Partnerships in Care Ltd Nelson House

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

We rated Nelson House as requires improvement because:

- In January 2016, we rated Nelson House as requires improvement. During this inspection (February 2017), although some progress had been made, this was not sufficient to amend the ratings for Safe, Caring, Responsive and Well Led. However, we were able to re rate Effective from inadequate to requires improvement.
- Nelson House had 32 beds and at the time of inspection, there were 18 patients. At the last inspection in January 2016, the provider had decided to restrict new admissions to allow staff to embed quality improvement changes. In January 2017, the provider closed the wards to all admissions, as staff had not embedded all of the identified quality improvements appropriately.
- At the previous inspection in 2016 the provider did not have effective systems and processes to assess, monitor and improve the quality of the service. This meant that they did not consistently identify and assess risks, monitor progress against plans to improve or take appropriate action where progress had not been achieved. During this inspection, we found that a number of issues identified in our January 2016 inspection had not been addressed effectively.
- At the last inspection in 2016, we identified that the leadership at Nelson House was not robust. At this inspection, leadership had not improved. Staff did not feel confident about raising concerns with the hospital manager. Sickness was high. The total absence percentage for Nelson House is 5.65% between January 2016 and January 2017. The average number of leavers per month was two.
- At this inspection we identified a number of health and safety concerns. Staff precooked food on a weekday and left it in the fridge with instructions on for the weekend staff to serve it. Staff did not record food temperatures. The kitchen was in need of a deep clean. The provider did not have an up to date legionella safety certificate. In addition, the provider had not carried out environmental work identified at the January 2016 inspection that was necessary to minimise the likelihood of risks to patients and /or staff. For example, to address blind spots and ligature risks (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation).
- At the previous inspection in January 2016, attendance of mandatory training was low. At this inspection, we saw that training had started to improve. However, completion of key subjects remained low. For example, only 25% of staff completed infection control and 43% completed safeguarding adults level one. The provider reported no concerns about staffing levels. However, at the time of the inspection there were 15 vacancies, this had increased since the last inspection in 2016 when they had eight vacancies.
- Patients reported staff sometimes cancelled activities due to staff shortages. The Clinical Psychologist was unavailable but they had recruited a social worker. The majority of staff had not received supervision since 2013.

However, we also found the following areas of good practice:

- Staff treated clients with kindness, dignity, and respect. The staff we met were conscientious, professional and committed to doing the best they could for the people in their care.
- We discussed our immediate concerns with the new Priory Group management team who were taking over the governance of Partnerships in Care. They had a good understanding of the current performance issues and had developed an action plan to address them. The provider was also responsive to all requests for action to be taken at the time of inspection.

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	Requires improvement 	See main report

Summary of findings

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Requires improvement

Nelson House

Services we looked at

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

Summary of this inspection

Background to Partnerships in Care Ltd Nelson House

Nelson House is a purpose built 32-bedded hospital that provides assessment and treatment for men and women within a locked rehabilitation setting. The patients have severe and enduring mental health problems, including schizophrenia and personality disorders. There are two 14-bedded wards (Trafalgar for men, Victory for women).The service also has four bedrooms on the ground floor, Mary Rose ward, which it is planning to use as a pre-discharge unit once the provider has completed changes to the environment. However, the manager told us patients who struggle within the main wards were able to use the bedrooms on the ground floor.

At the time of the inspection, the service had a registered manager in place. 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.

The manager of Nelson House told us that Partnerships in Care was merging with the Priory Group. At the the time of this inspection the service was in transition between providers which is why there is reference to both Partnerships in Care and The Priory Group throughout this report.

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

The Care Quality Commission last inspected Nelson House on 12 and 13 January 2016.

Our inspection team

The team that inspected the hospital comprised three inspectors. The lead inspector was Gavin Tulk.

Why we carried out this inspection

We undertook this short notice announced inspection to find out whether Partnerships in Care Ltd had made improvements to Nelson House since our last comprehensive inspection of the service in January 2016.

When we last inspected the provider in January 2016, we rated Nelson House as **requires improvement** overall.

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

Following the January 2016 inspection, we told the provider it must make the following actions to improve Nelson House:

- the provider must ensure that risk assessments in care records are comprehensive and use a recognised risk assessment tool
- the provider must ensure that the environment at Nelson House is safe for patients by reviewing the ligature point (anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) audit to ensure all risks are documented. Managers must make staff aware of the plans for the management of specific ligature risks and ensure that they follow them

Summary of this inspection

- the provider must ensure that patients assessed as ready for more independence and on the pre-discharge ward are not subjected to blanket restrictive practices and that their care is person centred to promote recovery
- the provider must ensure that they undertake a review of blanket restrictions in place for patients on Victory and Trafalgar wards, including access to fresh air and the hospital garden, and make care and risk management patient centred
- the provider must ensure that records are complete, up-to-date and consistently completed during the transition to the new computerised notes system
- the provider must ensure there is regular 1-1 clinical supervision and appraisals for staff
- the provider must ensure that all care plans are personalised and include the patient's views.

We issued four requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 (3)(a)(b) Health and Social Care Act (HSCA) 2008 (Regulated Activities)Regulations 2014. Person centred care.

Regulation 12(2)(a)(b) (d) Health and Social Care Act (HSCA) 2008 (Regulated Activities)Regulations 2014. Safe care and treatment.

Regulation 17 (2) (c) Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. Good governance

Regulation 18 (2) (a) Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. Staffing.

Overall, during the February 2017 inspection, we concluded that the service had taken sufficient action to meet the requirements set out in the our requirement notice relating to Regulation 9. However, the service remains in breach of a number of regulations of the Health and Social Care Act 2008 (regulated activities 2014) from the January 2016 inspection, Regulations 12, 17 and 18. An additional requirement notice against regulation 15 Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 (premises and equipment) was issued during this inspection is detailed at the end of this report.

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 we held about this service. During the inspection visit, the team:

- Undertook a tour of the hospital and looked at the layout of the ward and cleanliness of the environment.
- Spoke with nine patients.
- Spoke with the operations director and the hospital manager.
- Spoke with 10 other staff members including doctors, nurses, support workers, occupational therapists, administrators, and domestic staff.
- Attended and observed one morning meeting, and one community group.
- Reviewed 10 staff personnel files.
- Reviewed five treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patient feedback varied about Nelson House. We spoke with six patients who told us the majority of staff were kind, caring and helpful. Patients said there was now a good programme of activities and excellent food. During

Summary of this inspection

the inspection, we observed staff treating patients with kindness, dignity, and respect. Interactions between staff and patients were natural and caring. Patients generally felt happy about the care they received. However, some did not understand the hospitals no smoking policy, in particular, when they could smoke and why they could not have access to disposable e-cigarettes in the hospital garden. Patients told us some staff told them they could have a cigarette and other staff said they could not. Some patients said this caused them anxiety and stopped them concentrating on group activities.

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 provider did not consistently follow the management plans for specific ligature risks identified in the majority of bathrooms.(anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation)
- there was no cleaning schedule in placefor equipment in the clinic room and dust had built up on equipment
- staff did not carry out searching in accordance with the hospital's searching policy. Staff searched every patient on return from leave, regardless of risk and need
- staff did not consistently identify how patients are assessed for leave
- seventy six per cent of staff had completed mandatory training; however, the provider's target was 85%
- the provider held excessive stock of medicines. Staff did not always dispose of medicines effectively
- staff precooked food on a weekday and left it in the fridge with instructions on for the weekend staff to serve it. Staff did not record food temperatures. The kitchen was in need of a deep clean. The provider did not have an up to date legionella safety certificate.

However:

- all personnel files reviewed had a disclosure and barring certificate number and references were in place
- staff used a recognised risk assessment tool to identify and manage risk
- staff and patients were debriefed following incidents. Staff demonstrated knowledge of the principles of the duty of candour. They recognised the need to be open and honest with people who used the service and their carers (where appropriate) when things went wrong.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- staff did not always follow the hospital's medicines management policy; there was a lack of oversight to monitor this

Summary of this inspection

- only 47% of staff had been trained in the Mental Health Act, and only 43% of staff had completed safeguarding adults level one
- not all patients had a comprehensive up to date assessment of need. Care plans were not completely personalised and focussed on recovery
- staff had not received regular one to one clinical supervision or annual appraisals.

However:

- the occupational therapy staff used the Model of Human Occupation screening tool to measures outcomes for patients. They also incorporated SMART goals set by the patients in their individualised care plans.

Are services caring?

Good

We rated caring as good because:

- staff treated patients with kindness and respect and patients felt supported by staff
- staff held regular patient meetings to ensure that patients were able to inform developments within the hospital
- patients had regular access to independent advocacy.

However:

- the provider had not considered the impact the no smoking policy had on patients.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- access to open space and fresh air in the hospital garden was restricted and only happened when staff were available or during smoking breaks
- patients without a personal mobile telephone were not able to make a private telephone call
- the provider had not responded to complaints regarding cold water in patients' showers, even though ward staff confirmed they were aware of the issue
- there was no dedicated visitor's room, visits from children took place in the main meeting room there were toys available.

However;

- staff made adjustments to meet patients' needs, such as information leaflets in different languages and a choice of food to meet dietary requirements.

Summary of this inspection

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- the provider did not use effective systems and processes for consistently assessing quality and safety issues, or monitoring if actions taken had led to improvement. We found that a number of building maintenance issues had not been addressed and were still outstanding from our previous inspection
- the provider did not assess if staff attended mandatory training and the provider did not encourage staff to develop in their roles
- the provider did not monitor staff competence. For example, staff did not receive regular supervision and annual appraisals
- the provider did not carry out regular internal clinical audits
- staff did not know the organisation's vision and values. staff morale was low and the team felt senior managers were not approachable.

However;

- the provider had merged with the Priory Group. The Priory Group management team had assessed the concerns and created an action plan. This included stopping all admissions to allow for improvements to be carried out.

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.

Nelson House had a Mental Health Act administrator. Completed consent to treatment forms were located with prescription charts. Emergency treatment was given appropriately and second opinion appointed doctors (SOAD) requested. There was evidence the provider prescribed patients medication under Section 58 of the MHA. T2 forms were in place as per section 58 (3) (a) of the MHA as a certificate of consent to treatment. T3 forms were in place as per section 58 (3) (b) of the MHA where a certificate from a second opinion doctor is required. The provider kept these forms with the patients' drug charts. Staff attempted to read patients their rights monthly and recorded it in the patients notes. Information on how to access an Independent Mental Health Advocate (IMHA) was available to patients. An IMHA visited the hospital once a week.

At the time of the inspection, there were 18 detained patients. All patients knew which section of the Mental Health Act the provider had detained them under and they had information on their rights to appeal under the Act. The Mental Health Act administrator scrutinised documentation when staff admitted the patient.The provider carried out audits but had not scrutinised the results to identify any action they need to take.

The provider-implemented staff training in 2016 and at the time of inspection; only seven out 14 staff had received up to date MHA training 50% completed Mental Capacity Act and deprivation of liberty, 47% completed Mental Health Act and code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff had completed up to date training on the Mental Health Act, Mental Capacity Act (MCA) and Deprivation of liberty safeguards (DoLS). The hospital had made no DoLS applications in the 12 months prior to inspection.

Partnerships in Care had a policy in place to ensure staff worked within the principles of the Mental Capacity Act.

Staff understood the Act and documented capacity assessments in patient treatment records. The hospital worked closely with the local authority who took the lead on best interest assessments when required. Staff presumed patients had capacity unless indicated otherwise.

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	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- The hospital was generally clean and tidy. However, some areas required cleaning to remove built up dirt and grime. For example, there was thick dirt behind the water fountain on the female ward. Staff had a daily cleaning schedule but did not carry out cleaning audits. The manager told us they had booked an annual deep clean due to take place on the 13 February 2017.
- Some maintenance was required. For example, a floor plate was missing by a door on the female ward leaving a hole in the floor that required filling. A large section of splash back skirting was missing from a male bathroom and a door handle was missing from the main meeting room door. The manager told us they had recruited someone to carry out this work.
- The hospital had separate male (Trafalgar) and female (Victory) wards that ensured compliance with the same sex guidance. All bedrooms were en-suite and staff going on to ward areas carried an alarm to use if they needed to summon assistance. An outside company maintained these. We saw the last audit took place on 19 January 2017.
- Staff did not have a clear view of each ward from the nurse's station. At the previous inspection in January 2016, the provider had identified blind spots on each ward. The provider told us they would fit mirrors so that staff could observe patients at all times. However, at this inspection although the provider had an observation policy dated April 2016 we found staff did not follow the policy and the provider had not had the mirrors fitted.
- At the previous inspection in January 2016, the provider had identified that the communal bathrooms were fitted with non-ligature proof taps. They placed this on their environmental risk assessment as an action and said they would replace them with ligature proof taps. During this inspection we identified staff completed weekly ligature audits but had not followed the management plan. The previous actions remained on the environmental assessment and the provider had not carried out the work. There were no recorded ligature incidents.
- At the previous inspection in January 2016, we found that the provider kept all emergency equipment on the first floor, which meant staff had to use the lift or go down several flights of stairs to retrieve them in an emergency. At this inspection, emergency equipment was available on each ward and in the clinic room on the ground floor.
- Staff told us that the emergency bags had only been in place for a week. This meant staff had not yet completed a weekly check. Staff showed us the daily check records and the contents list for the bags. The provider did not keep these with the individual bags and did not include checking expiry dates of equipment. We identified that some water sachets had gone out of date and staff removed these immediately.
- The clinic room was clean, tidy, and appropriately equipped; except there was no examination couch. At the previous inspection in January 2016, the provider

told us they had ordered a couch. However, at this inspection staff stated that if a patient needed a physical examination this would take place in their bedroom.

- The provider had a contract with a local chemist to provide medicine and pharmacist support. Staff ordered all medicines as stock rather than for individual patients. Staff told us this was so they could administer medicine when the doctor prescribed it. Staff told us they recorded medicine that needed reordering on a sheet of paper. Staff told us the pharmacist who visited each week reviewed the sheet of paper and ordered the medicine
- There was no cleaning schedule in place for equipment in the clinic room and dust had built up on equipment. There was a new medicines fridge in the clinic to replace the old fridge that had broken. Staff recorded the temperature of the new fridge. There was an appropriate system in place for the disposal of medical and other clinical waste.
- In general, the kitchen was tidy, although it was in need of a deep clean. We raised this with the manager who told us they had arranged for a cleaning company to come to the service on the 3 February 2017 to carry out this work. The kitchen staff recorded the fridge temperatures, including the maximum and minimum temperatures for the kitchen fridges every weekday and we saw records from the previous three months that confirmed this. However, staff did not record the fridge temperatures in the separate kitchen specifically for patients to prepare their own snacks. Ward staff told us they thought that kitchen staff did this and the kitchen staff told us the ward staff did it.
- We saw up to date certificates for fire safety and gas safety. The provider did not have an up to date legionella safety certificate. The manager told us that the housekeeping staff ran the taps daily as a preventative measure to stop legionella developing. Housekeeping staff were unaware of why they needed to run the taps or the need to record that they had done this. Hospital policy advised that staff should run taps and record the temperature, the hospital was not following the policy. We brought this to the manager's attention and asked that they took action to address this. The manager told us that they had arranged for staff from another site to visit the next day and complete the preventative measures, they had also arranged for an outside agency to complete the testing until an appropriately trained handy man was in post.
- At the time of the inspection, the provider did not have kitchen staff working at the weekends. Staff told us that the chef would precook food and leave it the fridge with instructions on how to serve it. We saw hand written notes from the previous weekend advising staff to record the food temperature. However, ward staff were not recording food temperatures. We asked the provider to address this issue immediately and the manager informed us before we left the site that an agency chef had been booked for the weekend and that they would continue to employ agency chefs until they employed one.

Safe staffing

- Partnerships in Care had their own safe staffing tools to establish the number of staff required on each shift. However, the manager told us they did not use it as the Priory Group was bringing in their system. Staff turnover was high in the previous year, with 14 leavers from a total substantive team of 35 staff (42%), however managers were aware of this and had a recruitment plan in place. This figure also reflected bank staff. A breakdown of the reasons for this showed a mix of personal circumstances and an acknowledgement that some staff felt the job was not for them. The hospital had 18 patients at the time of inspection, the manager told us Victory ward had five female patients supported by two support workers and one registered nurse. Trafalgar ward had 11 male patients supported by three support workers, and one registered nurse.
- Mary Rose ward had two patients. A specific staff team did not support this ward. We discussed this with the manager who told us the ward was for patients ready to move on and staff allocated to Trafalgar and Victory wards would oversee patients on Mary Rose.
- A review of the previous four weeks rota from 21 December 2016 to 11 January 2017 confirmed that the provider had staffed shifts to the minimum safe staffing levels. However, this was with regular agency staff and did not take into account of the manager, ward manager, and therapy staff. The manager told us they were in addition to the number of staff usually required

for patient care. The manager reported no concerns about staffing levels. However, at the time of the inspection there were 15 vacancies, this had increased since the last inspection when they had eight vacancies. Patients reported staff sometimes cancelled activities due to staff shortages, but leave generally went as planned.

- We reviewed 10 personnel files, which showed that the provider had carried out relevant checks. For example, all files reviewed had a disclosure and barring certificate number and references were in place. However, the management of staff performance was inconsistent. For example, not all staff had received regular supervision or an appraisal. The total percentage of permanent staff sickness between 1 January 2016 and 7 February 2017 was high, for example, clinical staff sickness was at 6%, support service staff was at 4%, psychology staff was at 1% and management was 3%. The national NHS average is 4% by comparison
- The hospital had an on call rota. The responsible clinician provided cover on an evening and weekend with support from their clinical colleagues.
- Patients' treatment records showed that patients were having regular access to one to one support from the occupational therapist team. However, the manager told us patients did not have a named nurse or key worker and due to high levels of agency staff patients did not always know who was on shift each day to speak to if they needed advice or support.
- Partnerships in Care had a two-week external induction programme for all new staff. The programme included an introduction to the organisation and training such as managing violence and aggression. The local induction covered subjects such as security, confidentiality, communication, and dress code.
- At the previous inspection in January 2016, compliance with or completion of mandatory training was low. For example, two groups of staff had undertaken the corporate induction programme. Only four subjects had completion rates of above 50%, safeguarding, security, conflict resolution, and management of violence and aggression. The provider target was 85%.
- At this inspection, we saw that training had started to improve. For example, 86% of staff completed basic life support, 53% completed breakaway, 53% completed conflict resolution, 67% completed safe administration of medicines L2, 100% completed immediate life support, 77% completed information governance, and 86% completed security. However, completion of other key subjects remained low. For example, only 25% of staff completed infection control, 30% completed managing violence and aggression, 43% completed safeguarding adults level one, 29% completed safeguarding children level one and 48% completed suggestions ideas and complaints. We discussed this with the manager who told us, statistics are going up and managers encourage staff to do their on-line training. The Priory Group Director of Operations also confirmed that staff would have access to their training once the merger is completed.

Assessing and managing risk to patients and staff

- At the inspection in January 2016, we examined seven patient care records. Patients had risk assessment care plans in place. However, the nurses had not consistently written them based on the recognised risk assessment tools the service used. In the seven notes we examined one had a formal risk assessment in place. Staff had not received training to complete the risk assessments. At this inspection, we reviewed five patient files and identified that one did not have an up to date risk assessment in place. Staff told us this was because the provider had recently admitted the patient.
- Staff used the Historical Clinical Risk Management-20 (HCR-20) risk assessment, which staff uploaded to the provider's electronic notes system. The HCR-20 is a 20-item checklist to assess the risk for future violent behaviour. It includes variables that capture relevant past, present, and future considerations to determine an individual's treatment plan. However, the service did not use another risk assessment to assess other risks, for example falls, vulnerability to exploitation or home safety. The hospital had an observation policy and staff could explain this to us. Patient risk determined observation levels. A policy was not in place to ensure the safety of children visiting the ward.
- The provider had a contract with a local chemist to provided medicine and pharmacist support. Staff ordered all medicines as stock rather than for individual patients. Nurses could then administer medicines when the doctor prescribed it, rather than waiting for pharmacy to deliver. Nurses recorded medicines that needed reordering on a form for the pharmacist who

visited each week. The pharmacist reviewed the cupboards and ordered medicines from the list. We found many medicines in the cupboards. Staff told us that some of the medicine was not in use.

- We checked 10 of the stock medicines and found two were out of date. The out of date medicine was not prescribed for any of the patients admitted at the time of the inspection. Staff did not audit the expiry dates of medicines stored in the clinic. We found medicine for patients to take home that patients had returned and staff had not disposed of. We found a pot of tablets in one cupboard ready for staff to administer. Staff should prepare medicine immediately before they administered it, if a patient refuses the medicine this should be disposed of immediately. The prescription charts suggested the medicine had been prepared the day before and a patient had refused. We brought this to the attention of the manager.
- We reviewed all of the medicine cards in use at the hospital and staff had completed them all correctly. For example, doctors had signed all prescriptions and nurses had initialled all administration records or entered a code to explain why staff had not administered it. There was appropriate emergency medicine in stock. For example, there was naloxone, which staff can administer to counter the effects of opiate-based medicine and glucose for diabetes.
- There was an appropriate system in place for recording controlled drugs. For example, nurses recorded the amount of controlled drugs each time they administered it, a stock check took place between each shift, and two nurses signed each entry. There were appropriate systems in place for the disposal of medical and other clinical waste.
- There was a policy for the use of rapid tranquilisation (the use of medication to calm/lightly sedate the patient, reduce the risk to self and/or others, and achieve an optimal reduction in agitation and aggression). The policy included each medicines maximum dose and the physical health monitoring that must occur afterwards. The policy covered medicine given orally or by injection.
- The hospital did not have a seclusion room, and there were no recorded incidents of seclusion. Staff received training in managing violence and aggression. The most recent audit for restraint took place in April 2016 and covered a three month period. We found there were 10-recorded incidents of restraint, two into seated position, one was supine restraint (where the patient is on their back) one was into a prone restraint (where the patient is on their front), one was a figure of four hold and five restraints were forearm holds. However, staff did not record in patient care plans how the patient preferred staff to restrain them.
- The hospital had a list of 'contraband items' that were not permitted within the grounds. However, staff did not carry out searching based on individual need and risk or in accordance with the hospital's own policy. Staff told us they searched all patients when they returned to the unit. Staff did not have access to a criterion detailing the required search level for each patient following either escorted or unescorted leave and searching of patients was not in line with the patient risk assessment. Staff told us that random room searches took place.
- The hospital entrance was via locked doors. The exit door into the outside space was accessible with staff supervision and notices were in place on all entrance and exit doors to advise informal patients of their right to leave.
- At the inspection in January 2016, safeguarding training was not up to date. At the time of this inspection, we found the provider had not addressed this. Records showed safeguarding training remained low, 43% of staff had completed safeguarding adults level one. We saw how staff made regular referrals to the local safeguarding team. The provider held safeguarding alerts on their electronic system. Staff used the local authority threshold tool when deciding whether to raise an alert. At the time of inspection, there was one safeguarding case open with the local authority and the relevant partner agency was involved.
- During the period of August 2016 and December 2016, the provider raised eight safeguarding alerts. Staff told us they were awaiting feedback on one currently open with the multi-agency safeguarding hub, (a single point of contact for all professionals to report safeguarding concerns). The provider said they have difficulty getting the local authority safeguard team to feed back so when they make an alert the provider cannot always record the outcome.

Track record on safety

- Nelson House reported four serious untoward incidents since August 2016. Three involved patients absconding, one was alleged assault and one involved staff restraining a patient. The manager offered support that

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

included debriefs to all staff involved and investigation took place with an analysis of the findings. We saw evidence of lessons learnt, recommendations, and a letter sent to the staff member with the outcomes concluding their actions to restrain the patient was were both proportionate and appropriate.

Reporting incidents and learning from when things go wrong

- The hospital monitored their reporting of incidents via an electronic system. This documented the number of incidents, the type of incident, whether staff used restraint and if staff informed the appropriate agencies. We saw staff discussed serious incidents in minutes dated 13th October 2016 with lessons learnt. After serious incidents, staff and patients were debriefed. We saw evidence of this documented on incident forms. Staff told us they felt supported following an incident, and documented discussions in team meetings. The provider's policy highlighted what events staff should report but the policy was out of date.
- Staff demonstrated knowledge of the principles of the duty of candour. They recognised the need to be open and honest with people who used the service and their carers (where appropriate) when things went wrong. We saw evidence of this in minutes of meetings.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff told us they assessed all patients prior to admission. However, the provider did not have a robust referral and assessment criteria. The consultant psychiatrist assessed them on the day of admission and staff booked an appointment with the local general practitioner. In five of the records we reviewed, two had a physical health assessment completed on the day of admission. Staff told us that the previous consultant psychiatrist would not assess physical health needs but the consultant in post at the time of this inspection did. The current consultant told us they were in the process of reviewing the direction of the service towards becoming a unit for patients who had severe and enduring mental health needs. The five records we reviewed confirmed this.
- We reviewed 14 care plans at this inspection, five of which were occupational therapy care plans. The occupational therapy care plans were personalised and recovery focused. All of the occupational therapy care plans reflected the 12-week cycle for the occupational therapy treatment plan. However, on the five plans we reviewed, the date of review did not reflect this process. Staff told us that they had written the wrong review date on each one.
- Not all information was included in care plans. For example, we identified that a plan to manage aggression did not include information identified in the Historical Clinical Risk Management-20 assessment and a plan to manage substance misuse issues that did not include medication the doctor had prescribed for this condition. In addition, staff had not offered a patient with substance misuse issues, blood borne virus screening. We discussed this with the provider who told us they had appointed a nurse as the physical health lead but they had not started at the time of the inspection.

Best practice in treatment and care

- We saw evidence that although staff followed National Institute for Health and Care Excellence guidance for prescribing clozapine, patients did not have individual care plans around clozapine to manage compliance. The nurse we spoke with was able to explain what action they would take if a patient refused this medication and what the process would be for them restarting. We were advised that the provider had a central tracker to plan and ensure patients had the correct physical health monitoring when being prescribed clozapine.
- The occupational therapy staff used the Model of Human Occupation screening tool to measures outcomes for patients. They also incorporated SMART goals set by the patients in their individualised care plans. Patients had a twelve-week programme. However, there were no other outcome measures used

by the rest of the staff team. The consultant told us he planned to initiate training in Health of the Nation Outcomes Scales (HoNOS) a measure of the health and social functioning of people with severe mental illness.

Skilled staff to deliver care

- At the last inspection in January 2016, there was a range of disciplines within the staff team. The team included occupational therapists, a psychologist, a social worker, a consultant psychiatrist, and nursing staff. At the time of this inspection, the staff team had reduced. The provider did not have access to a social worker and the current substantiative clinical psychologist was unavailable. The provider had 15 vacancies in total. However, a part time locum psychotherapist had started two weeks ago and in the morning meeting, the staff team discussed using volunteers from a voluntary agency to deliver cognitive behavioural therapy.
- At the last inspection in 2016, occupational therapy staff worked with the team to help them provide activities for patients. The therapists were not permanent hospital staff. They were working on a locum basis or were coming in from other units. At the time of this inspection, the provider had recruited an occupational therapy team. The lead occupational therapist had developed a weekly-individualised programme of activities for patients that included budgeting, cooking and gardening. There were occasions that occupational therapy groups had to be cancelled if the occupational therapy staff were required to carry out other duties, such as driving, due to shortages of staffing.
- Patients told us that if they did not attend the groups they lost all or part of their leave. We discussed this with the consultant who told us that when patients had not attended groups or participated in any recovery focused work it affected their ability to leave the ward and live independently. However, the provider did not have a policy that reflected this rule.
- At the last inspection in January 2016, the manager confirmed that there had been a poor culture of supervision within the hospital. The supervision log showed the majority of staff had not received supervision since 2013, although we found some supervision records dated after May 2015. These records were of poor quality and did not relate to the majority of staff that were in post at the time of inspection. Two senior nurses in the transformation team were due to take over clinical supervision from January 2016. At this inspection, we found this had not improved. Staff told us they did not receive regular supervision or support from the management team.

Multi-disciplinary and inter-agency team work

- While the multi-disciplinary team reviewed each patient monthly, the meeting did not include a representative from all of the staff disciplines. For example, there was no one from psychology or occupational therapy at the meeting. Staff unable to attend did not submit updates for the team to consider. We observed three patient reviews and found staff working together to meet the needs of the patient and promote recovery and independence. The inspection team felt there could have been more focus on the patient view during these meetings, and that at times some staff did not hear the patient voice. For example, patients wanted to understand the providers policy on e- cigarettes, but staff had not explained it appropriately.
- Handovers occurred twice daily, and a morning meeting and handover log kept a record of all discussions. Senior staff would disseminate information to the rest of their team following the morning meeting. Staff reported close relationships within the team. The hospital also worked closely with another Partnerships in Care hospital in the South East and staff would access peer support and attend meetings across both sites.

Adherence to the MHA and the MHA Code of Practice

- We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in reaching an overall judgement about the Provider. At the time of inspection, Nelson House had 18 patients detained under the MHA.
- Detention documentation complied with the MHA and the code of practice. A Mental Health Act administrator scrutinised documentation, although, this was not their only role. The provider did not have effective systems in place to support staff in meeting the responsibilities of the MHA. For example, the provider carried out Mental Health Act audits but did not scrutinise the results to identify where they could improve.
- Staff kept completed consent to treatment forms with prescription charts. Staff administered emergency treatment appropriately and second opinion appointed doctors (SOAD) requested. There was no discrepancy

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

between medications administered and medications authorised by the SOAD. Detained patients being administered medication for longer than three months had a T2 or T3 form in place. Staff completed a T2 form when a patient who had capacity agreed to take medication after three months detention. A T3 is provided by a SOAD when a person who lacks the capacity to consent to medication remains on medication after the first three months detention, or the patient has capacity but does not agree to taken their medication.

- All patients were aware of which section of the Mental Health Act the provider had detained them under. Patients had information on their rights to appeal under the Act. This included a record of how the patient responded and their understanding of their rights.
- A standardised process was in place for authorising section 17 leave. Staff struck out forms or ended them after review. A risk assessment took place prior to patients taking section 17 leave. Staff told us the provider had increased patients leave. The provider was looking at more positive risk taking. Staff reviewed suspended leave daily and replaced it with escorted leave where appropriate. Between October 2016 and December 2016, patients had 1,227 episodes of leave and staff had cancelled 13 episodes.
- Patients had access to an independent mental health advocate and were aware of this service. Some of the patients interviewed were using this service.
- There were restrictive practices in place that were not in line with the Mental Health Act code of practice, for example visitors could not go into patients' bedrooms. The visitor's policy did not state this, but staff confirmed this was the case. The MHA revised code of practice, states that patients should be able to see all their visitors in private, including in their own bedroom if the patient wishes. The hospital did not document why it was deviating from the code of practice and there was no individual assessment of risk and need to explain this.

Good practice in applying the MCA

- Not all staff employed had completed combined training on the Mental Health Act, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The actual percentage who had attended was 73% of the current staff team. However, the remainder were either agency staff or new in post and undergoing the induction and not started on the wards.
- The hospital had made no DoLS applications in the 12 months prior to inspection.
- Nelson House had a policy and procedure on Mental Capacity Act 2005. It detailed the principles of the Act, the processes around decision-making and best interest assessments, the use of the independent mental capacity advocate and the legal obligations set out in the Act.
- Staff understood the principles of the MCA and were able to give examples of how they had appropriately assessed patients' capacity. Medical staff knew that an assessment of capacity was decision specific and the aim was to use the least restrictive option. Staff undertook capacity assessments in relation to medication and finances and documented these in the patient treatment records. The hospital worked closely with the local authority who undertook best interest assessments when required. Staff presumed all patients had capacity unless proven otherwise.

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

Good

Kindness, dignity, respect and support

- We observed staff and patient interactions during a number of activities. Staff treated patients with respect. We observed staff being polite. Communication was light hearted and natural during activity sessions. We saw staff in-group activities supporting patients and working well alongside them.
- Most patients felt that the staff treated them with respect. However, patients told us that they did not understand the hospitals no smoking policy, in particular, when they could smoke, and why they could

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Requires improvement

not have access to disposable e-cigarettes in the hospital garden. The manager told us this was a provider policy across all service and was due to e-cigarettes being classed as a fire hazard.

The involvement of people in the care they receive

- 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. The advocate felt communication with staff was effective.
- The occupational therapist held separate fortnightly community groups for male and female patients. The male patients attended their meeting regularly. This meeting gave patients the opportunity to feedback on the service. For example, patients requested a new menu and for it to be displayed in the communal areas which staff actioned. The occupational therapists aimed activities at promoting patient independence with sessions on cooking and budgeting.
- We saw evidence in care plans that staff recorded patients' opinions. For example, in one care plan, a patient had disagreed with what staff had written. Staff recorded what the patient disagreed with, what they would have preferred, and why this was not appropriate. Three out of five care plans recorded that staff offered the patient a copy of their care plan. There was no evidence that patients, family members or carers were involved in developing their care plan.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- Nelson House had 32 beds and at the time of inspection, there were 18 patients. At the last inspection in January 2016, the provider had decided to restrict new admissions to allow staff to embed quality improvement changes. In January 2017, the provider closed the wards to all admissions, as staff had not embedded all of the identified quality improvements appropriately.
- At the last inspection in January 2016, the provider did not have a robust admissions and discharge procedure in place. This had not improved at the time of this inspection. In the 12 months prior to this inspection the average length of stay increased from four months in February 2016 to 10 months in December 2016. Since July 2016, the provider had discharged six patients and admitted 14 patients. The manager told us they are still discharging patients who are not suitable or appropriately placed for locked rehabilitation.
- The manager told us that patient discharge would only occur following discussions with care coordinators. They would work together, along with the patient to identify an appropriate care pathway. This meant patient discharge would occur at appropriate times in the day. However, we identified two delayed discharges. The manager told us funding had been in place for one patient for some time but there was a difference of opinion in how to proceed. The medical and nursing team were working to promote discharge but felt that the patient needed more time. A plan was in place including input from occupational therapy staff to prepare the patient with skills they would need in the community was in place.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms and equipment in the hospital to support treatment and care. The lounge on the ground floor 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.
- Staff cooked food on site and patients selected their own meals. Hampshire County Council gave the hospital a hygiene rating of five, last assessed in 2015. Staff displayed the daily menu in the dining area. Comments about the food were generally good. Patients had access to a beverage area. Patients had a key to their bedroom and were encouraged to personalise their rooms. All bedrooms were single occupancy with an en-suite toilet, shower, and washbasin.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- At the last inspection in January 2016, Patients who were unable to cope with a ward environment used the bedrooms on Mary Rose ward. However, the provider had closed this ward to referrals. Mary Rose ward was cold and the furnishings were not as comfortable as the wards upstairs. Staff also locked the kitchen. The patients on Mary Rose had to access the male ward on the second floor to make hot drinks or sit in comfort. At this inspection, there were two patients on Mary Rose ward and the environment had not improved. The manager told us the provider had delayed plans to open the ward as a pre-discharge unit.
- The garden area was small and poorly designed. Access to the garden was restricted. At the last inspection in January 2016, the manager told us that patients could access the garden if they requested. However, at this inspection patients told us this had not improved and there was not always staff available to escort people to use the garden.
- At the last inspection in January 2016, water temperature in patient's bedrooms was variable. On one side of the building, it was lukewarm and sometimes cold in the sinks and the shower. Senior staff told us they did not know about it. Patients confirmed that they had been raising it as a complaint for some time. We found no record of this complaint, but support workers confirmed patients had raised it as an issue on a number of occasions. At this inspection, we tested 18 showers and found 14 were either lukewarm or cold. Three showers in the communal bathrooms sprayed into the bathroom over the toilet. Patients standing under the shower would not be under the directed water. One patient told us he was fed up of having a cold shower. Another brought it to the attention of the staff in the community group held that morning. We raised this with the manager who told us they were waiting for the maintenance person to start in post so that he could fix this.
- The provider did not have a policy in place for visitors. The manager told us visitors could use the lounge in Mary Rose ward. However, the manager preferred family visits to take place in the community where possible. Patients were able to have their own mobile phones depending on a risk assessment. There was access to an office phone for those who did not have a mobile phone. However, this meant patients did not have any privacy when making personal calls.

Meeting the needs of all people who use the service

- The hospital was accessible to patients in a wheelchair, with a disabled access lift. Wide ranges of information leaflets were available on the wards. These included details regarding treatment available, how to complain and how to access advocacy services. The staff had access to interpreters if required.
- Patients were able to prepare their own meals in the therapy kitchen with the support of staff as part of their therapeutic plan. Patients were able to request specific food based on their cultural and religious needs. Some patients followed a healthy eating plan and the kitchen-facilitated requests for these meals. Patients were able to attend their local church. Religious items were not available for patients to use such as a prayer mat and holy books. Staff told us they would assess this need at the admission stage and get any items required.
- The provider had a no smoking policy that was not effective as not all staff followed the policy correctly. For example, one staff member told three patients they could have a cigarette before they attended the group and another staff member told them they could not have a cigarette. Staff told us patients normally enjoyed the group but were frustrated at the lack of consistency about the smoking policy. During the inspection, we saw groups of patients waiting for staff to take them out on group leave; we heard staff and patients refer to this as a smoking break. Patients had a smoking care plan if they wanted to stop smoking but not to help manage patients who wished to continue. The manager told us that the service could not assist people to smoke.

Listening to and learning from concerns and complaints

- The provider recorded two complaints in the last 12 months. A detailed review of the complaints found that staff had recorded and investigated them following the hospital complaints procedure. The provider partially upheld one of the complaints. Staff recorded the patient's preferred outcome and took action where required. The manager gave staff feedback from the outcome of complaints in the morning meetings.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Patients reported they knew how to complain. There was evidence that patients could complain directly to the hospital or through the advocacy service. Staff told us they did not always document complaints, as the hospital was proactive in addressing concerns raised in the community meetings. Staff did not receive training on dealing with concerns at work as part of their mandatory induction-training package.

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

Requires improvement

Vision and values

- Partnerships in Care values were that patients and their families deserve the highest quality care possible. The provider did not display the organisational vision and values for staff and patients to read. We found that senior manager had an awareness of both the vision and values of the parent organisation. Staff did not know the organisations vision and values. The majority of staff told us that they had their own values about treating patients with respect and caring but they were not clear about the organisations values. Staff reported that the hospital management team was visible.

Good governance

- The manager at Nelson House attended a monthly clinical governance meeting that was part of another service. We reviewed the minutes of the three joint clinical governance meetings held in 2016, the last one being December 2016. The terms of reference for the meetings were unclear. The minutes showed evidence of a review of previous actions and an update on audits. However, the information for Nelson House was limited. This meant that the provider did not focus solely on the development needs of Nelson House. We discussed this with the Priory Operations Director who showed the inspection team minutes of their clinical governance meeting, the actions included Nelson House having their own clinical governance meetings in the future led by the new consultant in post.
- The provider used key performance indicators to measure the performance of the hospital. The manager compiled these from the electronic recording system that staff populated with certain patient data. The data reported on included number of incidents and safeguarding's, patient outcome measures, medication errors, restraints, additional observations, and unescorted leave. Staff told us that the hospital management did not share this information with the rest of the staff team. At this inspection we found some monitoring systems and processes were in place. However, these were not effective for consistently assessing quality and safety issues, or monitoring if actions taken had led to improvement. We found that a number of building maintenance issues had not been addressed and were still outstanding from our previous inspection.
- The Priory Group had introduced a risk register in January 2017, which had five items on it. This operated alongside the Priory's national risk register. The hospital was inspected one month after the introduction of the risk register and it was not possible to conclude whether the register was being used to effectively and routinely monitor risk. The items on the register had been added by the Priory Groups senior team and staff would be able to add items if required through discussion with the manager.
- The provider did not have a planned audit schedule. During 2016, the service had carried out various audits. However, these did not cover clinical audits such as medicine administration records, medical reviews, care plans, and risk assessments. Staff told us they reviewed medicine, care plans, and risk assessments in staff meetings. The provider did not have a system in place to check that staff had responded to any issues identified. However, the Operational Director told us the Priory Group had identified this as a risk and entered it onto their risk register.
- Mandatory training compliance was 90%. Overall completion was 76%.However, only 25% of staff completed infection control and 43% completed safeguarding adults level one. The provider did not have systems in place to ensure that staff received mandatory training. The majority of staff had not received a yearly

appraisal. Clinical supervision did not take place regularly. The manager said they had an open door policy to discuss any issues staff had. However, staff felt this was not always supportive.

- When incidents occurred investigations were prompt and staff identified lessons for the team to learn. There was evidence the provider had taken sufficient steps to ensure that staff embedded changes in practice from incidents. Staff demonstrated knowledge of the principles of the duty of candour. They recognised the need to be open and honest with people who used the service and their carers (where appropriate) when things went wrong.

Leadership, morale and staff engagement

- At the last inspection in 2016 Partnerships in Care identified that the leadership of the hospital needed to change to ensure the provider could make improvements. At this inspection, leadership had not improved. Staff told us the manager was visible as they worked on the wards daily. However, staff morale was low. Staff told us they valued the core team members but were not happy in the managerial support they received. For example, staff did not feel confident about raising concerns with the hospital manager. Sickness was high. The total absence percentage for Nelson House was 5% between January 2016 and January 2017. The average number of leavers per month was two. The provider did not carry out staff feedback surveys, which meant staff could not contribute to the development of Nelson House.

Commitment to quality improvement and innovation

- Nelson House did not participate in accreditation for inpatient mental health services (AIMS) although were considering it for the future.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

- 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 test 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 receives 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 clients. 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.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The provider should ensure that patients have the facility to make private phone calls.
- The service should ensure it identifies how patients are assessed for leave, when and for what reasons leave will be rescinded. If there is any link, between restricting leave and attendance at groups, this should have a clear rationale for all staff and patients to understand decisions made.
- The provider should ensure that all care plans are personalised and include the patient's views.
- The provider should ensure family members or carers are invited to attend patient care programme approach if appropriate.
- The provider should assess the impact the no smoking policy had on patients and support them with the changes.
- The provider should ensure that patients have regular access to outside space.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not employ proper and safe management of medicines. We found excessive medicines in stock, some of which were out of date. Staff did not dispose of medication appropriately.** **This is a breach of regulation 12(2)(f)(g)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider did not maintain standards of hygiene appropriate for the purposes for which they are being used.** **The provider had not ensured that equipment was effectively maintained and timely action was taken when improvements were required.** **There were a number of building maintenance and environment actions still outstanding.** **This is a breach of regulation 15 (2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The provider did not mitigate the risks relating to the health, safety and welfare of service users. The provider did not carry out actions identified on a ligature risk assessment or make sure staff were aware of management plans to reduce risk.

The provider had not ensured that regular health and safety risk assessments of the premises (including grounds) and equipment are undertaken.

The provider did not 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

This is a breach of regulation 17 (2) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure staff receive appropriate support, professional development, supervision and appraisal This is a breach of regulation 18 (2) (a)