# Meadow View

## Quality Report

**Willingham by Stow,**
**Gainsborough,**
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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? | Inadequate |
| Are services effective? | Requires improvement |
| Are services caring? | Requires improvement |
| Are services responsive? | Requires improvement |
| Are services well-led? | Requires improvement |

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

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

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

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

# Summary of findings

## Overall summary

We rated Meadow View as requires improvement because:

- We received limited assurance about safety. Managers had identified ligature risks throughout the hospital. They had identified ways to minimise the risk to patients, however there was no date for the work to be completed and no plan in place to immediately address the risk. Staff did not check emergency medical equipment regularly.
- Patients' privacy was compromised when they were in seclusion. The seclusion room window had no blind so patients in the activity kitchen could see in to the seclusion room.
- The service did not meet patient needs. They did not provide a range of activities for patients to take part in.
- Managers did not monitor the quality of the service or the performance of staff to ensure good quality care. Managers did not provide regular supervision for staff and appraisals were not taking place. The new audit schedule to monitor care and treatment was not fully embedded.
- Staff did not record discussions about consent with patients so it was not clear if people agreed to their treatment. There was limited evidence of patient involvement in their care.
- Patients told us they did not receive consistent care because of high agency and bank staff usage. The vacancy rate was an average of 9% for the previous 12 months.
- There was poor physical healthcare monitoring for patients.

However:

- Staff assessed risk to patients by completing a comprehensive risk assessment. Staff updated records when patients' risk level changed
- Managers were visible on the wards and staff knew the directors.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Forensic inpatient/ secure wards | Requires improvement | |

# Summary of findings

## Contents

Requires improvement

# Meadow view

**Services we looked at**
Forensic inpatient/secure wards

# Summary of this inspection

## Background to Meadow View

Meadow View is located in Gainsborough, Lincolnshire and provides a low-secure environment for male patients who are detained under the Mental Health Act 1983.

The regulated activities which Meadow View is registered to provide are:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

The manager was in the process of making the application to become the registered manager at the time of the inspection.

Meadow View provides services for up to 28 patients across two wards. Cedar ward is an admission ward and Ash ward is a rehabilitation ward.

The Care Quality Commission has inspected Meadow View on two previous occasions. In November 2013 we found the provider to be non-compliant across three outcomes. In November 2014 in a follow-up visit we found the provider to be non-compliant in patient care and welfare, supporting workers, monitoring service quality, and providing notification of other incidents and records.

Soon after we inspected this location it was transferred to another provider, Partnerships in Care and significant changes were made to the management structure.

## Our inspection team

Inspection manager: Margaret Henderson, inspection manager, Care Quality Commission

Lead inspector: Sean Nicholson, inspector, Care Quality Commission

Our inspection team comprised one CQC manager, three CQC inspectors, one CQC assistant inspector, one Mental Health Act reviewer, one specialist advisor (a mental health nurse), and one expert by experience. An expert by experience is a person who has direct experience of the care services we regulate, or is caring for someone who has experience of using those services.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service, asked a range of other organisations for information, and sought feedback from patients.

During the inspection visit, the inspection team:

- visited both wards and looked at the quality of the environment
- observed how staff cared for patients

# Summary of this inspection

- spoke with nine patients and collected feedback from six patients using comment cards
- spoke with the managers or acting managers for both wards
- spoke with seven other staff members including doctors, nurses and social workers
- interviewed the director with responsibility for the service
- attended and observed four handover meetings and a patient's council meeting
- looked at nine patient treatment records
- carried out a specific check of medication management on both wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

- Patients said that they felt safe within the service. They told us that they would like to have more things to do because not many activities took place each day.
- Patients reported that the permanent staff showed interest in them. However, they also said the number of different non-permanent staff was problematic and these staff were not always interested in them.
- The annual quality assurance patient survey 2014/15 received nine responses. The scores ranged from 60 to 100 on satisfaction. The survey asked about involvement in care, environment, facilities and food.

# 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?

Inadequate 

We rated Meadow View as inadequate because:

- Managers had identified ligature risks that required action but had set no date for completion of this work. They had not updated the plan to minimise the risks.
- Staff felt unsafe using some clinical and dispensing rooms. Patients had attacked staff in these rooms and the room sizes did not allow for easy escape.
- Staff did not regularly check emergency equipment, meaning there was no assurance that the equipment would work in emergency situations.
- Staff did not lock drawers in the clinic rooms. We found tweezers, scissors and forceps in unlocked drawers that patients could potentially access and use as weapons.
- The provider used a large number of bank and agency staff and this impacted on continuity of care.
- Qualified nurses sometimes left the communal area to attend ward rounds or complete paperwork leaving patients unattended. This could pose a risk to patients. There were times when staffing was below agreed levels.
- The consultant only visited the wards while completing weekly ward rounds.
- Staff did not record episodes of seclusion in line with the Mental Health Act code of practice.
- The provider had no formal processes to share learning from incidents with staff and managers did not share learning on a regular basis. Managers did not share any learning from incidents with the agency and bank staff. The provider did not maintain an audit trail to highlight learning from incidents or feedback to patients.

However:

- Staff could observe all areas of the wards because the layout provided good lines of sight.
- Staff completed risk assessments on patient admission and updated these assessments throughout the patient's stay. Staff carried out risk assessments before patients accessed the kitchen to make hot drinks.
- Managers were addressing recruitment issues and had recently employed six healthcare assistants who were due to start in September 2015.
- The premises were clean, tidy and well maintained.

# Summary of this inspection

## Are services effective?

Requires improvement

We rated Meadow View as requires improvement because:

- Managers did not set actions to improve compliance in the recording and monitoring of supervision and training. They did not monitor safeguarding notifications. We found errors in patient care plans. Managers did not provide all staff with up-to-date appraisals or clinical supervision.
- Staff did not regularly monitor patients' physical healthcare needs.
- Clinicians did not record what was explained to patients about their care and whether patients had consented to treatment. They did not record whether patients had fully understood the implications of their consent, including if there were any side effects.
- Staff were not aware of the hospital's policy on mental capacity and Deprivation of Liberty Safeguards (DoLS). Staff did not record mental capacity assessments in clinical notes. Managers did not audit or monitor the use of the Mental Capacity Act within the hospital.
- We spoke with nine patients. Four patients, on Cedar ward, stated they could not identify their named nurse.
- Patients told us there were limited groups and activities.

However:

- The historical clinical risk assessments (HCR-20) and health of the nation outcome scales (HoNOS) on both wards were completed comprehensively.

The multidisciplinary team met each morning to discuss current issues relating to patient care.

## Are services caring?

Requires improvement

We rated Meadow View as requires improvement because:

- We witnessed little staff to patient interaction. For example, staff mainly observed rather than engaged with the patients.
- Patients reported that the use of agency and bank staff was difficult for them as they felt uncomfortable talking to them.
- Staff did not encourage patients to be involved in their care planning.
- We spoke with four patients on Cedar ward who said that they did not know who their named nurse was.

However:

- Staff spoke with patients respectfully and responded to patients' needs. Staff supported patients to familiarise themselves with the ward environment on admission.

# Summary of this inspection

- Patients could use a telephone to access advocacy services as and when required.
- Staff encouraged families and carers to visit and be involved in their friend's or relative's care and treatment.
- Patients attended monthly ward council meetings.

## Are services responsive?

**Requires improvement**

We rated Meadow View as requires improvement because:

- Any cooking that took place was off the ward in a designated area. This facility was not available 24 hours a day.
- Patients told us there were few activities during the week.
- The service did not provide information for patients in different languages or display information on how to access interpreters.
- Staff did not provide patients with information on how to make comments or complaints about the service. Patients did not always receive feedback on complaints and felt complaints made little difference. Staff reported they did not always receive feedback from patient complaints.
- The wards did not offer multicultural or religion-specific foods on its menu. The menu offered choice but was repetitive, especially for evening meals.

However:

- The wards had a range of rooms that patients could use to engage in therapy. The service provided a multi faith room for patients within the secure perimeter.
- Patients were able to personalise their bedrooms and could lock away their belongings in their room.
- Discharge planning was in place. Patients were discharged via a discharge planning meeting (under the Mental Health Act 1983) following agreement between the clinical team and NHS England commissioners.

Staff only moved patients between wards when required because of their clinical presentations.

## Are services well-led?

**Requires improvement**

We rated Meadow View as requires improvement because:

- The service had no clear vision, objectives or policy statement for staff to follow.
- Nursing staff supervision and appraisal rates were low with 32% for Cedar ward and 25% for Ash ward compared to target rate of 85% (NHS England contract requirement).

# Summary of this inspection

- Managers used large numbers of bank and agency staff to ensure the wards were covered safely.
- Qualified staff spent time on administrative tasks which took them away from caring for patients.
- The service did not have any governance systems to monitor and audit overall performance. There was no process for monitoring records or how mental capacity was discussed with patients. Staff said they did not participate in clinical audits.
- Staff had limited opportunities for leadership development because of the pressure of covering the wards with safe staffing levels.

However:

Staff felt able to raise issues with senior management, who were regular visitors to the
wards.

# 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.

All the detention paperwork was correct and up to date.

There was limited evidence of documentation in clinical notes that patients had their rights read to them on admission and periodically thereafter.

Consent to treatment forms were kept with the medication charts. However, we saw one example where the responsible clinician had signed the T3 form on 28 November 2014 whilst the second opinion approved doctor had signed the form on 24 September 2013. It is good practice to review second opinion more frequently especially in reviewing capacity to consent to treatment.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff could not describe the local policy on mental capacity and deprivation of liberty safeguarding (DoLS), and whether DOLs applications were monitored. At the time of inspection all patients were sectioned under the Mental Health Act and there were no DoLS applications.

Staff did not complete mental capacity assessments with patients. The service did not audit the use of the Mental Capacity Act.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Forensic inpatient/ secure wards | Inadequate | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Overall | Inadequate | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |

Requires improvement

# Forensic inpatient/secure wards

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

## Are forensic inpatient/secure wards safe?

Inadequate

Safe and clean ward environment

- The hospital stored emergency equipment and stock medication in a central clinic room which was situated off the main wards. Staff had not maintained essential equipment in the clinic. The defibrillation machine and the electrocardiography (ECG) machine had no date of when they were last checked. There was no record of the electrical testing date and the pads used for defibrillation expired June 2014. Defibrillation is when someone's heart is re-started using an electric shock. Fridge temperatures were not recorded regularly.
- Staff identified ligature points across the service but did not provide a date for completion of this work or updated the plan to minimise the risks. Ligature points are things that patients can tie something to and strangle themselves.
- Staff administered medication from small rooms on each ward. Staff felt unsafe using these rooms. Patients had attacked staff in these rooms in the last 12 months and the room sizes did not allow for easy escape. The doors were stable doors and opened inwards, making escape difficult. Managers had not made any changes to the room layout which evidenced poor learning from incidents.
- Patients had access to the clinic under the supervision of a doctor. However we found unlocked drawers with eight items, including scissors, forceps and tweezers, which could be used as weapons. There were four sharps bins awaiting disposal in the clinic within easy access of patients in the room. Patients could retrieve sharp objects to use as a weapon.
- Meadow View had no environmental risk assessments. Staff had alarms to call for help in case of incidents.
- Staff were able to observe patients in all areas because the environment provided good lines of sight and good use of mirrors to assist.
- The wards were clean, tidy and well maintained.

Safe staffing

- Managers planned staffing levels using one rota that covered both wards. Morning handovers incorporated both wards which allowed all staff to be aware of any issues across the hospital.
- Staffing levels each day were two qualified and eight health care assistants (HCA) for a 12 hour day shift and six per shift at night with two qualified and four HCA staff. This was across both wards. Night staff reported that they felt isolated due to the number of staff on duty and the hospital's geographical location.
- The service had five vacancies. Staff turnover was 30% according to July 2015 data. The vacancy rate was an average of 9% for the previous 12 months.
- Managers did not use specific tool to calculate the number of staff required per shift, however the two team leaders met weekly to plan the staffing requirements. Team leaders on both wards had autonomy to increase staffing levels up to agreed limit when necessary.

Requires improvement

# Forensic inpatient/secure wards

- The service used agency and bank staff across the hospital. For the period 01 to 13 August 2015 Meadow View required 52 qualified shifts. Twenty were covered by bank/agency staff (38%). There was a qualified nurse on each shift.
- There was an active recruitment process in place with six new healthcare assistants starting in September 2015.
- Staff were trained in the management of violence and aggression techniques. Managers had changed the training programme on advice from NHS England commissioners. Not all were trained in new programme. The action plan stated that the training should have been implemented by April 2015. There was a rolling training programme in place to train all relevant staff but not everyone had received it.
- Staff and patients said they did not see the consultant on the wards apart from weekly ward rounds.
- Staff acknowledged that escorted leave and activities were sometimes cancelled because of low staffing levels, especially if a patient required escorting by a male member of staff specifically.

Assessing and managing risk to patients and staff

- Staff assessed patients prior to admission to the wards. Staff completed a historical clinical risk assessment (HCR-20) with patients on admission and updated it as and when risk changed. The assessments were of a good standard.
- Patients on Ash ward had an up to date and detailed risk assessment that was rated according to risk. These risk assessments were easy to follow and understand. Staff on Cedar ward staff did not update the risk assessments after an incident. Staff carried out risk assessments before patients accessed the kitchen to make hot drinks.
- Patients were not allowed to smoke between 19.30 hours and 08.15 hours. Staff stopped patients having cigarette breaks if they were late returning from their previous break. Patients were only allowed cold drinks at night. Staff locked the kitchen at night time so patients had to use the bathroom to access water to drink. This issue was discussed in the patient's council meeting held on the ward but focussed on patients not drinking out of the bathroom rather than resolving the issue of no drinks being made available. These were unjustified blanket restrictions.
- Meadow View had policies which included the observation of patients, absconsion and escape, and the management of challenging behaviour. Policies were stored on a local database accessed by all staff.
- Cedar ward had 11 episodes of seclusion between May to August 2015, two lasted for over 24 hours. There were no seclusions on Ash ward. Both wards said there was an emphasis on de-escalation which was taught on the management of violence and aggression training. There were 60 incidents of restraint on Cedar ward, only three of which were in the prone position. Prone means the patient was laid on their front which should only be used in exceptional circumstances. There were seven incidents of restraint on Ash ward none of which were in the prone position.
- The hospital had one seclusion room situated adjacent to Cedar ward. Staff did not record seclusion correctly. One nurse had signed for two hour nursing reviews. (The Mental Health Act code of practice requires that two nurses sign these records). Staff did not complete records in full. Times, dates and the rationale for ending seclusion were missing from the records. There was no record of medical reviews taking place.
- Staff secluded one patient in the low stimulus room because the seclusion room was in use. Staff used rapid tranquilisation in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Staff knew the safeguarding referral process. Staff had made 29 safeguarding referrals in the last 12 months. The referrals were recorded on a central safeguarding log.
- Children were able to visit privately within the secure area off the ward.

Track record on safety

- There was one serious incident recorded between June 2014 and May 2015. The incident related to physical abuse of a patient by a staff member resulting in the dismissal of the staff member. There were 12 notifications received by CQC between July 2014 and June 2015 which have all been reviewed and closed. Nine notifications related to abuse or allegation, one related to a serious injury and two related to a police Incident.
- From 31 July 2014, CQC received one alert and 10 safeguarding concerns regarding Meadow View Hospital, which have all been reviewed and closed.

Requires improvement

# Forensic inpatient/secure wards

Reporting incidents and learning from when things go wrong

- Staff reported incidents using a newly introduced online system. All permanent staff had access to this system.
- Staff received some feedback from incidents via managers in the morning MDT meetings. There was no formal process for ensuring that all staff, including bank and agency staff, had received this information.
- A psychologist assisted in de briefs to support staff following incidents.
- Managers did not review or identify lessons from incidents to share with the staff team.
- Meadow View had a duty of candour policy and copies of guidance were given to staff.

## Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff assessed patients prior to admission to the wards. Historical clinical risk assessments (HCR-20) and health of the nation rating scale secure (HoNOS on both wards were up to date and comprehensive. The assessments were not multi-disciplinary as they were collated primarily by the psychologist.
- Staff reviewed care plans regularly on Ash ward and care plans were specific to each patient. However, on Cedar ward the care planning was not individualised. Two patients had almost identical care plans with the wrong name in the care plan. There was a poor level of patient involvement in all care planning.
- The hospital held care programme approach review meetings for patients six weeks after admission and then six monthly. Staff did not record information which demonstrated that patients were involved.
- Staff on Ash ward routinely monitored the healthcare needs of the patients. For example one patient who had diabetes had good care planning and follow up. On Cedar ward physical health care was not always monitored.
- Clinical notes were secured within a cabinet in the office. Notes were archived after three months however, records were not kept in any form of order meaning it was difficult to locate historical patient information.

Best practice in treatment and care

- Medication was prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Medical staff did not review PRN (as required) medication within 14 days and one of these was rapid tranquilisation. This happened on four occasions according to the records we looked at.
- Patients told us that they had nothing to do. They said they only had groups twice a week.
- The psychologist was available to speak with patients when needed.
- Staff recorded physical healthcare checks on Ash ward but the records on Cedar ward were of a poor quality. No healthcare checks happened after the use of rapid tranquilisation.
- Records of supervision, appraisals and training records were poor with information missing.
- Meadow View had been creative in some of the groups. One being the use of a patient's experience as plasterer to train both patients and staff in this skill.

Skilled staff to deliver care

- The multi-disciplinary team (MDT) included a psychiatrist, a psychologist, an occupational therapist, a social worker and nursing staff. Nursing staff received a two week induction prior to starting work at the hospital. Staff said they felt the induction process had improved recently in content and relevance to the environment.
- Staff said they did not have an up to date appraisal and did not receive clinical supervision. Appraisal rates were low with 32% for Cedar ward and 25% for Ash ward compared to target rate of 85%.
- Nursing staff told us that they had training in personality disorder that they found to be beneficial in caring for patients with that diagnosis.
- Agency staff and bank staff that made up 38% of the workforce. We had concerns about who supervised or trained these staff because the process was not clear. They received minimal induction to the service.

Requires improvement

# Forensic inpatient/secure wards

- Staff held a meeting each morning including both wards' team leaders, the psychologist, the social worker and the occupational therapist to discuss any current issues.
- There were weekly MDT meetings where patients had the opportunity to have their care and treatment reviewed. Patients had stated that this was the only time they could speak with their psychiatrist.
- Meadow View was a stand-alone independent service and contacted other agencies when required.

Adherence to the MHA and the MHA Code of Practice

- The staff had a good understanding of the Mental Health Act (MHA) code of practice. However, they did not record in the clinical notes evidence of capacity issues discussed with patients.
- Consent to treatment forms were kept with the medication charts. One example showed the responsible clinician (RC) had signed the T3 (certificate of second opinion) form on 28 November 2014 while the second opinion doctor had signed the form on 24 September 2013. It is good practice to review second opinion more frequently, especially in reviewing capacity to consent to treatment
- There were two T2 forms (certificate of consent to opinion) which showed that the patient understood and consented to their treatment. The RC had signed the forms. The forms had been placed in the notes in the wrong section as the page numbers did not follow. There was also no clear explanation written in the clinical notes to state what had been explained to patients. Staff had not recorded whether the patients had fully understood the implications of their consent, or was aware of any possible side effects.
- Staff did not read patients' rights to them on admission or periodically during their stay at the hospital which is required by the MHA code of practice.
- Meadow View had recently requested an independent organisation to audit their MHA and Mental Capacity Act compliance. The service had provided a list of audits which were carried out but staff seemed unaware of these. We were not assured regular monitoring was in place.
- Patients were aware they could contact an advocacy. Notices were displayed on notice boards telling patients about the service. Staff had not made patients aware of the patients' advice and liaison service (PALS), none of the patients we spoke with knew about it.

Good practice in applying the MCA

- Staff reported that training was provided in the Mental Capacity Act.
- Staff could not confirm whether there was a local policy on capacity and deprivation of liberty safeguards (DoLS) and whether the use of DoLS was monitored. One staff member stated that any guidance on such matters they would research themselves.
- Staff did not record mental capacity assessments in the clinical notes. Neither did they record any discussion about capacity with the patient.
- The service did not have arrangements in place for the audit of the use and monitoring of the Act.

## Are forensic inpatient/secure wards caring?

Requires improvement

Kindness, dignity, respect and support

- Staff on the wards were respectful towards patients. However, we witnessed little staff to patient interaction. For example, staff mainly observed rather than engaged with the patients. Patients we spoke with told us that permanent staff were approachable and expressed interest in the patients' needs.
- Patients reported that the use of agency and bank staff was difficult for them as they felt uncomfortable talking to them.

The involvement of people in the care they receive

- Staff showed patients around the ward and told them about the service on admission. This process commenced when staff from Meadow View went to assess the patient before admission. Patients received an induction plan on admission that included occupational therapy information, information about 'my shared pathway' and a care programme approach leaflet.
- Staff did not encourage patients to be involved in their care planning. Some patients stated they were not involved. We spoke with four patients on Cedar ward who said that they did not know who their named nurse was.

Requires improvement

# Forensic inpatient/secure wards

- Staff encouraged carers to visit and be involved in their relative's care and treatment. A patient can be a distance from their relatives because patients came from all over the east midlands. Carer involvement was not always recorded in the patient's notes.
- Patients attended monthly patients' council meetings. We attended one of these meetings and saw that patients' views were able to speak about their views. Plans were for patients attend the clinical governance meeting. Each ward had community meetings which patients were invited to attend.
- Patients on Cedar ward felt that they lacked involvement in making decisions about what happened on the ward. No patients were involved in the recruitment of staff.

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## Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- The average length of stay was 732 days with six out of 14 patients having a stay above two years. Three patients had been there over four years.
- Patients may not live in the area and potentially can be a long way from home.
- Meadow View clinicians only moved patients between wards because of their clinical need. Patients were only discharged via a section 117 meeting following agreement between the clinical team and commissioners.
- Meadow View had one delayed discharge between 1 December 2014 and 31 May 2015. Staff told us a delay can be caused when they needed to negotiate with units elsewhere to take patients. There may not always be a bed available at the time it was needed.
- Meadow View stated it used a recovery model called 'my shared pathway'. However we saw no evidence in conversation with patients' or in their clinical notes.

The ward optimises recovery, comfort and dignity

- There were sufficient rooms for therapy and activities and to allow patients to have privacy. Both wards had a phone room where patients could make private phone calls away from others.
- Patients had access to outside space when facilitated by nursing staff.
- Patients could choose from a menu that ran on a three week cycle where there were choices of ten options. However these options were repetitive. The evening meal was a choice of either a meat or vegetarian option.
- Patients were assessed before they used the kitchen to make hot drinks to make sure they were safe to use it. Any cooking that took place was off the ward in a designated area. This facility was not available 24 hours a day.
- Patients were able to personalise their rooms and could lock away their belongings in the room.
- Patients told us that there were few activities during the week. We saw patients sitting around the ward, not engaging in any group or individual activities.

Meeting the needs of all people who use the service

- Meadow View was on the ground floor and was accessible by wheelchair. It had disabled bathroom access on each ward. We saw signs for advocacy but nothing for those who did not speak English or how to access interpreters.
- There was a multi faith room for patients within the secure perimeter. Multi-cultural food was available on the menu however, there was no food designated for specific religions. Meadow View Hospital was awarded a Food Hygiene Rating of 5 (Very Good) 13th March, 2014.
- Staff reported that they were able undertake their individual sessions with patients.

Listening to and learning from concerns and complaints

- The leaflets giving information to patients on how to complain or raise issues within the service were out of date. There was a complaints process in place. Patients said they knew how to complain but were unsure what the process involved. In the patient survey the score for knowing how to complain was 66%. Patients said they felt it made little difference and that they didn't always receive feedback from complaints.
- There were nine complaints registered over the previous 12 months, five of these were upheld.

Requires improvement

# Forensic inpatient/secure wards

- Staff were aware of the process for complaints and who to send them to. Staff reported that they did not always receive feedback from complaints.

## Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and Values

- Staff felt that the leadership of Meadow View had been more visible over last 12 month. However, Meadow View managers did not provide objectives or a policy statement for staff to follow. There was no vision or values identified for the approach to care.
- Staff were aware of all the senior managers and their roles. The managers regularly visited the wards and staff felt that they could approach them about any concerns.

Good governance

- Mandatory training rates had improved following the appointment of a training coordinator. The compliance had increased from 58% to 80% from December 2014 to August 2015.
- Staff supervision and appraisal rates for nursing staff were low.
- Staff did not participate in clinical audit. Staff interviewed felt that it was not their job and audit was the responsibility of the managers.
- Staff reported incidents and we saw evidence of an improvement in the process of sending notifications to the local authority and the CQC. The wards had implemented a tracker to keep a check on notifications.
- There was no evidence of systems in place to monitor assessment of mental capacity.
- Managers had no formal process for feeding back to staff and learning from incidents and complaints. Any learning was via an informal basis at handovers.
- Staff knew how to report safeguarding issues with guidance on the wards.
- Meadow View had a limited governance structure to monitor performance. The management were aware of this and had commenced a process to address these issues. For example they had implemented an improved supervision structure. We saw a recent health and safety action plan. However this had not been shared with the ward staff.

Leadership, morale and staff engagement

- Sickness rates were an average of 4.5%, from June 2014 to May 2015. This was a percentage of the permanent staff employed within the service.
- Staff we spoke with felt supported and able to report issues to their direct line managers.
- Staff morale was good and that training for staff had improved with the introduction of new managers. Psychology and occupational therapy staff, and the training coordinator spoke of a sense of empowerment and encouragement to undertake their roles.
- Staff had limited opportunities for leadership development because of the pressure on staffing.
- Meadow View had a duty of candour policy and copies of guidance given to staff. There were new managers who were working to address the issues raised in a previous CQC visit. They had identified six quality priorities which included improvements to the supervision structure, monitoring arrangement and reductions in staff turnover.
- All staff said the wards were moving towards being more open in attitude and communication. They felt able to raise issues to senior management who were regular visitors to the wards.

Commitment to quality improvement and innovation

- Meadow View was part of the quality network for forensic mental health services, who undertook a positive peer review of the unit in 2015. They reported that they have registered for the national audit of schizophrenia. This is the first year that they will be completing the audit.

# 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 all medical equipment is in date, maintained according to the requirements of the manufacturer and checked regularly.
- The provider must ensure that items in the clinic room that could be used as weapons are locked away appropriately and accounted for.
- The provider must ensure that the ligature risks within the wards are addressed and a timescale defined for completion of works.
- The provider must ensure that the seclusion facilities and records of seclusions meet the requirements of the Mental Health Act 1983 code of practice (2015), ensuring patient privacy and dignity for patients using the room.
- The provider must ensure that staff are supervised and have an annual appraisal.
- The provider must ensure patients and staff are informed about the outcome of any complaints and that learning is evident.
- The provider must ensure healthcare needs of patients are assessed, monitored and recorded.
- The provider must ensure there are robust and effective governance processes, including monitoring of record keeping, dealing with complaints, feedback from patients and management of risks.

### Action the provider SHOULD take to improve

- The provider should reduce the quantity of agency nurses used.
- The provider should ensure that records detail patients' understanding of the treatment that they are consenting to.
- The provider should have suitable facilities in place for the storage of archived clinical records.
- The provider should provide a range of meaningful activities throughout the week and at weekends.
- The provider should avoid the use of blanket restrictions and use only when justified.

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<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>Patients' privacy was compromised when they were in seclusion. The seclusion room window had no blind so patients in the activity kitchen could see in to the seclusion room.<br><br>This is a breach of regulation10(1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Managers had identified ligature risks throughout the hospital. They had identified ways to minimise the risk to patients, however there was no date for the work to be completed and no plan in place to immediately address the risk.<br><br>Staff did not record episodes of seclusion in line with the Mental Health Act code of practice.<br><br>Staff did not check emergency medical equipment regularly. We found tweezers, scissors and forceps in unlocked drawers that patients could potentially access and use as weapons.<br><br>This is a breach of regulation 12(1)(2)(a)(b)(e). |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment |

This section is primarily information for the provider

# Requirement notices

The information leaflets for patients on how to complain or raise issues within the service were out of date. Patients said they knew how to complain but were unsure what the process involved. In the patient survey the score for knowing how to complain was 66%. Patients said they felt it made little difference and that they didn't always receive feedback from complaints. Staff did not always received feedback and learning form complaints.

This is a breach of regulation 16(1)(2)

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>The provider did not have any governance systems to monitor and audit overall performance. There was no process for monitoring records or how mental capacity was discussed with patients. Staff said they did not participate in clinical audits.<br><br>Clinical notes were secured within a cabinet in the office. Notes were archived after three months however, records were not kept in any form of order meaning it was difficult to locate historical patient information.<br><br>Records were incomplete and disorganised.<br><br>This was a breach of regulation 17(1)(2)(a)(c)(e) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Managers did not provide regular supervision for staff and appraisals were not taking place.<br><br>Records of supervision, appraisals and training records were poor with information missing.<br><br>This is a breach of regulation 18(2)(a) |