Meadow Park

Quality Report

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

Ratings

Overall rating for this location	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.

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 Park as good because:

- Concave mirrors situated in the ceiling allowed full view of the corridors, thereby allowing staff to observe all parts of the ward. Ligature points were noted during the inspection, and the environmental risk and assessment plan showed that these points were considered and action was in place to address issues. The hospital furniture was well maintained, the hospital itself was very clean. Staffing levels were good, and followed policy. Care plans showed evidence of positive risk taking on the part of the staff at Meadow Park.
- Patient care plans were comprehensive, personalised, holistic, and recovery orientated. Each patient had signed that they agreed with their care plans. Positive behavioural support plans were in place. There was evidence of patient involvement in all aspects of their care. There was evidence that staff participated actively in clinical audit. Staff were regularly supervised and appraised. Discharge planning was evident in care records and case files. There was active physical health monitoring at Meadow Park, with a registered general nurse employed to take the physical health lead. Mental Health Act documentation was in order and audited. There was training in the Mental Capacity Act.
- We saw staff interacting with patients at Meadow Park, and it was clear that there were good relationships. Patients stated that staff were respectful, approachable, and interested in patient well-being. Staff were clearly knowledgeable about their patients, and this was reflected in their interaction and notes on case files. Patients commented favourably on the available activities, their named nurses and their plans for the future.
- Patients who were on leave did not have their beds filled in their absence, ensuring the bed was available on return. Patients had access to their bedrooms, and could securely lock the room. There was access to a telephone with a privacy hood, as well as patients having their own mobile telephones. On admission to Meadow Park, patients completed a questionnaire relating to dietary requirements. Likes and dislikes, allergies, and religion were considered.
- Staff knew senior managers; both qualified staff and support workers said that senior managers visited the hospital. Staff used key performance indicators to gauge and improve performance. Clinical audit was being carried out with full staff involvement. Staff felt they could raise concerns without fear of victimisation, and morale was reported as being high among staff. We saw evidence of good team working, and there was a high level of support from the hospital manager and senior staff.
- However
- Although patients had signed to agree with their care plans, there was no evidence to show that patients had received a copy of the care plan. Some patients told us they did not have copies, but that they were involved in the production, so they knew what the care plan entailed.
- Psychologist input was initiated through a service level agreement, but we could not fully determine the levels of input by the psychologist; guidance suggests 0.4 whole time equivalent for a psychologist in a 14-bedded unit, and Meadow Park is a 20-bedded unit.
- There was one full-time Occupational therapist at Meadow Park, a 20-bedded unit. This is the accepted guidance for a 14-bedded unit, and it was felt that an occupational therapy assistant could be utilised to ensure therapies were fully utilised.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Meadow Park

Services we looked at

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

Summary of this inspection

Background to Meadow Park

Meadow Park Treatment and Recovery Centre is situated in Ellesmere Port and sits within the Cheshire region of the Alternative Futures Group provider structure.

Meadow Park is a 20-bed treatment and recovery centre run by an independent provider for both male and female adults between the ages of 18 and 65, providing rehabilitation to people with severe and/or enduring mental illness. The service may be described as a high dependency rehabilitation unit. The treatment pathway averages 18 months but varies depending on a person's own journey of recovery. Patients were either detained under the Mental Health Act or informally admitted. At the time of inspection, there were 19 patients in the hospital, one of whom was informally admitted. A Mental Health Act review was carried out in March 2017, the findings of which were dealt with by an action plan.

The hospital is registered to carry out the following regulated services:

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

Meadow Park has been registered with the Care Quality Commission since 21 December 2010. There have been five inspections carried out at the location, the most recent taking place on 18 April 2016. The hospital was rated as good during its last inspection. There were no regulatory breaches requiring action at the last inspection.

There is a registered manager as well as a nominated individual for the location.

Our inspection team

Team leader: Richard O'Hara

The team that inspected the service comprised two CQC inspectors and two specialist advisers from the field of rehabilitation nursing.

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 asked the following three questions of the service and provider:

- Is it safe?
- Is it effective?
- Is it well-led?

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

During the inspection visit, the inspection team:

- Attended a presentation by the registered manager;
- toured the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with two carers;
- spoke with the unit manager for the service;
- spoke with five other staff members; including nurses, an occupational therapist assistant, and health care assistants;

Summary of this inspection

- reviewed five personnel files;
- reviewed Mental Health Act procedures and looked at six Mental Health Act paperwork files;
- looked at six care and treatment records of patients;
- carried out a specific check of the medication management on all wards, including a review of six sets of medication records;
- looked at a range of policies, procedures and other documents relating to the running of the service; and
- attended one multi-disciplinary team meeting.

What people who use the service say

We spoke with staff, five patients and two carers of patients at Meadow Park. Comments were positive about staff and the treatment at Meadow Park. Patients told us they were happy at the service, that staff were always polite, food was adequate, but they could prepare their own food if they so wished.

A carer told us that it was an excellent service; Meadow Park had really helped bring their relative forward in their treatment. Both carers said they were involved in decision making along with the patient, attended meetings with the consultant, and felt the whole process was well balanced and they felt fully involved.

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:

- Concave mirrors situated in the ceiling allowed full view of the corridors, thereby allowing staff to observe all parts of the ward. Ligature points were noted during the inspection, and the environmental risk and assessment plan showed that these points were considered and action was in place to address issues.
- Staff had personal alarms and all rooms had wall-mounted call buttons.
- Meadow Park was fully compliant with same-sex guidance.
- The outside area was well maintained, and had exercise equipment in good repair.
- The hospital furniture was well maintained and the hospital itself was very clean.
- Staffing levels were good, and followed policy.
- Patients told us that there was always a qualified member of staff in the main area, and that they were always approachable.

Are services effective?

Good

We rated effective as good because:

- The care plans were comprehensive, personalised, holistic and recovery orientated. Each patient had signed to show they agreed with their care plan.
- There was evidence of patient involvement in all aspects of their care.
- There was physical health monitoring taking place under the lead of a registered general nurse.
- There was evidence that staff participated actively in clinical audit.
- There was a range of mental health disciplines employed at Meadow Park, including a consultant psychiatrist, qualified nurses and support workers, and an occupational therapist. There was a service level agreement with a local GP and a psychologist.
- The multi-disciplinary meetings were attended by the consultant psychiatrist, a qualified nurse, a care coordinator, the occupational therapist, and other staff as required ensuring patient needs were met.
- Staff were regularly supervised and appraised.
- Discharge planning was evident in care records and case files.

Summary of this inspection

- Staff received training in the mental health act as part of their mandatory training, with additional training in the Mental Capacity Act.

However,

- There was no recording of whether a patient had received a copy of their care plan, even though there was a note to say they agreed with the care plan.
- Psychologist input was by service level agreement, and we could not fully determine the levels of input by the psychologist for a 20-bedded unit.
- There was one full-time Occupational therapist at Meadow Park, a 20-bedded unit. This is the accepted guidance for a 14-bedded unit, and it was felt that an occupational therapy assistant could be utilised to ensure therapies were fully utilised.

Are services caring?

Good

We rated caring as good because:

- We observed kind, caring and positive interactions between staff and patients.
- Patients said that staff were respectful, approachable and interested in patient well-being.
- Staff were clearly knowledgeable about their patients, and this was reflected in their interaction and notes on case files.
- Minutes of community meetings that involved the patients were reviewed and shown to reflect the feelings and demands of patients.
- Patients commented favourably on the available activities.
- Multi-disciplinary team reviews showed participation and consideration over all aspects of care.
- Carers we spoke to said that they had been involved in meetings with their relative and the multi-disciplinary team, and felt that their opinions had been taken into consideration.

Are services responsive?

Good

We rated responsive as good because:

- Patients who were on leave did not have their beds filled in their absence, ensuring the bed was available on return.
- Meadow Park had a range of rooms and equipment to support treatment and care.
- Patients had keys to their bedrooms and all-day access, and could securely lock the room.
- There was access to a telephone with a privacy hood, as well as patients having their own mobile telephones.

Summary of this inspection

- Meadow Park had a range of activities for patients, available seven days per week.
- Meadow Park had capacity to take patients with various physical disabilities as well as mental health problems.
- We saw evidence of consideration of physical health aspects such as sugar intake and smoking cessation initiatives.
- Complaints were fully investigated, and there was a low number of complaints in the 12-months prior to inspection, as well as a compliment to the service.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew senior managers; both qualified staff and support workers said that senior managers and executives visited the hospital.
- Staff used key performance indicators to gauge and improve performance.
- Mandatory training figures showed that none of the training was below 75%, and that updated training and refresher training had been organised and booked for staff.
- Clinical audit was being carried out with full staff involvement; the audit and assurance framework showing comprehensive auditing across the service.
- Staff felt they could raise concerns without fear of victimisation, and morale was reported as being high among staff.
- Trained staff had the opportunity to receive leadership training, and this was part of the management induction training.
- We saw evidence of good team working at Meadow Park, and there was a high level of support from the hospital manager and senior staff.

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.

At the time of the inspection there were 17 patients admitted to Meadow Park, 16 were detained under the Mental Health Act. Mental Health Act documentation was checked and found to be following guidance and the Code of Practice. A recent Mental Health Act review had been held on 29 March 2017, and an action plan had been submitted to deal with findings from that review. On inspection, we found that findings from the review had been acted upon.

A Mental Health Act administrator working for a local NHS trust was a central hub for all original documentation, as well as being a point of contact for any enquiries related to the Mental Health Act.

Audits on adherence to the Mental Health Act were carried out. Mental Health Act training was refreshed yearly for trained staff, and support workers only had to complete the training once. Training figures showed that more than 75% of staff had completed the training, with dates arranged for on-going training.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was not given as stand-alone training; it was included in the support essential training module. Staff were knowledgeable about the Mental Capacity Act and the principles, the qualified nursing staff being more knowledgeable than the support staff.

There was a policy on the Mental Capacity Act and Deprivation of Liberty safeguards. At the time of the inspection there were no patients detained under Deprivation of Liberty safeguards. The six care plans that were reviewed showed that capacity was being considered and recorded in patient notes. Best interest meetings would be held if required. Patients were being supported to make decisions where appropriate.

Although the Mental Capacity Act was included in the quality assurance meeting minutes, there was no evidence to show that the Mental Capacity Act was being audited.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Meadow Park was a 20-bedded unit, comprised of 16 en-suite bedrooms and four bedsit-style rooms. The bedsit-style rooms had their own kitchen. The rooms were all personalised and kept clean by both patients and staff of Meadow Park. The cleaning roster for the hospital was reviewed and showed that each bedroom and bathroom was cleaned by staff once a week. Patients were assisted in maintaining their own rooms as part of their treatment pathway. Staff used a template called the 'Warrington tool' that identified all aspects of infection control at Meadow Park; the template for 28 Jan 2018 showed very high cleaning rates across the service.

The unit had parabolic mirrors (convex) situated at blind spots in the design of the hospital allowing staff and patients to see corridors that were not visible from the nursing office. Bedroom doors did not have viewing windows built into them. Staff were observed to knock and ask permission to enter bedrooms when contacting patients. Patients had free access to their bedrooms at any time. The hospital itself was brightly decorated, including pictures painted by patients that displayed great skill in art. There was a positivity tree mural on a wall, with labels for patients to write comments and attach to the tree. There was a large "onward and upward" mural that depicted five figures in the process of jumping into the air. Each bedroom had a nurse call button, and all staff carried a personal alarm.

A ligature risk assessment was in place. The ligature risk assessment was relevant to the patients at Meadow Park. A ligature point is something a person intent on self-harm may use to assist in choking themselves by external pressure on the throat. There were two low-ligature risk rooms in place at Meadow Park, with full consideration given to minimalizing ligature risk. The environmental risk assessment for Meadow Park included the ligature risk assessment, and it was due for review in August 2018. The ligature risk assessment had been updated on 26 February 2018, and appeared to include all ligature points noted during the inspection. We saw that legionella tests were regularly carried out, along with water temperature checking and cut-off valve monitoring. A full fire assessment had been completed, along with relevant health and safety checks, all were in date. Staff wore personal alarms and nurse call buttons were situated in each room.

Patients had access to fresh fruit and a range of juices in an accessible dining room. There was a hot drinks machine in the dining room, and patients had four drinks available a day: the drinks available in the machine were more varied and specialised than just tea and coffee, which was available at all times. There were two activity-of-daily living kitchens, where patients could make their own food and drinks, and these could be accessed at any time by patients.

Furniture at Meadow Park was in good condition and appropriate in style and functionality. Infection control procedures were in place and seen to be followed.

Infection control was audited by staff. Department of Health guidance in relation to mixed-sex accommodation was being followed. There was a separate lounge for female patients, and sleeping areas were segregated. The availability of en-suite bathrooms meant patients of the opposite sex did not need to pass bedrooms to reach a bathroom or toilet. There were two stand-alone bathrooms should patients not want to return to their room.

Patients had access to a large, well-kept outdoor area. Patients could access this area without requiring staff to unlock the door. The area had exercise equipment that we saw being used by patients.

There was a clinic room for the dispensing and administration of medication. There was a separate health promotion room, which had an examination couch, weighing scales, blood pressure measuring equipment, and other equipment to monitor physical health. Each piece of equipment had a valid review date. Fridges were checked and found to have temperatures monitored and recorded daily. Drugs cupboards were in order, and stock was checked to ensure that medication was in date. The resuscitation equipment was checked, with the oxygen tank for renewal in 2020 and the other equipment (such as facemasks) was due for replacement in 2021. There was a defibrillator in the clinic room, and this was in date. The service had employed a registered general nurse with experience in monitoring and dealing with physical health problems, and this work was apparent in care records.

We saw evidence that all staff had received induction training for the service.

Safe staffing

Data provided showed 29 substantive staff at Meadow Park. There had been six substantive staff leavers between October 2017 and March 2018, with no staff vacancies at the time of the inspection. A new qualified member of staff had been recruited and was due to start in May 2018. The sickness rate reported was 3.8 percent overall. There were 10 qualified nurses working at Meadow Park and 13.5 support workers.

The working shifts were 12 hours in length, starting at 0745 hours until 2015 hours for the early shift. The early shift was staffed by two registered mental health nurses and four support workers, as well as one occupational therapist, one clinical lead nurse and one senior nurse practitioner. The occupational therapist worked Monday to Friday. During the night shift, there was one registered mental health nurse and two support workers. Staff numbers were increased should the need arise, for instance due to increased patient observations. The service had one regular bank nurse and two bank support workers who knew the service and had undergone an induction programme. We were told that agency staff were known to the service and were familiar with routines and the needs of the service. Data provided suggests that no agency staff had been used in the period from October 2017 to April 2018. Staffing numbers had historically been estimated against bed numbers.

The provider for the service had an electronic rota system called “people planner” that allowed for safe staffing levels to be maintained by utilising staff from other services within the provider group. The system also monitored mandatory training, and would prevent staff being rostered unless they were up to date with their training. There were no shifts left uncovered either by bank or by agency staff. The registered manager told us that they had the authority to bring in extra staff should case mix so require. During the inspection, we noted that there was a staff nurse in the ward area at all times, and were told that this was a regular shift occurrence.

There was a planning and allocation book in place that monitored and ensured patients were receiving regular one to one time with staff. This was reflected in care records. Leave for patients under section 17 of the Mental Health Act was being effectively monitored, and the forms in use showed consideration of risks and actions to be taken in relation to a particular patients should they fail to return to the unit or abscond whilst on escort. We saw no evidence of leave being cancelled due to staff shortage.

The responsible clinician was contracted by service level agreement from a local mental health NHS trust, and attended the service two days a week. When the responsible clinician was not on site, the agreement included out of hours cover by the same NHS trust. For planned leave, another consultant psychiatrist would take the place of the responsible clinician.

Handovers were taking place for each shift, and the handover sheet was a prepared document that included important aspects for both staff who knew the service or staff who were new to the service. The document outlined aspects including current occupancy, numbers on home leave, patient numbers currently in the building,

environmental checks, security checks, and a comprehensive description of each patient. Each patient handover had a diagnosis, detention status, observation level, current mental and physical health situation, current and historical risks, and any medication issues or communication issues with the patient.

Assessing and managing risk to patients and staff

We reviewed six risk assessments during the inspection. The risk assessments were up to date or up for review in the week of the inspection. The risk assessments were individualised and included a risk management plan. The service used a generic START (short term assessment of risk and treatability) summary sheet for each patient, with a risk assessment and management plan attached. This included identified risks, risks to others, risk of self-harm/suicide, risk of unauthorised leave and substance misuse, physical health risks, and a risk management and intervention (crisis) plan. Risk assessments were co-signed by patients. Risk assessments showed they had been revised after incidents involving patients.

There were relevant policies in place. The observation policy outlined the different levels of observation depending on the behaviour or need of a patient. There was a ligature risk policy related to the needs of the service and the patients being rehabilitated. There was a search policy rarely used due to the relationship between the staff and the patients. There was a policy regarding police involvement should the need arise, again a policy that was rarely used. All staff had therapeutic management of violence and aggression training. This was regularly updated, and if staff had not kept up to date then they would not be rostered for work until this was complete.

We were told that staff used verbal de-escalation techniques to limit possible heightened tension in the unit, as well as distraction techniques. Meadow Park used primary responders to identify when a patient was becoming a risk to self or others, identified in positive behavioural support plans. Staff monitored possible forms of abuse by being aware of care plans, watching and listening to patients and visitors It was reported that there had been four incidents of restraint in the six months prior to the inspection, involving two patients at Meadow Park. No face down restraint had been used, and there was no policy for rapid tranquilisation at the location, with rapid tranquilisation never being used. We saw that restraint was used mostly to prevent self-harm by a patient. There had been no reports of staff injuries for the six months prior to the inspection. . We saw no evidence of blanket restrictions in place. There was clear indication that risk assessments would identify if a patient was limited in access to an item or situation.

The service was controlled access rehabilitation, to this end, the entrances to the building were secured and staff were required to open doors for patients. At the time of the inspection, there was one informal patient in the service, however during the multi-disciplinary team meeting attended on the inspection, another patient had their section rescinded and agreed to stay informally. There was a sign by the main door, advising patients who were informally staying at Meadow Park to ask staff to open the door when they wished to leave the building. Although the service was controlled access rehabilitation, there was evidence to show that the staff at Meadow Park were actively involved and encouraging positive risk taking with regard to leave and discharge.

Mandatory training for staff was monitored by the “people planner” electronic system, and data supplied by the provider showed that mandatory training was up to date. The clinical lead at the service was also able to review training and book further training when required. We saw that training dates had been included in a local training matrix, and other training dates were being arranged. It was noted that Mental Capacity Act training was not included in the training matrix as a stand-alone subject, but we saw that it was included in the support essentials training and also in the safeguarding for managers training. No training fell below 75% attendance by staff.

Meadow Park had a safeguarding policy that had first been issued in 1997 by the provider, and updated every two years. The policy was due for review at the time of the inspection. Safeguarding training was mandatory for all staff, and data indicated that staff had completed the training. The service manager knew the policy, as did staff who were interviewed. In the 12-months prior to the inspection, there had been no safeguarding alerts reported by the service. Two safeguarding concerns had been raised and dealt with appropriately. Staff described the relationship with local safeguarding structures as ‘excellent’.

Long stay/rehabilitation mental health wards for working age adults

Good

A child visiting policy was adhered to, with any visit to be planned. Each visit was risk assessed. A sign near the main entrance of the unit reminded patients of the procedure and policy to be followed.

Meadow Park obtained all medication from a local pharmacy, which also provided the medication administration recording charts that were used by the service. Medication was obtained using a prescription written on a NHS FP10 (green) prescription form. A monthly prescription order was completed by a qualified nurse then sent to the GP with whom the service had a service level agreement to provide the service. The GP also provided diagnostic monitoring for the service. We saw evidence of regular auditing on medication administration and monitoring of medication. A monthly audit form was used at Meadow Park, the form using the basis of the CQC domains of safe, effective and well-led to ensure compliance with fundamental standards. Controlled drugs were in a separate locked cabinet and daily checks were completed to ensure that records were maintained. The registered manager for Meadow Park was the controlled drugs accountability officer.

There were no nurse prescribers employed at Meadow Park. When new patients were admitted, a copy of the patient's current medication would be sent to Meadow Park, and this would be used to formulate a new medication administration record. Medication would be ordered from the supplying pharmacy for the service by the use of standard prescription forms.

Track record on safety

There were no serious incidents reported at Meadow Park. We were told of an incident whereby a patient complained about an agency staff member who did not appear to be following the care plan for the patient. A short investigation showed that the complaint had merit. This led to action with regard to keeping staff aware of the importance of knowing care plan content and delivering treatment in line with this. The fact that the patient was aware of the content of their care plan showed that practice regarding involvement of patients in their care plans was in place.

Reporting incidents and learning from when things go wrong

Incident reporting at Meadow Park was carried out using an electronic reporting system that could be completed by trained staff. Should there be an incident involving agency staff who did not have access to the system, then a paper recording of the incident would take place and the incident loaded on to the system by a staff member as soon as practicable.

The minutes of the local quality/compliance assurance meeting held in March 2018 showed consideration and feedback of learning from incident reporting. The minutes reminded staff of the need to ensure that patient capacity and whether the patient had been informed of the report and any outcomes was to be reported. We were told that learning was also fed back by email, handover and staff meetings. The shift handover template included information on incidents.

We were told that there was a newly formed incident management review committee that would be notified, scrutinise plans, reports, learning and action plans from serious and untoward incidents. Trends and themes from incidents and root causes would be picked up, responded to and escalated to the quality and safety governance committee. An annual report would be produced and recommend systematic improvements were appropriate.

Minutes of team meetings showed that patients had been debriefed after incidents and complaints had been investigated. We were told that staff had also been debriefed after incidents, but did not see evidence of this during the inspection.

Duty of Candour

There was a Duty of Candour appendix in the Standards of Business Conduct policy at Meadow Park that outlined actions to be taken to inform patients and carers if anything untoward had occurred. Patients would be informed as per the policy, and this would be recorded in the case notes. We saw no direct evidence regarding Duty of Candour in the notes we reviewed, with no evidence seen of the Duty of Candour threshold being reached. The service reported that there had been no notifiable events under the Duty of Candour policy. However, staff we spoke to were aware of the policy and how and when it would be used.

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

Long stay/rehabilitation mental health wards for working age adults

Good

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed six sets of case notes at Meadow Park. They were up to date, personalised (included the views of the patient), and holistic. Positive behavioural support plans were in place. Care plans were recovery focused. However, care plans, whilst signed by the patient, did not indicate if a copy was given to the patient. This was pointed out to the registered manager of Meadow Park, and they agreed that the care plan template would need a way to indicate that copies had been received or accepted. Some patients said they did not have copies of their care plan, but because they were involved, they knew what was in it.

There were a number of care plans for each patient, including physical health medication care plans, mental health care plans, sleep hygiene care plans, and budget care plans. These care plans indicated patient involvement in the compilation of the plan, including signatures. Observation charts were being recorded for patients.

Meadow Park employed a registered general nurse who had oversight of the physical health care of the patients, and physical health care plans reflected this. Records of one to one meetings were recorded, as well as health improvement profiles that documented patient input and advice given. There were wellness recovery action plans that indicated patient involvement which were signed by the patient. We saw care plans for medication and as-and-when medication, as well as mental health care plans. They were in date and had been signed by patients.

Meadow Park had admission criteria for patients who were for consideration for admission. The time from referral to initial assessment was within two weeks; normally they would be seen within one week as agreed with their gatekeeping protocol. Should all documentation be correct, the patient could be admitted to Meadow Park. Data provided showed that these referral times were adhered to.

Clinical notes were stored both on paper and electronically, paper notes being stored securely in the nursing station. Notes were available to staff when needed, the files were noted to be in a format that made access easy, were comprehensive and well organised. We saw that items that needed to be scanned into the electronic system could be scanned into the system.

Best practice in treatment and care

Meadow Park had medication policies that were designed to comply with the guidelines of the Pharmaceutical Society and the Nursing and Midwifery Council Standards for Medicines Management. We saw that the policies were regularly updated, and that medication management policy was due for review shortly after the date of inspection. The registered manager was the accountability officer for the management of controlled drugs. We saw evidence that guidance from the National Institute for Health and Care Excellence was being followed, including the application of guidance relating to the treatment of schizophrenia, psychosis, personality disorder and bipolar affective disorder.

Meadow Park had a service level agreement with a psychologist, in order that patients requiring psychological therapies could receive treatment. Patients were assessed and the relevant therapy provided by the psychologist. We saw evidence in care notes of patients who had received psychological therapies whilst at Meadow Park. However, we could not fully determine the levels of input by the psychologist; guidance suggests 0.4 whole time equivalent for a psychologist in a 14-bedded unit, and Meadow Park is a 20-bedded unit.

Meadow park employed a full-time occupational therapist, and various activities were available to patients seven days a week. These included social community drop-ins, walking groups, baking and cooking groups, swimming groups and a moving on group designed to prepare patients for a return to the community. Guidance suggests that there should be one occupational therapist for a 14-bedded unit, and Meadow Park is a 20-bedded unit. In order to facilitate the work of the occupational therapist, it was felt that an assistant occupational therapist might be required. The provider also had access to a recovery college that allowed for educational sessions and focused responsive recovery courses. Most of the courses at the recovery college were assisted by former patients who had experience of mental health conditions. There was also the opportunity for employment whilst at Meadow Park. Each patient had a monthly planner that they completed to indicate the activities they wished to take part in.

We saw evidence that the GP had visited the service when requested, and that physical healthcare was being recorded and monitored within care records. Meadow Park actively tried to get patients to live healthier lives. Many of the activities in and around the service had a physical aspect to them, and exercise equipment was available to all. During the inspection, we saw patients using the exercise equipment.

Patients had access to a computer and the internet at Meadow Park, with relevant safeguards in place regarding the sites that could be accessed. Some patients had their own telephones that could access the internet. A risk assessment was completed concerning the level of technology available to patients. Should a patient need assistance using the computer, staff would help those were not technically proficient.

Meadow Park used the recovery star tool to measure mental health improvement in patients.

Staff were involved in clinical audit. The calendar of audits and assurances for 2018 clearly displayed audit requirements. This included infection control, Mental Health Act audit, high dose anti-psychotic prescribing audit, and quality of appraisal and supervision audit.

Skilled staff to deliver care

The multi-disciplinary team at Meadow Park included a consultant psychiatrist, an occupational therapist, a qualified nurse, a support worker and the patient. As well as these team members, care coordinators, advocates, family members and commissioners regularly attended team meetings. Should they be required, the psychologist could also attend. The skill mix allowed for suitable interventions for patients. The team was a mixture of full and part time staff. A pharmacist would visit every six to eight weeks, or as required, under the terms of a service level agreement.

Induction programmes were completed by all staff, and the dates and details were held both in personnel files and on an electronic recording system. Learning needs were identified through appraisals and supervision, with staff being able to apply for specialist training. At Meadow Park, a qualified nurse was studying for a Master's degree in cognitive behavioural therapy. All qualified staff at Meadow Park were engaged in leadership training run by an external company, the learning was classroom, webinar and practical-based. Supervision was taking place for staff, and annual appraisals were completed between April and June each year. Supervision was being audited. We saw that an action plan was in place to ensure that supervision rates were improved and maintained. Supervision rates for non-medical staff stood at 100%. Supervision rates for other staff stood at 80%, with dates arranged to cover those who needed supervision but had not yet received it. The responsible clinician had been revalidated.

We reviewed five personnel files and confirmed that disability and barring service checks had been completed. The provider operated a system of annual checks on one third of their staff to ensure that any changes were being raised by staff during their annual completion of a standard declaration form. Certificates were being held, although not all certificates that could be printed by staff were being held.

We saw minutes of recent staff and team meetings, including the minutes of an away-day for the whole of the staff unit in March 2018 that showed consideration for the needs of the service and its patients. Minutes from a qualified staff meeting in December 2017 showed communication among the team including patient needs, an update on the no smoking policy and methods to try to reduce smoking among patients, supervision needs and the need for Section 17 leave for patients to be planned and considered. Staff told us that information was continually disseminated in order to ensure all staff knew the most up to date information.

There were processes in place to deal with staff issues effectively. There was one reported staff suspension in the 12-months prior to the inspection.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings were regularly taking place and were recorded in care records. The meetings took place two days a week. The responsible clinician was part-time at the service, attending only two days a week, but remained on call for the rest of the week, and out of hours cover was available when the responsible clinician was not present. Consultant psychiatrist cover was in place from a local trust during annual leave. We attended a multi-disciplinary team meeting regarding a patient who was being considered for informal status at Meadow Park. The meeting was attended by the consultant psychiatrist, an occupational therapist, the unit manager, a qualified nurse, a support worker, an administration staff member

who recorded the notes directly onto a computer, and the patient. The care coordinator contacted the team shortly before the meeting to apologise about non-attendance, they were in another meeting. The service utilised a comprehensive reporting template to outline patient history and current presentation, including medication notes. The attendees discussed all aspects of the care of the patient before the patient was invited in. The patient's views were listened to, discussed and recorded. The outcome of the meeting was agreed by all.

Handover notes were seen to be effective and well considered. The template in use was comprehensive, and talking with staff showed that they were aware of the relevant needs and requirements of their patients. We saw evidence of discharge planning for patients at Meadow Park.

We were told that care coordinators regularly attended meetings regarding their patients; however, some care coordinators were not as involved as others. The service regularly contacted care coordinators to invite them to the service to attend multi-disciplinary meetings, and this was recorded in care records. Links with social services were maintained and were said to be good.

Adherence to the MHA and the MHA Code of Practice

Meadow Park had associate lay hospital managers. Meadow Park was last visited by a Mental Health Act reviewer in March 2017. At that time, the reviewer found no issues with Mental Health Act documentation, reporting that all aspects of documentation were in order. We saw evidence of Mental Health Tribunals and Managers hearings were recorded.

All staff had received training in the Mental Health Act, and this was revisited yearly. The training was provided by a local trust. Staff we spoke to had a working knowledge of the Mental Health Act, and were aware of the detention status of each patient at Meadow Park.

Consent to treatment and capacity requirements were adhered to, with copies of consent to treatment forms attached to medication charts. We confirmed the findings of the Mental Health Act reviewer in that capacity to consent forms had been completed in all the files we examined. All the treatment given appeared to be given under appropriate legal authority. Consent to treatment was audited within the service.

We saw evidence that patients at Meadow Park regularly had their rights explained to them, starting with their admission to the service. Meadow Park staff used a checklist to ensure that rights were read, understood, and recorded appropriately, then audited.

The Mental Health Act administrator for Meadow Park was based in a local NHS trust, and we saw notices in files and in the nursing station giving direction to contact the administrator should questions arise in relation to application or understanding of the Mental Health Act. A copy of the Mental Health Act code of practice was available to all staff, situated in the nursing station. There were good systems in place to support and ensure adherence to the Mental Health Act. There was a regular audit of the Mental Health Act paperwork.

All paperwork reviewed was in order and stored appropriately. We reviewed six sets of Mental Health Act records relating to patients at Meadow Park. The records we checked were generally well kept. There was a full set of detention papers in each file. Patients were regularly informed of their rights. Section17 leave forms were well documented, with copies being given to patients. Mental Health Tribunal paperwork was apparent. There was evidence that patients had access to an independent mental health advocate.

Notices on how to access the independent mental health advocate were attached to noticeboards within the patient accessible areas of Meadow Park.

Good practice in applying the MCA

Mental Capacity Act training was included in the support essential training at Meadow Park. At the time of the inspection, 100% of staff had undergone training that included Mental Capacity Act training. Staff we spoke to had knowledge of the Mental Capacity Act, and how to apply it.

Meadow Park had a Mental Capacity Act and Deprivation of Liberty Safeguards policy in place, the policy was due for review in February 2019. The policy was available to all staff on the provider computer system. We were told that staff could access information relating to the Mental Capacity Act from the policy, the responsible clinician, or from the Mental Health Act administrator at the local trust. During

Long stay/rehabilitation mental health wards for working age adults

Good

the inspection, we noted that some noticeboards had easy-read booklets relating to both the Mental Health Act and the Mental Capacity Act; these could be accessed at any time.

At the time of the inspection, there were no patients detained under Deprivation of Liberty Safeguards, although the service had taken these patients in the past.

We saw evidence of consideration of capacity in the six care records we reviewed. We saw no evidence of best interest meetings in the patient care records we reviewed; however, there was no evidence in the records to show that a best interest meeting had been required. We were told that should a best interest meeting be required then one would be held, and an independent mental capacity advocate would be invited to attend, if agreed with the patient. During a multi-disciplinary team meeting attended during the inspection, we saw evidence of patients and staff discussing discharge planning, with support given to make decisions where appropriate.

Capacity was not routinely audited at the service. However, care records did reflect consideration of capacity in an open manner, making a visual check easy. Quality assurance meeting minutes from 06 March 2018 showed consideration of capacity and the need to include capacity of patients when making safeguarding referrals and alerts.

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

Good

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. There was clearly a therapeutic relationship between staff and patients at Meadow Park. New patients would be invited to visit and possibly stay at Meadow Park before their formal admission, in order to ensure they felt comfortable in the location. New patients were allocated a patient buddy on admission, and this would help the new patient to orient to the ward.

We spoke with five patients at Meadow Park who told us that staff were caring, and they felt staff were genuinely interested in their needs. Patients said that staff were always available on the unit, and that they felt safe. Patients told us that they had never had leave or therapy sessions cancelled.

Patients told us that they could access their rooms when they wanted, and use their mobile telephones within the unit. We were told that patients were welcomed to the ward on admission, shown around the unit, and met staff and other patients. Some patients told us that their family were not involved in their care, but that was the choice of the patient.

We spoke to two carers of patients at Meadow Park. They were complimentary about the service and treatment received by their family members. One carer told us that family from all over the country visited their relative at Meadow Park and were all impressed at the progress they had made. We were told that family were regularly involved in meetings concerning their relatives, and that they felt as though they were listened to and their opinions respected.

The involvement of people in the care they receive

Patients had the opportunity to take part in regular meetings with staff, chaired by the unit manager. The meeting followed an agenda of standing items, but patients could put forward other suggestions at the time. The minutes from the meeting on 27 February 2018 were viewed and noted to be inclusive and holistic in recording. Copies of minutes were on notice boards for patients to view. The notes showed clear patient involvement in the meetings.

A feedback wall, designed to allow patients to use chalk to comment on whatever was on their mind, was available at Meadow Park. The wall was full of comments from patients that were positive in outlook and content.

There were leaflets and noticeboards regarding treatment information and patient rights in various areas of Meadow Park. We saw information telling patients of the complaints procedure. The key performance indicators for Meadow Park included a patient feedback section; patients could approach staff or give feedback via a care coordinator or family member. Multi-disciplinary team meetings showed clear evidence of patients being involved in their care. There was a comments and complaints policy within the organisation. The organisational protocol ensured all complaints were acknowledged within three working days and a full investigation carried out within 28 days. All

Long stay/rehabilitation mental health wards for working age adults

Good

comments and complaints were logged on to the organisation electronic management system. An annual report was produced analysing information produced from the database. A complaints leaflet had been developed for families and carers that used free postage to alert a central complaints coordinator. A recent Carers survey was completed in October 2017, all relatives and friends of service users within the organisation were given the opportunity to take part. The results were positive.

We were told that patients could be involved in the recruitment of new staff, and that new or prospective staff could be shown around the unit by a patient who would then give feedback on the applicant. We saw no evidence to corroborate this.

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

(for example, to feedback?)

Good

Access and discharge

At the time of the inspection there were 17 patients admitted at Meadow Park. Meadow Park kept four beds available for any clinical commissioning group to access, if not occupied. Staff from Meadow Park attended the weekly gatekeeping meeting for the local area, and acted as gatekeeper for all rehabilitation referrals for the area. We saw clear guidelines in place for the admission of patients to Meadow Park, including a two-week report deadline for new referrals.

All referrals were seen within two weeks, most referrals were normally seen within 1 week as set out by standards agreed at gatekeeping. If a bed was available and all documentation/information was secured, admission took place at the earliest possible date. The registered manager was included in acute outcome meetings, thereby gaining information on admission needs and whether the admission was urgent. The registered manager had the authority to refuse an admission if the case was deemed likely to disrupt patient treatment at Meadow Park. All patients on leave from Meadow Park were assured of a bed on their return.

We saw active discharge planning in evidence in care records. All members of the multi-disciplinary team, including care coordinators and social workers, were involved in discharge planning. We attended a multi-disciplinary meeting where a patient had their section rescinded prior to discharge to an area that they had indicated they would prefer. At the time of the inspection, there were two delayed discharges at Meadow Park, both delayed due to waiting for decisions from external bodies. We were told that discharges from Meadow Park would take place during working hours if possible, or at a time that was suitable to the patient and their needs.

The average length of stay for patients discharged in the 12-months prior to the inspection was 490 days (approximately 16 months).The average bed occupancy for Meadow Park for the six-months prior to inspection was 97.5%.

The facilities promote recovery, comfort, dignity and confidentiality

Patients at Meadow Park could access their bedrooms at any time of the day. Patients were allowed their own mobile telephones, which could include internet access. There was a landline telephone for patients who did not have their own mobile telephone, this was situated in the corridor, and had a privacy hood attached. We saw that patients had personalised their own bedrooms. Each bedroom had a nurse call button in place.

A large, well-kept outdoor area with exercise equipment could be accessed at any time by patients. There were rooms that could be used by visitors to Meadow Park to speak to patients. We saw that there was fresh fruit in bowls in the dining room, along with jugs of fresh fruit juice and water. A hot drinks machine in the dining room was available in the dining room, with patients being given up to four drinks from the machine each day. Patients could access either of two activities-of-daily living kitchens at any time to prepare drinks and food.

There were activity rooms that were accessible to patients at any time. This included a sports lounge that had a pool table and tables and chairs for people to sit and talk. An activity noticeboard was apparent in the main corridor. This showed that Meadow Park staff arranged a monthly trip out of the area for patients. There were two kitchens for use by patients, as well as a cooking planner that

encouraged patients to maintain their skills in the kitchen. Other activities for patients were displayed on the noticeboard, and included a baking group, a life skills group, a moving on group, exercise groups for both in-door and outdoors, and an active social group. Patients also had access to a recovery college that allowed for educational sessions and focused responsive recovery courses. Most of the courses at the recovery college were assisted by former patients who had experience of mental health conditions. The activities were available seven days a week.

There were opportunities for patients to work in the community, along with various projects that allowed patients to volunteer and assist.

Meeting the needs of all people who use the service

Ward activities were taking place regularly. Staff provided a variety of meaningful activities both on and off the unit. We saw weekly activity planners for the unit in general as well as individual activity planners that had been compiled with input from the patient.

Meadow Park was all on one floor, negating the need for stairs or lifts. There were double doors to the unit that could accommodate wheelchairs if necessary; bedroom doors were also wide enough to accommodate wheelchair access. There was a bathroom that could be utilised by disabled patients, the room adapted to manage most physical ailments.

There was a noticeboard by the clinic that was well stocked with information leaflets regarding both medication and treatments for mental health problems. Leaflets for patients for whom English was not a first language could be accessed via the internet. Interpreters could be accessed if required.

Noticeboards throughout Meadow Park contained information regarding local services, and how to access services. The same noticeboards had information on how to complain and how to contact an independent mental health advocate. A staff picture board helped readily identify staff members to patients. In the dining room was a large noticeboard relating to sugar content in various foods, designed to show patients how much sugar was in their everyday food and snacks. There was a noticeboard designated to the Care Quality Commission, including ratings and the role of the Commission, and how to contact the Commission.

Food choice considered options for patients, including vegan and vegetarian. We were told that if a patient required halal then it could be managed. Religious consideration was in place, with close ties to a local church. We were told that should a patient require access to a specific religious leader, then this would be accommodated.

Listening to and learning from concerns and complaints

Meadow Park had received four complaints in the 12-months prior to the inspection. Three of the complaints were not upheld, one was upheld, and none referred to the Ombudsman. The complaint that was upheld was not a reflection on the service, but a patient – relative situation. There had been one compliment in the 12-months prior to the inspection.

Meadow Park had a complaints and compliments policy that had been reviewed shortly before the inspection, and was due for review again in 2021. The policy showed how it was informed by related legislation, regulation and national standards. Complaints featured as a key performance indicator in the quality report template submitted by Meadow Park.

In the minutes of a quality assurance and clinical team meeting held on 06 March 2018, complaints policy and procedure was discussed as an agenda item. We were told that, should a complaint be made and investigated, policy would be followed. The policy stated that all staff had a role to play to learn from complaints and effectively implement change from that learning. Minutes of the most recent staff meetings did not have any reference to complaints, as there had been no recent complaints.

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

Good

Vision and values

Staff were aware of the visions and values of the service. The visions and values had recently been changed after consultation with staff and patients across the provider services. The new vision was adapted to “A world where

people control their lives", and the mission statement of the provider was "Together with our people and partners we will unlock skills, gifts and talents to support everyone's right to choose and achieve their aspirations". These visions and values were displayed in the service.

The staff we spoke to knew the names of senior staff in the organisation. We were told that there was a regular 'safety walkabout', where senior executives and board members would visit the service and talk to staff and patients, thus promoting "ward to board assurance " on safety and quality of service.

Good governance

Ratings from the previous Care Quality Commission inspection of Meadow Park were displayed at the service. A noticeboard dedicated to meeting the five domains of safe, effective, caring, responsive and well-led was prominent on the wall at Meadow Park.

We saw evidence that managers in the service used key performance indicators to gauge and improve performance. A quality assurance framework template was completed, and we saw an example of this in the quality requirements monthly report for February 2018. The report included information regarding infection control, organisational risk, incidents by type (including restraints, self-harm, staffing, and equipment), complaints and concerns, safeguarding, mandatory training and staff sickness rates. We saw that performance information was discussed in minutes of meetings at senior levels and staff meetings.

We reviewed minutes of staff meetings for March 2018, as well as patient meetings for the same period. The minutes showed standing agenda items and discussion that allowed input from both patients and staff.

Audits were being regularly completed by staff, including infection control audit, mattress audit, medication management audit, metabolic side effects audit, and a Mental Health Act audit.

The registered manager told us they felt that they had enough authority to do their job effectively. The manager told us that they felt supported by senior managers and had access to administrative support.

There was an organisational risk register that showed each item was regularly reviewed with a view to negating the risk. All items on the risk register had been reviewed and updated within the six-months prior to inspection. Staff could submit items to the risk register through the registered manager. We requested and reviewed policies relating to Mental Capacity Act, the Mental Health Act, complaints, medication management and administration, and safeguarding. The policies were in date and showed a service committed to improvement.

Leadership, morale and staff engagement

Staff told us that they felt supported by senior management. An annual employee engagement survey had been completed prior to the inspection, with a view to gaining a clear understanding of what was important to staff. The highest scoring positive questions were that staff knew what was expected of them at work, that staff had high standards in their work, and that staff knew where to get the information needed to do their job. The lowest scoring positive questions were that staff thought they were paid fairly in comparison with similar organisations, communication across the provider, and knowledge of the employee partnership forum. The employee partnership forum was formed in April 2017 with elected members, including union members, the forum meeting several times a year and was representative of the workforce of the provider.

Staff said that they felt respected and valued, and had admiration and respect for the management and senior staff of Meadow Park. We were told that the relationship with senior multi-disciplinary team staff was good, and this was witnessed during a multi-disciplinary team meeting. There were no bullying and harassment cases reported at the service at the time of the inspection.

Commitment to quality improvement and innovation

Meadow Park was not registered with any accreditation schemes (such as the Accreditation for In Patient Mental Health Service scheme) at the time of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there is a method of recording whether a patient has received or refused a copy of a relevant care plan, even though the system shows that the patient is agreeing with the content.
- The provider should ensure that psychologist input at Meadow Park is appropriate for a 20-bedded unit.
- The provider should ensure that occupational therapy is appropriate for a 20-bedded unit.