Meadow Lodge

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

Overall summary

- Staff did not always ensure the young people received urgent and emergency treatment. There was no policy or procedure for staff to follow in a medical emergency. The staff trained as first aiders did not provide first aid to young people on a number of occasions despite the young people requiring first aid intervention. Staff did not record physical and neurological observation of the young people as required to identify if a young person's physical health was deteriorating. Nurses did not update care plans and risk assessments to reflect young peoples' needs. Agency staff, including registered nurses who took charge of shifts, did not receive an induction to the hospital. Managers did not notify the young people and their families when errors in their care and treatment had been made and did not offer an explanation or apology.
- We issued a warning notice telling the hospital it must make immediate improvements in how staff responded to young people who need hospital treatment, that the hospital needed a policy and procedure about the management of medical emergencies, that staff needed to carrying out and record physical and neurological observations when clinically indicated, that care plans and risk assessments needed to be updated following changes to the young person's risk, that all agency staff received and induction to the hospital and that staff followed their duty to act in an open and transparent manner with young people and their families.
- When we returned on 20 December 2018 found that managers had made staff aware of their responsibility to ensure the young people received urgent or emergency medical assessment and treatment without delay. The ward manager had circulated a policy and procedure and displayed it in the hospital and staff had signed a record to say they had read the them and discussed them with the ward manager. Staff were recording physical and neurological observations when needed and the quality of the record had improved and were robust. Staff had updated risk assessments and care plans to reflect the young peoples' changing needs. All registered nurses had received an induction to the hospital. The senior management team had circulated guidance on the duty of candour and introduced a checklist to show when it had been used, staff had signed a record to say they had read the guidance and discussed their responsibilities with the ward manager.
- There had been one incident involving a young person where they had not received a medical assessment

and treatment following an injury for over 12 hours. This occurred after the inspection on the 30 November 2018 but before we issued the warning notice. On this occasion, staff had not signed all recordings of physical and neurological observations.

- Following our second inspection on the 18 December 2018 we made the decision to leave the warning notice in place. The hospital had been placed on enhanced surveillance by the regional quality surveillance group, chaired by NHS England following our recommendations. We continue to work with NHS England and other partner organisations to monitor the hospital closely. We will return to inspect the hospital shortly to ensure the changes the provider has made are embedded and to ensure young people are kept safe.

Summary of findings

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Location name here

Services we looked at
Child and adolescent mental health wards

Summary of this inspection

Background to Meadow Lodge

Meadow Lodge is an independent child and adolescent mental health (CAMHS) inpatient hospital, providing specialist care and treatment for male and female young people aged 13-17 years. The hospital is registered for 10 young people and is split between a two-bedded high dependency area and an eight-bedded general adolescent unit. Young people can be admitted informally or detained under the Mental Health Act (MHA) 1983.

NHS England commissions Meadow Lodge to provide specialist CAMHS inpatient services. CAMHS inpatient units are specialised services that provide assessment and treatment for children and young people with complex emotional, behavioural or mental health difficulties that require inpatient treatment. The hospital accepts young people with a learning disability or an autistic spectrum disorder if their primary diagnosis is a mental health condition.

The hospital is part of the specialist mental health services division of Huntercombe (Granby One) Limited.

Meadow Lodge is registered to provide the following regulated activities: treatment of disease, disorder or injury, assessment or medical treatment for persons detained under the MHA and diagnostic and screening procedures.

The hospital did not have a registered manager in post at the time of the inspection as the previous manager had left the role following long-term sickness.

Meadow Lodge was previously inspected in April 2018. The service was rated as requires improvement overall. Following the April 2018 inspection, we issued four requirement notices for breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and we told the provider it must take the following actions to improve Meadow Lodge:

- Care plans needed to be person-centred and the young people should be involved in developing their care plans.
- The anti-climb fence need to be fit for purpose. The fence in place posed as a significant ligature risk and no action had been taken by the provider to mitigate this.
- The provider did not ensure that referral forms were completed in full, which could lead to the hospital accepting inappropriate referrals.

Our inspection team

The team that inspected the service on the 30 November 2018 comprised two CQC inspectors and one CQC assistant inspector.

The team that inspected the service on 18 December 2018 comprised of two CQC inspectors.

Why we carried out this inspection

In September 2018 we received allegations from permanent staff members that agency workers had been putting young people in the hospital at risk by falling asleep on duty. We spoke to the provider who took appropriate action to no longer use the agency who had provided these staff and conducted internal investigations. The provider gave appropriate assurances that the concerns had been addressed. However, we increased our engagement with the provider and raised the issues with the quality surveillance group, chaired by NHS England; the service was placed under enhanced surveillance. We also shared the information with the local safeguarding authority and police, who have

Summary of this inspection

conducted their own investigations into the concerns. We have worked with these organisations to ensure that a joint approach to responding and addressing the concerns.

On 30 November 2018, following a notification to the CQC that contained information that staff had not ensured that young people received urgent and emergency treatment when needed, we conducted a focussed inspection. Following the inspection, we issued a warning notice telling the provider it must make immediate improvements.

The warning notice served to notify the provider it must improve the service provided at Meadow Lodge because:

- Young people were not receiving hospital treatment for injuries promptly.
- There was no policy in place to manage medical emergencies.
- Staff did not always complete physical and neurological observations when clinical indicated and did not record the observations to a satisfactory standard.
- Staff did not update risk assessments and care plans to reflect increases in a young person's risk.
- Agency staff, including qualified nurses leading shifts, did not receive an induction to the hospital.
- Staff did not follow their obligations to act in an open and transparent manner, sometimes called duty of candour.

We returned on the 18 December 2018 to complete a focused inspection and see if the hospital had improved.

We did not review the three outstanding requirement notices. These will be reviewed during future inspection activity and remain in place.

How we carried out this inspection

As this was an unannounced, focussed inspection to follow up on specific areas of concern, we did not consider all of the five key questions that we usually ask.

Instead we concentrated on the areas of concern and inspected specific aspects of the safe domain.

During the inspection visit on 30 November 2018, the inspection team:

- visited Meadow Lodge,
- spoke with the ward manager,
- spoke with three other staff including the positive behavioural support lead, the quality and assurance manager and the consultant psychiatrist
- reviewed three care and treatment records of young people,
- reviewed the hospital's staff rota,
- reviewed a range of incidents on the hospital's electronic incident reporting system and
- looked at a range of policies, procedures and other documents relating to the running of the service.

During our inspection on 18 December 2018, the inspection team:

- visited Meadow Lodge,
- spoke with the ward manager,
- spoke with nine other staff including qualified nurses, support workers, a social worker, a youth engagement officer and the consultant psychiatrist,
- reviewed four care and treatment records of young people,
- reviewed the hospital's rota,
- reviewed a range of incidents on the hospital's electronic incident reporting system and
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

What people who use the service say

We did not speak to any young people during the focussed inspection on 30 November 2018 or 18 December 2018.

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?

We found the following issues that the service provider need to improve:

During our inspection on 30 November 2018 we found that:

- Staff did not ensure that young people received prompt medical assessment and treatment when needed.
- Staff were not always recording physical and neurological observations, recording was inconsistent and staff did not document a clinical reason for stopping observations.
- The provider had not ensured that agency staff, including registered nurses in charge of shifts, had received an induction to the hospital.
- Staff did not update risk assessments and care plans to reflect changes in the young people's risk.
- We found staff did not fulfil their duty of candour.

During our inspection on 18 December 2018 we found that:

- There had been one incident when staff had not sought medical assistance for a young person when needed. This happened after the inspection on 30 November 2018 but before the warning notice was served. Staff had received and read a policy and procedure telling them when to access prompt medical assessment and treatment for young people.
- Staff were recording physical and neurological observations, when clinically indicated, and the quality of the recordings had improved.
- The manager was now providing agency staff with inductions to the hospital but not all agency support workers had received an induction to the hospital.
- Staff were updating care plans and risk assessments to reflect current risk levels.
- The ward manager had put a system in place to ensure staff followed the duty of candour. The manager had circulated information about staff responsibilities under the duty of candour.

Are services effective?

Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.

Are services caring?

Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.

Summary of this inspection

Are services responsive? Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.	
Are services well-led? Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.	

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe staffing

When agency staff were used, those staff did not receive an induction. None of the agency staff who had worked within Meadow Lodge in the four weeks prior to our inspection on the 30 November 2018 had received an induction into the hospital.

Agency staff including support workers and registered nurses, with no induction, were on every shift in the four weeks prior to the inspection. On 17-night shifts and one-day shift, the nurse in charge of the hospital was an agency registered nurse without an induction.

When we returned on the 18 December 2018 we found Induction records were in place for 17 out of 20 agency staff. All qualified nurses leading shifts had received an induction.

Assessing and managing risk to patients and staff

On the 30 November 2018 we reviewed five care records and saw that they all had a risk assessment completed using the risk assessment template on the electronic care record. However, staff did not update risk assessments and care plans to reflect changes to the young person's risks. For example, we saw that care plans and risk assessments had not been updated following an increase in the severity of self-harming behaviour.

When we returned on the 18 December 2018 we found, staff had updated risk assessments following incidents and care plans identified a consistent approach for staff to manage risk behaviour.

Staff did not arrange for the young people to have access to urgent and emergency health care when needed. On the 30 November we found two occasions when staff did not make sure physical health care was provided to young people in their care. Young people needing access to the local emergency department for serious and minor injuries had to wait extended periods, over 12 hours, before getting the care they needed. Staff had not administer first aid on site or sought advice or medical assistance from any source including the hospitals on call doctor, 999 or NHS 111. Staff had not recognised the seriousness of injuries and told young people there was not enough staff to take them to hospital.

When we returned on the 18 December 2018 we reviewed 7 incidents involving four patients that had occurred since our visit on the 30 November 2018. Six of the records showed staff had responded to the young people's needs in a timely and effective manner. One record showed that staff had not sought medical assistance until the following day. This incident had occurred before we issued the warning notice. However, senior staff had assured us that this issue would be addressed before we had left the hospital on the 30 November 2018.

On the 30 November 2018 staff were unable to show us or explain any policy that showed them what should be done when there were medical emergencies at the hospital. This included under what circumstances they would summon medical assistance or escort a young person to the emergency department.

When we returned on the 18 December 2018 we saw a standard operating procedure, including a flow chart, had been put in place and shared with staff via email, team meeting and displayed on notices boards.

On the 30 November 2018 staff did not always record physical or neurological observations of young people when clinically indicated. Staff had not followed advice from the local emergency department to continue physical and neurological observations and did not record the reason they had not.

Child and adolescent mental health wards

Record keeping of physical and neurological observation was not of an acceptable quality. We reviewed 19 incidents from four young people. On seven occasions where staff had recorded that physical observation would be completed, we could not find them recorded on the young peoples' physical observation charts. Senior staff told that there were three locations observations could be recorded (PEWS form, in electronic care record or the post physical intervention recording form). This meant there was not a consistent record and that staff could not easily see any deterioration in physical health. Where staff had recorded physical observations, they did not always sign the record.

When we returned on the 18 December 2018 we found physical and neuro observations had taken place following incidents and staff had recorded the observations on the PEWS charts. When young people had refused to have observations completed staff had recorded relevant information about the patient's wellbeing.

Reporting incidents and learning from when things go wrong

On the 30 November 2018 we found an incident where staff should have followed the duty of candour; an obligation to be open and honest with patients when something goes wrong with their treatment or care. Senior staff reported in the morning multidisciplinary team meeting that staff had followed the duty of candour. We reviewed records relating to this and saw that staff had not told or apologised appropriately to a young person or their family following errors in their care and treatment. The staff team corrected this during the inspection.

When we returned on the 18 December 2018 we found that the ward manager had circulated guidance on the duty of candour to all staff and displayed it on notice boards around the hospital. A checklist had been developed to help staff identify and record that they had followed the duty of candour guidance. However, staff had not yet needed to complete the checklist so we could not review if they had been completed correctly.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.

Are child and adolescent mental health wards caring?

Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.

Are child and adolescent mental health wards well-led?

Since our inspection in April 2018 we have received no information that would make us re-inspect this key question.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that young people receive prompt medical assessment and treatment when needed.
- The provider MUST ensure that staff record physical and neurological observations when clinically indicated.
- The provider MUST ensure that all staff, including agency staff, receive and induction to the hospital.
- The provider MUST ensure that staff update care plans and risk assessments following changes to a young person's risk.

The provider MUST ensure all staff understand and follow the duty of candour.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care plans were not person-centred.** **The provider had not ensured that young people were involved in their care plans. Most care plans served as instructions for staff, and were not recovery focussed.** **This was a breach of Regulation 9 (1)**

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 anti-climb fence was not fit for purpose.** **It posed as a significant ligature risk.** **The anti-climb fence had been in place since the opening of the service, and the provider had not taken sufficient action to mitigate this risk.** **This was a breach of Regulation 12 (2)(b)(d)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service had not ensured that referral forms were completed in full.**

This section is primarily information for the provider

Requirement notices

This could have led to inappropriate referrals being accepted to the service.

This was a breach of Regulation 17 (2)(c)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Young people who use services did not receive safe care and treatment because: Staff did not ensure young people received urgent and emergency care when needed. There was no policy or procedure for staff to follow when young people needed urgent or emergency care. Staff did not record physical and neurological observation as required to effectively monitor if a young person's physical health was deteriorating. Care plans and risk assessments were not updated to reflect changes in a young person's risk. Agency staff, including registered nurses leading shifts, did not receive an induction to the hospital. This is a breach Regulation 12, (1) (2)(a)(b)(c).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Managers had not been transparent and open when errors had occurred in a young person's care. This is a breach Regulation 20, (1).