff to deliver care

The hospital employed mental health professionals including; psychiatrists, a clinical psychologist, nurses and occupational therapists. This was an improvement from our last inspection in 2017 when there were gaps in the multidisciplinary team. For example, at that time there was no clinical psychology input and the occupational therapists were on locum contracts.

Most of the multidisciplinary team had a background in working with patients with a mental health issue. Staff who did not have a mental health background were clinically supervised from staff with mental health experience employed at other hospitals. There was an introduction to working in mental health that staff could attend and staff who did not have a background in mental health were due to attend this course.

All staff working in the hospital received an introduction to the Priory Group and a local introduction to Nelson House. The local introduction covered local policies, including the observation policy and ligature risks.

At our last inspection in 2017 there was a poor culture around supervision with most staff not receiving any supervision. At this inspection we found staff received regular monthly clinical supervision in line with the Priory Group policy. Managers kept a record of when supervision took place which they uploaded on to the providers electronic record system. If staff did not receive supervision, managers kept a record of why it had not taken place. For example, if they were on leave or nights.

Long stay/rehabilitation mental health wards for working age adults

Good

The Priory Group set a target of 85% of staff receiving supervision every month, in the past six months Nelson House had met or exceed this target on three occasions. In May 2018 100% of staff received supervision.

There were regular staff meetings. The hospital held daily flash meetings for the staff team. These were team meetings held at the most appropriate time for the staff team on duty that day. We attended a flash meeting led by a senior manager and attended by most staff on duty. The manager created a relaxed atmosphere and staff appeared happy to contribute to the meeting. It covered lessons learnt from a recent incident and offered staff the opportunity to reflect and contribute to the learning from this incident.

The Priory Group had set a target that all staff should receive a yearly appraisal, at the time of this inspection 97% of staff had received an appraisal. Staff could discuss their training needs with a senior hospital manager during their appraisal and apply for any specialist training required.

Managers addressed staff performance when there was an issue. There were no staff under performance management at the time of our inspection. Senior staff could explain the staff performance management process and showed us examples of when they had used it.

Multi-disciplinary and inter-agency team work

The clinical team held effective multi-disciplinary meetings for patients weekly. We observed a meeting and saw that all staff involved in a patient's care attended the meeting. Family members could attend if the patient wanted them invited. Staff always invited the patients' care co-ordinators, the hospital director told us that most attended regularly, but not every meeting, and staff always sent an update to those that did not attend. The staff team worked well together and all professionals had the opportunity to give their opinion. Patients always attended the meeting, had the opportunity to prepare before the meeting and were involved in decisions made during the meeting about their care.

There was an effective handover between shifts. All staff from the oncoming shift attended the handover. The staff team kept records of these meetings and staff discussed changes to the patients' treatment and risk. There was also a daily week day meeting, attended by the wider multidisciplinary team to ensure all staff were up to date with patients' needs.

The team had working links with other agencies. The staff liaised with discharge teams from the local NHS trusts and attended regular safeguarding update meetings which discussed current learning from incidents.

Adherence to the MHA and the MHA Code of Practice

Staff had completed training in the Mental Health Act. During this inspection 100% of eligible staff had completed the mandatory training in the Mental Health Act.

Staff followed the Mental Health Act effectively. Patients had their rights read to them in line with the hospital policy. Patients could appeal against their sections at managers' hearings and Mental Health Act Review Tribunals held at the hospital. Staff referred patients to independent mental capacity advocates and posters advising patients of the service were on the walls in the wards. There was a Mental Health Act code of practice in the nursing stations and staff knew where to find it. The consultant psychiatrist had given section 17 leave to patients (section 17 leave is a section of the Mental Health Act (1983) which allows the responsible clinician to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital) and they were using it regularly and staff kept records securely on the electronic recording system. Staff assessed patients' mental state prior to going on leave and we saw this recorded on the electronic record. Staff requested an opinion from a second opinion appointed doctor when necessary. For example, one patient previously consented to their medicine but staff felt had lost capacity to make this decision. Therefore, staff requested a second opinion appointed doctor to make sure that the patient was receiving the right treatment and the consultant psychiatrist had put the correct section in place to continue with the treatment in the interim. There was a Mental Health Act administrator based in the hospital who could support staff with any concerns or advice.

We reviewed 12 medicine records, nine patients had either a T2 or a T3 form in place (a T2 form lists all the psychiatric medicine a patient has given consent to be given and a T3 form lists all the psychiatric medicine that a patient can be given if they withdraw consent or no longer have capacity

Long stay/rehabilitation mental health wards for working age adults

Good

to consent to treatment. A second opinion doctor completes a T3 form). The consultant had not accurately recorded on a section 62(2) form (used to continue treatment to prevent harm coming to a patient while waiting for a second opinion appointed doctor) what medicines a patient could be given, so nursing staff would not have been able to check this against the medicine records. We spoke with staff about this at the time of our inspection and found the consultant had completed a form correctly but this was not with the medicine records, staff told us that they would correct this.

Good practice in applying the MCA

Staff understood their responsibilities under the Mental Capacity Act and the provider's policies. Staff could get support and advice from the Mental Health Act administrator.

Staff had completed training in the Mental Capacity Act. During this inspection 85% of eligible staff had completed the mandatory training in the Mental Capacity Act. This was below the provider's target of 90%. However, only four eligible staff were untrained at the time of the inspection.

There was evidence of patients having their capacity assessed in all nine patient files we reviewed. Assessments were specific to the individual patient's need and where patients lacked capacity staff supported them to make decisions or took decision in the patient's best interests.

There had been no applications under Deprivation of Liberty Safeguards in the past 12 months.

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

Good

Kindness, dignity, respect and support

All interactions between staff and patients we saw demonstrated that they treated patients in a dignified and respectful manner. Staff spoke with patients in a relaxed and friendly way. Patients told us they felt able to approach staff when they needed to speak to them.

Only four doors had lockable viewing panels, the remaining doors had peepholes style observation points which staff could not lock to prevent other patients from looking into the bedroom. However, there had been no reported incidents of patients looking into other patients' bedrooms. The estates manager told us that they were planning to install more viewing panels, but there was no agreed plan to replace all the peephole style observation points

There had been one complaint in the past 12 months relating to staff attitudes. Managers had investigated this and addressed any learning with individuals and the whole team where necessary.

Carers felt that their relative received a good quality of care. We interviewed two carers of a patient. Both carers felt that staff had cared well for their relative. Staff invited them to meetings with the patient's consent and they felt fully involved. Staff listened to them and were kind and supportive. The carers felt they could raise a concern with either the keyworker or another member of staff and would be listened to.

The involvement of people in the care they receive

Staff provided patients with a good introduction to the ward. Patients received a welcome pack on admission and carers received information about the service. Staff gave all patients a tour of the ward on admission and introduced them to the other patients and staff on duty. There was a suggestion box available on the wards for patients or carers to give feedback and suggestions. There were monthly patient council minutes and the staff displayed patients' suggestions and requests on the notice boards with the outcome. There was a patient representative who attended clinical governance meetings on behalf of the patient group and fed back any issues that patients wanted raised.

We reviewed nine patient records and saw that all patients had been involved in developing their care plans and risk assessments. Care plans and risk assessments were holistic and focused on developing the skills needed to improve independence. Staff had given or offered all patients a copy of their care plan. However, we found that staff had recorded the care plans and risk assessments in professional language and the copies offered to patients were print outs from the electronic patient record and were not in a user-friendly format. Staff did not give simplified care plans to patients and there was not an easy read care plan for a patient found to have a learning disability.

Long stay/rehabilitation mental health wards for working age adults

Good

Patients had access to an independent mental health advocate who had a weekly presence in the hospital. All patients were aware of the advocate and accessed them when needed.

Staff invited patients' families to be involved in their care if this was what patients wanted.

At the time of our visit none of the patients had advanced decisions in place. An advanced decision is when a patient records what treatment they would prefer to receive if they lost the capacity to make their wishes known.

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

Good

Access and discharge

The average bed occupancy in the 12 months prior to our inspection was 61%. This was due to the service changing from being a mixed sex service to an all-male service.

As Nelson House was an independent hospital owned and run by the Priory Group the senior management team accepted referrals from the whole of the country. At the time of our inspection they had available beds and were actively recruiting staff so they could open the third ward and admit to their full capacity.

Staff only moved patients between wards when there was a clinical reason to do so. We saw examples of where staff had moved patients from Victory Ward to Mary Rose ward because they had found the busier environment difficult and it had affected their treatment.

The hospital director told us that patient discharge would only occur following discussions with care coordinators. They would work together, along with the patient, to find an appropriate care pathway. This meant a patient's discharge would occur at an appropriate time of the day. The hospital director showed us an example of where a patient had declined a potential placement. The staff team had then worked with the patient and care co-ordinator to find a suitable alternative.

In the past six months there had been no delayed discharges.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms and equipment in the hospital to support treatment and care. The lounge on the wards had several seating areas. There was a dining area, an occupational therapy room and a therapy kitchen. A laundry room was available for patients to do their own laundry under staff supervision. There was always quiet space available for patients.

During our last inspection there were no facilities for patients who did not have a personal mobile phone to make a private phone call. On this visit we saw that the ward had mobile phones that patients could use, in private, if they did not have a mobile phone of their own.

All patients had access to a secure garden, patients told us that they used this garden to vape in, it was bare of any plants or flowers and had a garden bench in the middle of it and was not a pleasant environment to relax in. There was supervised access to a second garden. Patients told us that staff were not always available to support them to use this garden which patients and a member of staff had redeveloped and included flower beds. Patients could view this garden from the dining room and commented on the pleasant view this gave them. There was a closed third garden awaiting redevelopment.

Patients told us that food was of a good quality and that they enjoyed it, the patient forum minutes supported this. In the patient forum minutes patients had asked for the main kitchen to serve more convenience type foods, such as chicken nuggets, the chef was considering this at the time of our inspection. Patient had access to drinks and snacks throughout the day and night.

Patients could personalise their rooms. Patients used their own bed linen, put pictures and posters on the walls and had televisions, video game systems and stereos in their rooms. Patients also had a safe in their bedrooms. However, there was no secure storage in the bedrooms for larger personal items. Staff did not issue patients with a key to their bedroom and patients had to ask staff to lock their rooms.

There was a full programme of activities, in addition to therapeutic activities, available to patients seven days a

week. The occupational therapist assessed patients interests to ensure the hospital was offering the appropriate activities. We saw timetables that included trips to the local gym, leisure centre and cinema. The staff also offered activities on the ward including bingo, pets as therapy dog and a monthly talent show. On the day of our inspection, an occupational therapy assistant was supporting a patient in the community to assess their road safety.

Meeting the needs of all people who use the service

The wards were on three floors, there was a lift that enabled access to all wards for patients with mobility issues. However, at the time of our visit the lift was not working and staff did not know when it would be fixed. If the management team did admit a patient with mobility issues, the service would accommodate them on the ground floor. There were very few adaptations, such grab rails and raised toilet seats, for people with reduced mobility. However, the hospital director could get equipment to address patients' physical needs when needed and showed us an example of when they had done this.

There were information leaflets available to patients. Staff could obtain leaflets in languages other than English. At the time of our visit there were no patients who needed them. Staff told us that they could access an interpreter, including sign language interpreters.

The kitchen staff could cater for all dietary needs. At the time of our visit they were offering vegetarian meals. We saw, in the patient forum notes, that a vegetarian patient had thanked the staff for knowing what food he could eat and had advised him when he had inadvertently selected something that was not vegetarian. If a patient was admitted with special dietary needs such as vegan, kosher or halal, the chef would order in the food needed.

The service had information about local places of worship for different faiths. The staff would support patients to attend services and could arrange for visits to services and for spiritual leaders to visit patients.

Listening to and learning from concerns and complaints

There had been two complaints in the past 12 months and the provider had upheld both. Patients knew how to make complaints and staff supported them to do so when needed. There were posters informing patients how to complain and suggestion boxes on the wards. Staff encouraged patients to raise concerns at the patient forum. We saw evidence that senior staff investigated complaints following the local policy. The manager who investigated the complaint gave face to face feedback to the patient and sent them a letter which explained what action they had taken. Managers made sure all staff were aware of learning from mistakes by feedback at team meetings, emails and local service newsletter. Managers addressed any personal learning with staff directly.

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

Good

Vision and values

Managers and staff knew what the vision and values of the service were. We saw how the staff team put the values into practice. For example, patient involvement, honesty in the complaints process and helping to teach patients ways to manage their conditions. The team aims reflected these values and we saw how the staff team used them when developing the service and planning patient care. For example, offering more community based activities and reviewing policies to ensure they continued to meet patients' needs.

The local senior management team were visible and approachable in the hospital. Staff felt supported by the leadership team. For example, a patient had recently become unwell and was showing some aggressive behaviour on the ward. Senior management attended the ward to support staff in de-escalating the patient. Senior management from the wider organisation visited regularly and staff knew who they were.

Good governance

There were strong local governance processes in place. However, there were many restrictive practices in the hospital that the management team had not recognised as being used. The provider did not have a programme for reducing restrictive practice and meetings to discuss this had been cancelled. The hospital's senior management

team were able to show that staff, including longer term agency staff, had completed their mandatory training, received regular supervision and there were enough staff available to make sure they did not need to cancel therapy sessions and activities. The hospital director was actively planning to ensure there would be enough staff available when the hospital re-opened the third ward.

There was a strong incident reporting culture at the hospital. The senior management team reviewed all incidents and, when needed, investigations occurred without delay. Managers documented any lessons learnt from incidents, complaints or any actions needed following audits and passed this on to staff. The management team had systems in place to check this had occurred.

The managers we spoke to told us they had the authority to do their jobs. There was a risk register in place and staff knew the process for putting issues on the risk register. The senior management team reviewed the risk register at the clinical governance meetings. There were management plans in place for all risks on the register.

Leadership, morale and staff engagement

There was a strong local leadership team in place. Sickness rates were low, staff felt able to raise concerns and there were no reported incidents of bullying or harassment. Staff knew how to raise concerns and the hospital director had made sure whistle blowing information was displayed in the hospital.

Staff morale was high. There were regular staff surveys which showed staff morale at Nelson House had been improving. The most recent survey showed that staff were more engaged (85%) working at Nelson House than the average for the Priory (77%).

There were leadership opportunities for staff. There was a ward manager training course that covered all areas of the role including leadership. The senior management team encouraged staff to give feedback to develop the service via team meetings and surveys.

Commitment to quality improvement and innovation

The hospital had recently joined a national accreditation scheme organised by the Royal College of Psychiatrists that worked with services to improve the quality of inpatient rehabilitation wards. The hospital was in the first stage of this process which could take up to two years to achieve.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that restrictions on patients are based on an assessment of the individual risk posed by each patient and blanket restrictions are kept to a minimum.

Action the provider SHOULD take to improve

- The provider should ensure all patients have a care plan that is free from jargon and easy to understand and, when needed, in an easy read format.
- The provider should ensure that appropriate observation panels are in place for all bedrooms and are only accessible to authorised staff.
- The provider should ensure that they have easy access to the equipment needed to meet the needs of patients with mobility issues.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment The provider had blanket restrictions in place that did not consider the level of risk presented by the patient group receiving care in the hospital or the individual risk level of patients. This is a breach of regulation 13 (1) (4) (b)