Park Villa Independent Hospital

Quality Report

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Date of inspection visit: 7 and 8 February 2018
Date of publication: 13/04/2018

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

Ratings

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

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

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

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

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 Park Villa as good because:

- There was enough staff to provide care and treatment to patients at Park Villa.
- Patients' risk assessments were well completed and reviewed.
- There were minimal significant incidents but when incidents did occur, staff learnt lessons.
- Staff carried out regular physical health checks with patients.
- Care plans were well completed, personalised and holistic.
- There was good multidisciplinary working with thorough occupational therapy assessment and input.
- Staff were adhering to the Mental Health Act and Mental Capacity Act.
- Comments from patients on the standards of care and treatment were universally positive.
- Patients were involved in identifying their recovery goals and developing their care plans.
- There were regular weekly patient community meetings occurring for patients to discuss day to day issues.
- Staff were focused on patients' recovery and worked to discharge patients with all patients having discharge goals.
- Staff had regular contact with community mental health team professionals and the hospital had links with the wider community.
- There were minimal numbers of patient complaints but when complaints were made they were managed well.
- Staff morale was good and there was good local leadership.
- Governance arrangement and checks in place were largely good.

However:

- While staff were ensuring that safety building checks were taking place, we found a small number of shortfalls which staff had not identified or addressed.
- Staff had carried out fire drills but two out of three recent fire drills showed a delay in evacuating the building with no remedial action.
- Staff were still not carrying out a Mental Capacity Act audit which we raised as a recommendation on the last inspection and we saw some minor shortfalls.
- Patients were sometimes discussed in formal meetings without patients being present.

Summary of findings

Contents

Good

Park Villa independent Hospital

Services we looked at

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

Summary of this inspection

Background to Park Villa Independent Hospital

Park Villa is a community-based independent hospital providing rehabilitation and recovery for up to 11 women aged between 18 and 65 years, with severe and enduring mental health needs.

The service was managed by Partnerships In Care 1 Limited which formed part of the Priory Group. The hospital had a registered manager and a nominated individual. At the time of the inspection, the registered manager was on maternity leave. There were interim management arrangements in place.

Park Villa was registered for the following regulated activities:

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

We have inspected Park Villa on three occasions, with the last inspection taking place in November 2015. On that inspection, the hospital was rated as good overall and across all key question areas (safe, effective, caring, responsive and well led); and we found it was meeting the required standards. These ratings were displayed at Park Villa and on the provider's website.

Our inspection team

The team that inspected the service comprised of a CQC inspector, a CQC Mental Health Act reviewer, one specialist advisor with a background in occupational therapy and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about Park Villa and requested a range of information from managers.

During the inspection visit, the inspection team:

- visited the hospital
- looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the registered manager (who came in from maternity leave), the acting manager and the hospital director from a sister hospital who was also providing management support
- spoke with five other staff members; including the consultant psychiatrist, nurses, the occupational therapist, and a support worker

Summary of this inspection

- spoke with the independent mental health advocate who provided independent advocacy support to detained patients
- attended and observed one multi-disciplinary care programme approach meeting
- looked at six care and treatment records of patients
- looked at the arrangements for medication management; and spoke with the visiting pharmacist
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five patients who used the service. Patients were universally complimentary about the care they received from staff at Park Villa. Patients told us that staff were kind, amenable, caring and friendly. Patients told us that staff were always around, available to talk to and that they were professional.

Patients were also complimentary about the progress they had made at Park Villa and felt staff helped them to stay mentally and physically well.

Patients told us that there was a good variety of activities available to them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There was enough staff to provide care and treatment to patients at Park Villa.
- Patient risk assessments were well completed and reviewed with significant risks reflected.
- There were minimal significant incidents but when incidents did occur, staff learnt lessons.
- There were no restraint incidents and the provider had recently updated the training to staff in restraint.
- Staff carried out regular physical health checks with patients.
- Patients had personal evacuation plans in place to ensure they received assistance in the event of a fire.
- There was a duty of candour policy in place and staff understood their responsibilities.

However:

- While staff were ensuring that safety building checks were taking place, we found some shortfalls which staff had not addressed:
- There were fixed non-collapsible curtain rails in communal areas which the provider remedied soon after the inspection.
- There was a domestic sink in the clinic room with plug and overflow which did not meet good infection control measures. The provider remedied this on the first day of the inspection.
- Staff had carried out fire drills but two out of three recent fire drills showed a delay in evacuating the building with no remedial action.

Are services effective?

Good

We rated effective as good because:

- Care plans were personalised and holistic.
- There was a good range of therapies and approaches available to patients.
- Staff followed national guidance in relation to the treatment of patient conditions such as schizophrenia.
- There was good multidisciplinary working with medical, nursing, psychological input and a very well respected occupational therapy input.
- Staff were adhering to the Mental Health Act with good systems in place.

Summary of this inspection

- There was good understanding of Mental Capacity Act with staff completing capacity assessments for major decisions (e.g. informal patients/ serious medical treatment).
- Staff ensured that the relevant Deprivation of Liberty Safeguard paperwork was in place.
- Staff recorded independent advocacy support to the patient subject to a Deprivation of Liberty Safeguards authorisation.

However:

- Staff were still not carrying out a Mental Capacity Act audit which we raised as a recommendation on the last inspection.
- While overall adherence to the Mental Capacity Act was good; we did see one decision requiring a best interest consideration which was not available and the records did not clearly indicate whether a patient subject to a Deprivation of Liberty Safeguards authorisation had been informed of their rights by hospital staff.

Are services caring?

Good

We rated caring as good because:

- We observed positive and respectful interactions between patients and staff.
- We received universally positive comments from patients on the standards of care and treatment they received.
- Patients were involved in identifying their recovery goals and developing their care plans.
- Records showed that patients were offered a copy of their care plan with patients signing a copy.
- There were regular weekly patient community meetings occurring for patients to discuss day to day issues.
- Managers had started to consider how patients could be more fully involved at strategic, policy or governance levels.

However:

- Patients were sometimes discussed in formal meetings without patients being present.

Are services responsive?

Good

We rated responsive as good because:

- Staff were responsive to patients' needs and timely assessments took place.
- Staff worked to discharge patients with all patients having discharge goals and two current patients were very near discharge.

Summary of this inspection

- Staff had regular contact and communication with community mental health team professionals.
- The hospital had links with the wider community and patients were encouraged to use public transport and local facilities.
- The environment was homely and patients could personalise their bedrooms.
- There were minimal numbers of patient complaints but when complaints were made they were managed well.

Are services well-led?

Good

We rated responsive as good because:

- Staff morale was good.
- There was good local leadership and interim arrangements whilst the registered manager was on maternity leave.
- Managers felt well supported with ongoing support from the director of a nearby, larger Priory hospital.
- Staff were focused on patients' recovery.
- Governance arrangement and checks in place were largely good.
- There was good adherence to requirements relating to staffing, training and mental health legal requirements.

However:

- We identified a small number of shortfalls relating to safety which were not identified or managed through the provider's own audit systems.

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.

We carried out a routine Mental Health Act monitoring visit in August 2016. On that visit we found good overall adherence to the Mental Health Act and Mental Health Act Code of Practice. We identified some shortfalls on that visit. Managers of Park Villa provided an action statement telling us how they would improve adherence to the Mental Health Act and the Mental Health Act Code of Practice. On this inspection we saw that the issues raised had been addressed, for example improved staffing levels and information displayed about the independent mental health advocacy service.

The hospital had a Mental Health Act administrator who ensured that the responsibilities of the Mental Health Act were met. There were good systems in place to support adherence to the Mental Health Act.

The records we saw relating to four detained patients were well kept: with a full set of detention papers on each file, good evidence of patients being informed of their rights and good adherence to the rules around informed consent for treatment for mental disorder for detained patients.

Staff were aware of their duties under the Mental Health Act. Ninety-one per cent of ward staff had attended a training session on the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with demonstrated a good awareness of the Mental Capacity Act. Ninety-one per cent of ward staff had attended a recent training session on the Mental Capacity Act. Most patients had capacity to make informed choices over most day to day decisions. Staff understood that there was a presumption of capacity and in what situations the patient's best interest would need to be considered as prescribed by the Mental Capacity Act.

Staff were completing capacity assessments for major decisions. For example when patients stayed informally, serious medical treatment was proposed and over significant financial decisions.

Park Villa had a policy and flowchart for the consideration of Deprivation of Liberty Safeguards. This supported staff to consider whether a patient was being deprived of their liberty due to significant restrictions on patients. There was one patient subject to a standard Deprivation of Liberty Safeguard authorisation at the time of our inspection. Staff ensured that the relevant Deprivation of Liberty Safeguard paperwork was in place and ensured relevant patients saw an independent mental capacity advocate supporting them with their rights while under Deprivation of Liberty Safeguards.

Although we found generally good adherence to the Mental Capacity Act, staff were still not carrying out a Mental Capacity Act audit which we raised as a recommendation on the last inspection. We saw one decision requiring a best interest consideration which was not available and the records did not clearly indicate whether a patient subject to a Deprivation of Liberty Safeguards authorisation had been informed of their rights by hospital staff. For example whether they had been informed of their right to request a review of the deprivation and their right of appeal to the Court of Protection.

Good

Location

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

Is the location safe?

Good

Safe and clean environment

Park Villa provided rehabilitation to patients with enduring mental health needs. The hospital was a converted, detached house over three floors. There had been adaptations to the building to remove major risks including adding internal walls and improving the layout of the office rooms in the cellar for fire safety purposes and an external fire stair case from the first floor to improve evacuation. Externally, there had also been improvements to the path around the garden as well as grab rails to make it safer when patients accessed the outside space.

The hospital had a number of safety and ligature risks throughout the unit. Ligature risks were places to which patients intent on self-harm might tie something to strangle themselves. The ligature risks included domestic taps, exposed pipework and door closures. The new provider had identified that the hospital had non-collapsible curtain rails in the building. in the communal rooms and corridors throughout the building. The failure to install collapsible rails leading to an inpatient attempting or completing a suicide using non-collapsible rails is a never event in NHS funded care. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. The provider had a detailed ligature risk assessment, had put a plan in place and was in the process of reducing the ligature risks having prioritised fitting anti-ligature bathroom fittings and collapsible curtain rails in bedrooms and changing the door closure mechanism throughout the building.

There were still some non-collapsible curtain rails in the communal rooms and corridors throughout the building which were not fully detailed in the ligature risk management plan we saw on the inspection. However these risks were largely mitigated by the ligature risks being in high traffic areas and staff knowing patients well. Staff also carried out robust, individualised admission assessments to ensure that only accept those patients who could safely be managed with these environmental risks using positive risk taking approaches. Care records confirmed that none of the current patients had recent history of self-harm, suicide or ligaturing. There had been no incident of ligaturing. Patients told us that they felt safe. There were ligature cutters available in staff areas and staff knew where they were kept so staff could respond if an incident occurred.

Following the inspection, we received written assurance that the hospital had removed all the non-collapsible rails in the communal areas.

The hospital cared for women only so complied with rules on gender segregation.

The hospital was clean and well maintained. Patients and staff commented favourably on the cleanliness of the hospital. Patients were encouraged to take responsibility of the tidiness of communal areas and cleanliness of their room as part of their recovery. The only shortfall was an unclean shower slip mat which we highlighted to the managers of the hospital who took immediate action to rectify.

Good

Location

The clinic room was clean and tidy. The clinic rooms and refrigerators were checked daily by nursing staff to ensure that medicines were stored at the correct temperature and were safe to use. The clinic room had a domestic sink with a plug and overflow. This went against national infection control advice which said sinks in clinic rooms used for hand hygiene should be of suitable specification without a fitted plug or overflow. There was also no risk management plan associated with having a clinic room sink which did not meet the required national standard. As soon as we identified the shortfall, managers took remedial action to remove the plug and cover the overflow temporarily and intended to replace the sink entirely. Park Villa had emergency and resuscitation equipment, including a defibrillator which was checked regularly to ensure it was working correctly.

The hospital was homely and comfortable. Regular checks on the environment included health, safety and fire arrangements and cleanliness of the communal areas. There were daily cleaning schedule records and checks on the operating and storage of food temperatures of fridges and freezers in the kitchen.

Patients at Park Villa did not present with ongoing management problems and were relatively stable in their mental health. Care plans showed that there were no patients with a current risk of violence and aggression at Park Villa. Park Villa, therefore, did not have a seclusion facility. If patients could not be de-escalated, staff would look to transfer the patient to the nearby local mental health acute wards or psychiatric intensive care unit run by the local NHS mental health trust.

All bedrooms had fire alarms and nurse call systems. We tested the call system on the first floor and staff responded to the alarm within 60 seconds. This meant that staff responded well to the alarms when they were pressed. On the last inspection we found that staff did not have personal alarms which we raised as a something the provider should improve. On this inspection, we found staff now had personal alarms

The hospital carried out an annual survey of patients with the last results in June 2017 with all nine patients completing the survey. The results in relation to the safety of the environment were positive. For example, the survey results showed that 78% of patients agreed that the ward environment was clean and comfortable and 78% patients agreed they felt safe on the ward.

There were a number of regular health and safety checks including a fire risk assessment, legionella risk assessment and gas safety checks. While staff were ensuring that safety building checks were taking place, the shortfalls we found in relation to non-collapsible curtain rails and the domestic sink in the clinic were not fully identified and the risks were not fully mitigated by the audits carried out by the hospital staff. The safety building checks staff used did not fully reflect national health building guidance and other guidance such as the infection control Code of Practice.

Safe staffing

The hospital used an establishment tool to set the staffing levels for each ward. Managers at Park Villa used a staffing ladder which outlined minimum staffing dependent on number of patients on the ward and skill mix needed. This led to the establishment levels required for safe staffing at Park Villa.

Park Villa's staffing establishment level was 6.8 whole time qualified nurses excluding the registered manager and 8.6 whole time nursing assistants. On each day shift, there were two qualified nursing staff plus the registered manager and clinical lead nurse and two nursing assistants working; at night there was one qualified nursing staff and two nursing assistants. At the time of inspection, there was one nurse and one nursing assistant vacancy with active recruitment to try and fill these posts. There were eight beds out of 11 occupied at Park Villa at the time of inspection. If patients' risk were assessed as being high or any patients required 1:1 nursing care, then this would be seen as additional to the established staffing numbers.

Staff told us that there was usually enough staff on duty and rotas we saw supported this. There were rare occasions when they were short staffed with a small number of shifts where there was only one nurse on duty. Managers could authorise the use of bank and occasionally agency staff to cover gaps, and these tended to be staff who had worked in the unit before. Staff and patients told us activities or escorted leave were never cancelled. Staff confirmed that they had sufficient time to have weekly one to one meetings with patients for whom they were key workers.

Patients were registered with a local GP who provided medical input for physical health conditions. A recently appointed consultant psychiatrist provided approved

clinician input to the wards. The psychiatrist attended weekly and ensured that patients were discussed at least monthly at ward round meetings. During out of hours and when the psychiatrist was on leave or away, psychiatric input came from the doctor on call in a larger hospital nearby run by the Priory Group. Staff reported they rarely requested on-call medical advice but stated the arrangements worked well with no concerns about delays in the on-call medical advice or input.

The provider had a core programme of mandatory training for staff which covered subject areas such as safety, safeguarding, medicines management, confidentiality, life support and mental health legislation. The overall compliance rates for uptake of mandatory training for qualified and unqualified staff at Park Villa were at 90% with many courses having 100% uptake of required staff and the lowest uptake levels being 90% compliance for some training including infection control. This meant that most staff were up-to-date with their mandatory training.

Mandatory staff training uptake levels were captured electronically, which enabled managers to view all team members and review compliance by individual and by course. This system highlighted staff who were due to have training soon and staff who were overdue.

Assessing and managing risk to patients and staff

We looked at six care records. These all contained a detailed risk assessment. Patient risk assessments were completed using a recognised risk assessment tool on admission and this was reviewed regularly to monitor any changes in risk. One patient had more complex physical health needs and they had an individualised risk assessment and management plan about managing their condition.

Patients at Park Villa were settled; therefore restraint, seclusion, long-term segregation and rapid tranquilisation were not used. For example, there were no restraint incidents at Park Villa since 1 November 2016 up to the time of the inspection.

We looked at prescription charts and associated authorities across Park Villa. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, the relevant legal authorities for treatment were in place. Staff had acted on medicines alerts as appropriate. For example, staff had acted upon an alert relating to the risks of women patients of child bearing age receiving an anti-epileptic drug (Sodium Valproate) due to risks in pregnancy. Records showed that patients prescribed this drug (which can be used as an anti-epileptic or mood stabiliser) were informed of the risks in detail and supported to make decisions about whether to continue on it.

The ward received regular clinical support from a visiting pharmacist to review prescription charts and complete medicines related audits. The medicines management reports for the three months prior to the inspection showed good overall adherence to safe medicines management practices with a few minor shortfalls with staff taking action on shortfalls and making improvements over the audit cycle.

Medications were stored appropriately in a securely lockable room within a locked cupboard. Stock levels of medication were audited on a weekly, monthly and quarterly basis. There were processes for the management of medication, which included prescribing, ordering, storage, administration and disposal. There were no controlled drugs on site and the hospital had not used controlled drugs for some time. Controlled drugs are medicines that require extra checks and special storage because of their potential for misuse. There was a controlled drugs accountable officer at the hospital who could ensure that proper systems were in place if controlled drugs were prescribed.

The hospital had a procedure for the staged process for patients self-administrating their own medication, with decreasing levels of supervision from nursing staff. This was risk assessed based on patients' level of insight and responsibility around taking medication. Some patients at Park Villa were at the stage of self- administration where they attended the clinic room to collect and take their medication.

Staff undertook appropriate fire drills so that, in the event of a fire, staff and patients would know what to do. There had been three fire drills in the last 12 months; two of these showed quite a delay in evacuation largely due to one patient refusing to evacuate due to the negative effects of their mental health. There was no remedial action recorded as part of the fire drill response to prevent a similar delay for future drills, or in the event of an actual fire. However, there was a new health and safety lead attending Park Villa. The most recent fire drill was

recorded correctly with a very good evacuation response time. The new health and safety lead was aware of the need to ensure staff recorded the remedial action in the event of a delay. In addition, relevant patients had personal evacuation plans in place to ensure they received assistance in the event of a fire.

The Priory Group had its own safeguarding policy and procedure. The policy guided staff to follow the local safeguarding procedures. There were posters displayed for patients to inform them of their right not to be subject to abuse and how to raise a safeguarding alert directly to the local authority. Staff could describe the safeguarding reporting process in the hospital. Staff described that they reported any incidents to the clinical lead nurse or registered manager. Managers of the hospital had notified us of safeguarding alerts they had made. For example, staff had raised an alert relating to missed medication as suspected neglect. There were no ongoing safeguarding investigations at the time of the inspection. Managers and staff reported active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

The provider kept money on behalf of a small number of patients, either at their request or because there was a legal framework for overseeing patient's money, such as appointeeship. Money was kept securely in the hospital's safe within securely tagged bags for each patient. Two staff members were required to manage and record any money transactions in and out of the securely tagged bags. Staff also recorded the tag numbers of the money bags once sealed. The records we sampled showed that the money recorded matched the money in the bag. This meant that patient's money was safeguarded when staff within the hospital took responsibility for it.

Patient records were held electronically with some paper records kept in a locked staff office. Staff were aware of their responsibilities to keep patient information confidential.

Track record on safety

We looked at the incidents that had occurred recently at this hospital. All independent hospitals were required to submit notifications of incidents to us. The hospital had notified us of appropriate relevant events including safeguarding incidents and incidents which involved the police. Managers had taken appropriate action to manage these incidents.

There had been 47 incidents recorded between 28 November 2016 and 28 November 2017. The most frequently occurring types of incidents were minor medication errors or medication near misses followed by physical health issues (namely slips, trips and falls).

In the 12 month period up to 31 January 2018, there were two significant incidents which required investigation within the service. One was an unwitnessed fall leading to a patient fracturing their limb; the other was staff failing to give a patient prescribed anti-psychotic medication.

Reporting incidents and learning from when things go wrong

Staff reported incidents on an electronic incident reporting system immediately after an incident has occurred. Information included a full description of the incident as well as the time, date, category and the individuals involved as well as an assessed grading for the type and severity of the incident. All incidents inputted onto electronic system were subject to review by the registered manager the following working day to ensure any outstanding actions were completed and to see if any 'lessons learnt' needed to be made. The electronic incident reporting system was directly linked to the provider's electronic clinical notes system so all incident details recorded were automatically copied over to the patient's care notes. This assisted staff in ensuring all information was effectively captured and recorded.

Any serious incidents requiring investigation were subject to the provider's incident review known locally as the SBAR process which stood for situation, background, assessment, and recommendations. Once such a review took place, a team incident review was then scheduled so that information about incidents was shared with staff, patients and other stakeholders, for example, local clinical commissioning groups and NHS England. Lessons learnt were shared with the service and the wider group.

In relation to the incident of the patient fracturing a limb, the incident review and lessons learnt focused on the individual needs of the patient and how these could safely and effectively be managed. In addition, managers considered issues around assessment of patients' mobility and the environment. One of the actions focused on the updating the building to make it more user-friendly for patients with mobility issues, including the development of a wet room with level access into the shower. Following the incident of the staff failing to give a

patient prescribed anti-psychotic medication, individual staff were sent on a medicines management refresher course and also prescribing staff were required to make any amendments to the medicines chart clearer. Both the consultant psychiatrist and the visiting pharmacist were fully aware of the circumstances of the incident.

There were, therefore, minimal significant incidents but when incidents did occur, staff learnt lessons.

Duty of Candour

There was a duty of candour policy in place which described how legislation around duty of candour was met. Staff were informed about duty of candour through online training as well as it being covered during face-to-face safeguarding and complaints training. Information on duty of candour legislation had been distributed to all staff. Staff understood their responsibilities to apologise and offer support to patients if patients suffered harm. Staff told us, and data confirmed, that because of the low numbers and types of incidents, there had not been an incident where the threshold for the duty of candour had been reached.

Is the location effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at six care records. Staff used recovery approaches to support patients' recovery. Care and support plans were developed from patients own identified recovery goals. Staff worked with patients on their care plans and saw care planning as a collaborative tool which allowed patients to set their own goals and map their own progress against these goals. Care plans included detailed information and focused on key areas for keeping safe, keeping well, and keeping connected. Patients' care plans also included positive behavioural support plans so staff could support patients proactively based on their own individual likes and dislikes.

Care plans and risk assessments were updated on an electronic records system while a paper patient file was also kept and available to all staff. Care plans were personalised, holistic, and recovery focused to support patients' rehabilitation. Care plans therefore provided good information for patients and staff (including new staff) to fully understand what patients' strengths and needs were and how their needs were being met.

Patients received detailed assessment carried out prior to and after admission. Physical healthcare checks had been carried out by the medical and nursing staff on admission. Patients accessed physical healthcare through the GP and had regular ongoing physical health checks. All patients had received a thorough, formal annual physical health check. Each patient had a 'keeping well' care plan which included patients' physical health care needs with evidence of on-going monitoring of health conditions. Care plans were in place to support patients' physical healthcare needs such as diabetes. One patient had complex individualised care needs and this was underpinned by a comprehensive care plan to manage the condition. Nurses could administer discretionary non-prescribed medicines for the symptomatic relief of minor ailments.

Patients received individualised practical support to aid their recovery. For example, access to appropriate welfare benefits support, help with budgeting, and assistance with activities of daily living, such as shopping, cooking and cleaning. Patients were supported to access public transport by the occupational therapist so that when they were discharged they could access community facilities independently. Park Villa was within walking distance of a local college so many patients accessed education and vocational courses to help aid their recovery. Patients were also supported by staff with a variety of social, cultural and leisure activities.

Best practice in treatment and care

Staff at Park Villa followed best practice based on National Institute for Health and Care Excellence guidance such as guidance on the treatment of schizophrenia. Patients received medical and clinical interventions to minimise symptoms of their mental health through ongoing mental state monitoring, medication, nursing care, as well as psychological interventions.

Patients were able to discuss their medication with either their consultant psychiatrist or the visiting pharmacist. We saw that where needed therapeutic drug monitoring was carried out and recorded. For example when patients were prescribed Clozapine or Lithium. When patients

were prescribed high dose anti-psychotics this was monitored to ensure they did not experience strong side effects. Additionally, patients were routinely supported to use a recognised formal side-effect rating tools for reporting and monitoring side effects in order that these could be managed effectively. Nurses had access to leaflets and further medicines information from an electronic pharmacy database to share with patients.

Patients had access to physical healthcare, which included specialists when required. Patients were registered with a local GP. The occupational therapist carried out assessments using recognised occupational assessment tools.

Patients had access to clinical psychologists. Whilst Park Villa's psychology post was vacant, following the recent departure of the clinical psychologist, patients had access to clinical psychology from a psychologist from another Priory Group hospital who was attending the hospital on an interim basis. This meant that patients had access to talking therapy and other treatments to aid their recovery in line with best practice, including cognitive behavioural therapy. Patients could also access eye movement desensitization and reprocessing treatment which was a recognised psychotherapeutic approach in the treatment of post-traumatic stress disorder.

Staff were committed to providing recovery based care. Staff regularly recorded, monitored and updated patients' recovery goals and progress. However, managers did not routinely monitor the overall effectiveness of patient rehabilitation and recovery progress such as formally reviewing the progress across all patients' recovery across the hospital.

Skilled staff to deliver care

We spoke with a number of staff including the registered and acting manager, nursing staff, and other professionals including the consultant psychiatrist and occupational therapist and unregistered nursing staff. Staff were motivated to provide high quality care and treatment and had a positive attitude about their work. Staff were able to tell us about the work they did to support patient's rehabilitation potential and recovery including optimising patients' mental health, supervising patient medication regimes, physical health promotion, psychological interventions, self-care, everyday living skills and support with meaningful occupation.

Staff confirmed that they had the opportunity to attend additional training and this was confirmed by training records seen. This included training on positive behavioural support, crisis management, observations, self harm and suicide prevention. We found that staff had access to regular supervision with all but one member of staff having regular supervision which for most staff usually occurred every other month. Managers told us and records confirmed that 95% of eligible staff had received an annual appraisals in the last year. This meant that staff were supported to provide a good standard of care.

Multidisciplinary and inter-agency team work

There was good multidisciplinary working with medical, nursing, psychological input and a very well respected occupational therapy input which was valued by staff and patients.

Patients received multidisciplinary input from a newly appointed consultant psychiatrist, registered nursing and unregistered nursing staff and other professionals including an occupational therapist, and a registered psychologist. The newly appointed consultant psychiatrist worked as lead psychiatrist across three of the provider's North West rehabilitation hospitals which were within short travelling distance of each other. There were well developed plans to employ a speciality doctor to support the psychiatrist in their clinical duties.

Patients were registered with a local GP for physical health assessment and ongoing checks. One of the nursing staff had a specialist role to promote patients' physical health needs. Patients had access to other professionals through the GP service. For example, access to dietitian or speech and language therapy input. There was domestic support, a maintenance manager and a chef was employed to prepare meals.

Multidisciplinary meetings occurred every week with each patient being discussed at least once a month. We observed a care programme approach meeting for one patient. The meeting was attended by the patient's psychiatrist, nursing staff, the occupational therapist and the patient's community care coordinator. Decisions on recovery and discharge were supported by a very detailed occupational therapy report. There were respectful

discussions between the professionals to inform decisions about future holistic care needs. Records identified that patient's community mental health team were invited to care programme approach meetings.

All the beds at Park Villa were spot purchased for patients who required rehabilitation with different clinical commissioning groups. Staff provided reports to the clinical commissioning group on patient's progress depending on each contract.

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

We carried out a routine Mental Health Act monitoring visit in August 2016. On that visit we found good overall adherence to the Mental Health Act and Mental Health Act Code of Practice. We identified the following shortfalls on that visit:

• no information displayed on the independent mental health advocacy service

• staff not having training on searching detained patient's

• staffing levels impacting on patient care such as restrictions on escorted section 17 leave

• shortfalls in the recording of patient risks.

Managers of Park Villa provided an action statement telling us how they would improve adherence to the Mental Health Act and the Mental Health Act Code of Practice. On this inspection we saw that the issues raised had been addressed, for example improved staffing and information displayed about the independent mental health advocacy service.

The hospital had a Mental Health Act administrator who ensured that the responsibilities of the Mental Health Act were met. There were good systems in place to support adherence to the Mental Health Act. The Mental Health Act administrator had flagging systems to ensure that any key deadlines or tasks required by the Mental Health Act were met.

The records we saw relating to four detained patients were generally well kept:

- There was a full set of detention papers on each file.
- There was good evidence of patients being informed of their rights as detained patients on a regular basis.
- There was good records relating to the approval of section 17 leave with clear conditions of leave.
- There were good arrangements to seek informed consent for treatment for mental disorder for detained patients with all patients having appropriate legal authority to treat on the appropriate legal form (T2 or T3 certificate). The new consultant had reviewed all relevant legal certificates as required by the Mental Health Act Code of Practice.
- Where patients were subject to a restriction order, patient's leave was also authorised by the Ministry of Justice and annual progress reports were sent to the Ministry of Justice, as required.
- There were systems to carry out medical scrutiny of detention papers where the detention was initiated at the hospital, through for example, arrangements with clinicians in sister Priory hospitals.

Staff were aware of their duties under the Mental Health Act. Ninety one per cent of relevant ward staff had attended recent training session on the Mental Health Act.

Detained patients had access to an independent mental health advocate who visited the hospital regularly. The advocate told us that staff referred qualifying patients regularly to the independent mental health advocate service. The advocate stated that Park Villa staff understood advocacy's role and there was good professional working relations between each other.

Good practice in applying the Mental Capacity Act

Staff we spoke with demonstrated a good awareness of the Mental Capacity Act. Ninety one per cent of ward staff had attended recent training session on the Mental Capacity Act.

As Park Villa was a rehabilitation hospital, most patients had capacity to make informed choices over most day to day decisions. Staff understood that there was an presumption of capacity and in what situations the patient's best interest would need to be considered as prescribed by the Mental Capacity Act. For example, for treatment for physical health and financial decisions.

Staff provided information to patients to enable them to make informed choices. There were two informal patients who were consenting to stay on the unit, who were free to leave and were not subject to restrictions. Staff had

completed a corresponding capacity assessment to assure themselves that each patient had the capacity to stay in hospital as an informal patient without any legal restrictions.

Before agreeing that patients could administer their own medication, systems were in place so that staff assessed patients' capacity to understand their responsibilities to keep medicines safe as part of a staged process for self-medication.

Staff were completing capacity assessments for major decisions. For example when serious medical treatment was proposed and over significant financial decisions. Where capacity assessments were carried out, these were decision specific and followed the principles and stages set out in the Mental Capacity Act.

Park Villa had a policy and flowchart for the consideration of Deprivation of Liberty Safeguards. This supported staff to consider whether a patient was being deprived of their liberty due to significant restrictions placed on them. There was one patient subject to a standard Deprivation of Liberty Safeguard authorisation at the time of our inspection. Staff ensured that the relevant Deprivation of Liberty Safeguard paperwork was in place. They had also notified the CQC of the Deprivation of Liberty Safeguards outcome as they were required to do.

The patient had regular access to an independent mental capacity advocate, who was acting as a paid relevant person's representative, to support them with their rights while under Deprivation of Liberty Safeguards. Staff recorded the time the paid relevant person representative supported the patient subject to a Deprivation of Liberty Safeguards authorisation. The patient's care plan reflected that they were on a standard authorisation and why this was in place.

Although we found generally good adherence to the Mental Capacity Act, staff were still not carrying out a Mental Capacity Act audit which we raised as a recommendation on the last inspection. We saw one decision requiring a best interest consideration which was not available and the records did not clearly indicate whether the patient subject to a Deprivation of Liberty Safeguards authorisation had been informed of their rights by hospital staff. For example whether they had been informed of their right to request a review of the deprivation and their right of appeal to the Court of Protection.

Is the location caring?

Good

Kindness, dignity, respect and support

We spoke with five patients who used the service. Patients were universally complimentary about the care they received from staff at Park Villa. Patients told us that staff were kind, amenable, caring and friendly. Patients told us that staff were always around, available to talk to and were always professional. One patient stated that staff were good, respectful and went the extra mile. Patients were also complimentary about the progress they had made at Park Villa and felt staff helped them to stay mentally and physically well.

Patients told us that there was a good variety of activities available to them, including arts and crafts, games, relaxation, trips out and cooking. Patients told us that the activities met their needs and interests and kept them busy.

We observed positive and respectful interactions between patients and staff.

The hospital carried out an annual survey of patients with the last results in June 2017. The results were positive and confirmed that 78% of patients agreed that if a friend or family member needed similar care or treatment they would recommend the service. The same percentage (78%) of patients agreed that their privacy and dignity were respected and that they were listened to and understood by staff.

The involvement of people in the care they receive

Patients told us that they were involved in their care and treatment. Patients felt involved in their own care and the day to day running of the hospital. In care planning, patients were supported to identify their own recovery goals. Where staff had identified further needs that the patient had not considered or the patient did not always agree with, staff wrote supplementary details in the care

Good

Location

plan as multidisciplinary goals to identify professionally identified needs or goals. Records showed that patients were offered a copy of their care plan with patients signing a copy.

Patients were encouraged to attend their ward round and care programme approach meetings. Patients were encouraged to speak at ward rounds through completing a ward round prompt sheet. Patients could be supported to attend these meetings by having an independent mental health advocate accompanying them and empowering the patient to speak to the clinical team. However patients were sometimes discussed by the clinical team without patients present. This was not fully in line with recovery principles. For example, we observed a care programme approach meeting and the clinical staff and community team representative discussed the patient first and then the patient was brought in at end of meeting. There was no reason given for why this patient could not have been party to all discussions about their progress and future care and treatment.

Patients had regular weekly community meetings led by the hospital's occupational therapist. At the community meeting, patients could comment on the day to day running of Park Villa such as the environment including any repairs required, activities and trips, patient suggestions and complaints. The minutes showed that an action plan was produced following each meeting and that staff acted promptly to address matters brought up by patients at the community meetings.

Patients were involved in the recruitment of staff working in the hospital. While there was limited involvement of patients at strategic, policy or governance level, the managers were looking into progressing regional patient involvement within the hospital group so patients could comment more widely on strategic and policy issues.

There were posters advertising patients' rights to an independent mental health advocate.

Is the location responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Park Villa had 11 beds and, at the time of the inspection, there were eight patients. This gave a bed occupancy rate of 81%. This was below the optimal maximum bed occupancy level of 85% to support quality and safety of adult in-patient care as suggested by the Royal College of Psychiatrists. The beds at Park Villa were spot purchased and paid for by local clinical commissioning groups for patients who were resident in their area. Most patients were from the North West area.

Staff carried out timely assessments of patients who were usually already in another hospital to consider the appropriateness of admission for rehabilitation to Park Villa. Staff worked with other providers' staff to coordinate the transfer of patients from acute mental health wards and secure care, including transferring patients who were already detained under the Mental Health Act. Once accepted for admission, there were occasional delays which were beyond the control of the hospital. For example, if the patient was on a restriction order there were sometimes delays as they needed permission from the Ministry of Justice prior to transferring hospitals.

The average length of stay in the twelve months up until November 2017 was 647 days which amounted to approximately one year and nine months. This was within the length of stay for patients with complex care needs as many of the patients at Park Villa had significant rehabilitation needs, associated physical health needs and some had stepped down from forensic settings. There were no episodes of patients being considered delayed discharges from Park Villa at the time of the inspection or in the ten months up to 31 October 2017.

We saw records of regular contact and communication with community mental health team professionals, including invitations to attend regular care programme approach meetings.

Good

Location

Each patient's care plan had information on goals towards discharge. Where patients were closer towards discharge, these plans were more detailed. For example, we saw two patients were being considered for discharge with a bespoke package of care to live together. There were detailed discharge goals for these patients. Patients' discharge progress was considered at care programme approach meetings.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms to support treatment and care. There was a large TV lounge, a dining area, a conservatory, a therapy room and a small lounge where patients could go to spend time alone or to meet with staff.

There was no separate occupational therapy kitchen but the main kitchen was domestic in scale and was used for cooking sessions and formal cooking assessments. The kitchen was open at all times and patients could access this with staff whenever they wanted to make a hot drink or snack.

Patients could have their own mobile phones and could use these in the privacy of their own room if they wanted to make a private phone call. However, if patients did not have access to their own mobile phone there was also a fixed pay phone on the ward for patients to use.

Patients had their own key for their bedroom and could lock this when they were not using it. Patients had a lockable drawer in their room and told us they felt their possessions were safe on the ward. The hospital also had a secure safe and patients were encouraged to store items of value or sums of money in the hospital safe.

Patients were able to personalise their bedrooms with their possessions and photographs of family, items from home and posters.

Activities were available with a detailed activities programme which was led by the occupational therapist. The activities available varied; they included ward-based activities such as cooking, breakfast groups, crafts, and games; and outdoor activities such as bowling, cinema, swimming and shopping trips. Patients were encouraged to use public transport to get to places in the community. The hospital had recently purchased a car which sat seven people for longer trips and also to help facilitate escorted leave for those patients who lived further afield.

Meeting the needs of all people who use the service

During the tour around the ward we observed information was available for patients, carers and family members including information on what was available at Park Villa including local facilities, local public transport, health living, the food menus and legal matters.

The hospital had some bedrooms on the ground floor and a wet room so could accommodate patients with mobility difficulties. However the hospital was unable to accommodate patients who used a wheelchair as there was no fully accessible toilet or bathroom. Staff considered this as part of any decision on the suitability of patients for admission.

The ward manager advised us that all of the current patients had English as their first language. Interpreters were available if required if a patient was admitted whose first language was not English so that patients, family members or carers could understand what care and treatment was provided. The hospital was planning events around the forthcoming Chinese New Year for patients.

We were also told how patients' cultural and religious requirements could be supported. Patients with religious needs were encouraged to attend community religious services as part of their reintegration back into the community in line with recovery and rehabilitation principles.

Listening to and learning from concerns and complaints

There were three formal complaints made about this service in the previous twelve months up to end of November 2017. Two out of three complaints were upheld. None of the complaints had been taken further to the parliamentary and health service ombudsman. The records showed that the small number of complaints received were investigated fully and apologies given where appropriate. Staff were informed of the results of complaints to prevent a reoccurrence.

Patients were given information about how to make a complaint. Detained patients were proactively informed about the CQC's role in looking at complaints about the Mental Health Act as this was separately recorded on the

patients' rights form that staff completed. Patients also had access to independent advocacy service if they wanted to speak to someone who was independent about an issue.

Posters on the ward explained to patients and relatives how to complain if they were not happy with any aspect of the hospital's services. There were also posters about the CQC's role in looking at complaints about the Mental Health Act.

Patients attended weekly community meetings which was a forum to discuss and address informal concerns from patients. Minutes from community minutes confirmed that issues such as repairs, maintenance and activities had all been discussed in an open transparent way. Patients told us that the staff were approachable and that they would speak to them directly initially if they had a complaint.

Is the location well-led?

Good

Vision and values

Park Villa Independent Hospital had the following mission statement: 'we believe that all individuals have the capacity to recover and you will be supported to achieve this at a pace suited to your individual needs.' The mission was in line with its recovery and social inclusion focus as a rehabilitation hospital.

Park Villa shared its values and behaviours with the wider Priory Group. Their purpose was to make a real and lasting difference for everyone they supported. The values they had were described through a prescribed list of expected behaviours for staff to follow, which were chosen by Priory staff from across the company. These behaviours were:

- Putting people first. We put the needs of our service users above all else.
- Being a family. We support our colleagues, our service users and their families when they need us most.
- Acting with integrity. We are honest, transparent and decent. We treat each other with respect.
- Striving for excellence. For over 140 years, we have been trusted by our service users with their care. We take this trust seriously and constantly strive to improve the services we provide.
- Being positive. We see the best in our service users and each other and we strive to get things done. We never give up and we learn from our mistakes.

Posters outlining the organisational values and behaviours were displayed at site and 'credit cards' were available to staff detailing the purpose and expected behaviours. The values and behaviours were integrated into the new care certificate workbooks which were used to enhance new healthcare assistant skills and knowledge. Managers told us that the values and behaviours would underpin the next appraisal process due in March 2018.

Staff told us that they felt supported by the managers at Park Villa. They told us that they would not feel worried to approach managers and felt confident any grievance would be looked into. Managers and staff felt well supported by the hospital director from a larger Priory Hospital nearby who visited regularly.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. The hospital had a registered manager and had recently introduced the clinical lead role who was a senior nurse who would oversee the quality of clinical care on a day-to-day basis. Managers conducted weekly audits of patients' records and raised issues as they arose. The lines of communication from the managers of the wider Priory Group to the frontline staff at Park Villa were effective. Staff were aware of key messages, initiatives and priorities of the service and were committed to a providing a good quality, community facing, recovery based service.

The service regularly requested and acted on feedback from staff and patients through community and staff meetings respectively and through annual surveys. As the service was relatively small often any changes could be implemented locally and quickly.

Good

Location

Park Villa had good arrangements and good levels of adherence in relation to staff requirements such as ensuring staff were recruited safely and all required recruitment information was captured, good uptake of mandatory staff training levels and appraisal.

The service had good arrangements and good levels of adherence to the requirements of the Mental Health Act and Mental Health Act Code of Practice, underpinned by regular audit. There were also good arrangements and good levels of adherence to the requirements of the Mental Capacity Act. The Mental Health Act administrator had undertaken an informal check of the documentation relating to the Mental Capacity Act and the Deprivation of Liberty Safeguards but this was not formulated into a written record or as part of regular formal audit. This was despite the fact that we raised it as a recommendation on the last inspection.

Records confirmed that all building, fire and health and safety assessments were in order and up to date.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients. Managers completed quality walk arounds which included walk arounds relating to the environment, service user experience, staffing and documentation checks which provided further assurance as part of the clinical governance arrangement. The walk arounds were conducted by members of the management team at site, regional quality improvement leads and service users. The outcomes of the walk rounds were collated and actions were followed up and disseminated in clinical governance meetings.

This meant that that the quality assurance processes were in place to ensure that managers were checking that the care provided by the hospital was good and, where improvements were needed, that relevant action was taken in a timely way and in line with the organisational values and behaviours. However we identified a small number of minor shortfalls such as the sink in the clinic room and the fixed ligature points in the communal areas that had not been identified through the walk arounds and quality assurance systems in place. However, the provider took immediate action to address these shortfalls.

Leadership, morale and staff engagement

There was an experienced registered manager in place. The registered manager was on maternity leave but attended the hospital on both days of the inspection. There was an interim manager in place who oversaw the running of Park Villa who was the registered manager at a local Priory rehabilitation hospital

Sickness and absence rates across the hospital were low with a rate of 4% at December 2017. At the time of the inspection, there was no longer term sickness.

Staff reported that morale in the team at Park Villa was high and that they all supported each other. Staff felt they were listened to and their input was valued at regular staff meetings. Staff we spoke with told us they were happy in their job role.

Staff we spoke to told us they felt confident to raise concerns to their managers if they had a problem. Staff said that they would not fear victimisation if they spoke up. There were no ongoing bullying and harassment cases reported at the time of the inspection.

Managers told us that they had received leadership and mentorship training to enhance their management skills. Managers felt supported in their role and had received support from managers from Partnership in Care and the Priory Group. Staff felt empowered to make decisions to solve problems.

Commitment to quality improvement and innovation

There was a commitment to improving the quality of care and further embed recovery principles in the services provided at Park Villa. Managers held staff to account through clinical audits.

There were plans for the three Priory hospital services which provided rehabilitation services based in Cheshire and South Manchester to work more closely together and develop rehabilitation pathways and services.

The hospital did not formally participate in any relevant, external quality initiatives such as the Royal College of Psychiatrists' peer review network which provided accreditation of rehabilitation services, or the Implementing Recovery through Organisational Change programme which was a programme for changing how the hospital runs to optimise meaningful recovery of people with mental health needs.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that it improves its safety building checks to reflect national health building guidance and ensure that any identified shortfalls are addressed.
- The provider should ensure that where a fire drill shows a delay in evacuating the building, there is remedial action to address any delay.
- The provider should ensure that staff carry out Mental Capacity Act audits to identify and address any shortfalls in adhering to national guidance around capacity assessments, best interest considerations and Deprivation of Liberty Safeguards.
- The provider should ensure that staff work to maximise patients' involvement in their own care so that patients were usually present when their care is being discussed in formal meetings.