John Munroe Hospital - Rudyard

Quality Report

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Rudyard
Leek
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Website: www.johnmunroehospital.co.uk

Date of inspection visit: 7th December 2018
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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

Are services safe?

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

Letter from the Chief Inspector of Hospitals

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

The provider had implemented a full program of staff training and awareness to address all the issues raised in the warning notice issued on 28th June 2018 in relation to medicines management and learning lessons from incidents. This included enhanced pharmacy support and liaison, a continuing review of policies and the employment of a health consultant to ensure the implementation of the action plan they had developed.

- The provider had ensured there was managerial oversight of the clinical monitoring and safety of patient's medicines.
- The provider had ensured that all nursing staff had completed the competency assessment to administer and manage medicines.
- The provider had ensured that all staff were aware of the incident reporting policy and criteria for reporting incidents.
- The provider had ensured oversight of the reporting of incidents to identify themes and trends in their medicine management and that there was a process for learning lessons from these themes.

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		

Summary of findings

Contents

Location name here

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to John Munroe Hospital - Rudyard

John Munroe Hospital is an independent mental health hospital that provides care, treatment and rehabilitation services for up to 57 adults, aged 18 or over, with long-term mental health needs. It provides both longer term high dependency rehabilitation and a service for older adults with mental health problems.

Patients may be informal or detained under the Mental Health Act 1983. John Munroe Hospital is one of two hospitals run by the John Munroe Group Limited. The Edith Shaw Hospital is located nearby and both hospitals share the same registered manager. John Munroe Hospital is registered to carry out the following regulated activities:

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

John Munroe Hospital has five wards located on a secure site. Three wards (Horton, Kipling and Rudyard) are located in the main hospital building. Larches and High Ash wards are located in self-contained bungalows.

- Horton ward is a male ward that supports up to 16 patients with chronic or complex mental health needs.
- Kipling ward is a female-only ward for up to 13 patients with chronic or complex mental health needs.
- Rudyard ward is a mixed-gender ward that supports up to 15 patients with organic conditions such as dementia
- High Ash is a female-only ward for up to seven patients and provides locked rehabilitation.
- Larches is a male-only ward for up to six patients and provides locked rehabilitation.

The issues addressed in the warning notices affected all clinical areas.

Our inspection team

Team leader: Nick Maiden

The team that inspected the service comprised of one CQC inspector and a pharmacist specialist from CQC medicines optimisation team.

Why we carried out this inspection

This inspection was a focussed unannounced inspection in response to a warning notice served to John Munroe Hospital issued on 28th June 2018 regarding medicines safety. The purpose of this inspection was to check that John Munroe Hospital had made improvements to the areas covered in the warning notice that the CQC required to be in place by 21st September 2018.

Following the June 2018 inspection, we told John Munroe Hospital it must take the following actions to improve long stay/rehabilitation mental health wards for working-age adults and wards for older people with mental health problems:

- The provider must ensure there are sufficient quantities of prescribed medicines for people using the service. The provider must ensure the safe management and administration of medicines in accordance with the provider's Safe and Secure handling of Medicines policy.
- The provider must ensure the incident reporting system is used in line with the provider's policy to record when medicines are not available, as staff had not reported incidents on the provider's system and were unclear of the incident reporting criteria.
- The provider must ensure staff nurses complete the competency assessment to administer and manage medicines. The provider must ensure there is oversight of the clinical monitoring and safety of patients' medicines.

Summary of this inspection

- The provider must ensure there is oversight of the reporting of incidents to identify themes and trends around medicine management and lessons learned or changes in practice are implemented.

Following that inspection, John Munroe Hospital kept CQC informed and up to date about the progress they were making. At monthly meetings with the CQC, local commissioners and safeguarding lead, the provider presented an action plan to address these failures.

This inspection set out to consider these issues within the key question are services safe?

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location, reviewed the providers action plans at monthly meetings and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited Horton ward, The Larches and Rudyard ward at the hospital
- spoke with the registered manager and clinical nurse managers for each of the wards
- reviewed 15 prescription charts
- carried out a specific check of the medicines management on three wards; and looked at policies and procedures for medicine management

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?

- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health. Medicines were stored securely in clinic rooms and medicines safely disposed of, when no longer required.
- Staff were following the provider's safe and secure handling of medicines policy. This policy had been reviewed and was now in date. Prescription charts contained the correct administration signatures and no 'medicine unavailable' codes were recorded on prescription charts. There was evidence of a stock record system to maintain adequate medicine stocks. Liquids, creams, inhalers and eye drops were annotated with either their opening dates or new expiry dates where appropriate.
- All staff nurses had received training on medicines competency in line with the provider's local policy
- The hospital's incident reporting system was being used in line with local policy to record when medicines were not available.
- The service now managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew how to report incidents on the provider's system and were clear of the incident reporting criteria.

Detailed findings from this inspection

Mental Health Act responsibilities

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

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Long stay/rehabilitation mental health wards for working age adults

Safe

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

Medicines management

- Following the unannounced inspection in June 2018 and the warning notice issued by CQC, the provider had instigated an immediate revision of their safe administration and management of medication policy. In addition, they developed an action plan which included an immediate stock reconciliation of medication. This was completed in consultation with their contracted local pharmacist who visited the hospital twice per month to conduct medication and clinic room audits. The pharmacist also developed and provided prescription charts meeting best practice standards.
- Since the inspection in June 2018 the provider had recruited three new clinical nurse managers. The provider had ensured that these managers were fully aware of the medication management action plan in place and that they conducted daily medication stock checks and reconciliation. The nurse managers were also responsible for ensuring all nursing staff under them were familiar with and adhered to medication management policies.
- During the inspection, we reviewed 15 prescription charts, the providers safe and secure handling of medication policy and the emergency ward stock medication policy. We also inspected the clinic rooms on Horton ward, the Larches and Rudyard ward.
- Storage and security of medication on all three wards inspected was good. All clinic rooms were kept locked, with cupboard and trolley keys held by a staff nurse. Hatches were also locked and medicines taken to patients by a staff nurse. All medicine cupboards and fridges were locked and all the open liquids and creams examined had opening dates recorded on them and were labelled with the name of the patient.
- All three clinics had sufficient quantities of prescribed medicines for patients on each of the wards.
- A specific brand of inhalation capsules was only to be administered for up to 60 days after the container was opened. All four containers had no dispensing label on them, and had no opening dates recorded on them. We were unable to verify when the medicine had been first opened or dispensed. This medicine may no longer have been as effective due to degradation of the medicine. The provider was informed of this at the time of inspection.
- The provider was using a stock record system to maintain adequate medicine stocks and this was not accurate for one patient. The provider was aware of the missing medicine but not the inaccuracy of the stock record, and had already ordered a replacement.
- All nurses had completed a nurse competency assessment developed by the local pharmacist. This ensured that they were competent to administer, store, order and manage medicines in accordance with policy. Staff knew the requirements for managing controlled drugs. They knew how to manage and report medication errors and how to recognise the adverse effects of some medicines.

Track record on safety

- All staff we spoke to told us that senior managers had instructed them to ensure that all medication was counted and that all discrepancies were documented. The provider also ensured that staff reported all incidents concerning medication in accordance with their revised medication management policies.
- Nursing staff told us that they knew how to raise incidents with the registered manager and were confident in the processes for learning lessons from incidents and errors. They were in daily contact with the registered manager who ensured that all learning was shared across all wards. Any identified themes and trends around medicines management were discussed with the consultant psychiatrist and the hospital clinical governance group.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should continue to work collaboratively with the local pharmacist to fully embed all their changes to medicine management practice, policy and procedure.