John Munroe Hospital

Quality Report

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

Overall summary

We completed this focused inspection based on concerning information received about the alleged abuse of patients and the impact on staff safety. We specifically focused on our safe and well led domains.

We did not rate this inspection.

We identified the following areas of concern:

- Staff did not make a safeguarding alert when they recognised possible abuse. Staff said they were not always supported to report all incidents appropriately and felt that leaders did not investigate all incidents. The provider did not follow their own policy in raising concerns and investigating them. Lessons learned were not always shared effectively with the whole team. Not all risk assessments were up to date.
- Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records, whether paper-based or electronic.
- Not all staff felt respected, supported, and valued. They did not always feel able to raise concerns without fear of retribution. Leaders were not always visible or approachable. Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level.

However:

- The provider used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. Staff managed risks to patients and themselves well and had training on how to recognise and report abuse.
- Leaders had the skills, knowledge, and experience to perform their roles, had a good understanding of the services they managed.

Summary of findings

Contents

Not sufficient evidence to rate

John Munroe Hospital

Services we looked at

Wards for older people with mental health problems and Long stay rehabilitation mental health wards for working age adults

Summary of this inspection

Background to John Munroe Hospital

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.

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
- Diagnostic and screening procedures.

John Munroe Hospital has five wards. Three wards (Horton, Kipling and Rudyard) are located in the main hospital building. Larches and High Ash wards are located in self-contained bungalows. During this inspection we visited Rudyard ward. This is an older adult male ward that supports up to 14 patients with organic mental health conditions such as dementia.

The last comprehensive inspection of John Munroe Hospital was in November 2019 when it received ratings of good in all domains, and an overall rating of good.

Our inspection team

Our inspection team included one inspector and one inspection manager who completed the inspection on-site. They were supported by three inspectors and one expert by experience who completed inspection activities off-site. We reduced the number of staff on-site because of COVID-19. Experts by Experience are people who have recent personal experience (within the last five years) of using or caring for someone who uses health, mental health and/or social care services that we regulate.

Why we carried out this inspection

We carried out an unannounced responsive inspection, which focused on specific areas within the safe and well-led domains. We did not re-rate the service because we were looking at specific concerns. This meant we did not gather enough information across the whole service to re-rate it.

The inspection was in response to concerns raised directly to the CQC by a whistle-blower. A person who reports wrongdoing in the place where they work is often called a whistle-blower. In the CQC, the term 'whistle-blower' means someone making a disclosure who is directly employed by or provides services for a provider who is registered with CQC. Examples of a worker who provides services to a registered provider include, but are not limited to, agency staff, visiting community health staff, GPs, independent activities organisers and contractors. A whistle-blower may also be someone who has left their job after they have made a disclosure and is raising it again, perhaps because they remain concerned about vulnerable people or wrongdoing and are not confident that the management has dealt with it.

The whistle-blower contacted the CQC on the 23 August 2020. An unannounced responsive inspection was organised for 3 and 15 September 2020.

The whistle-blower told us they had concerns about:

- The hospital not properly managing a case of misconduct of a member of staff.
- Controlled drugs not being accounted for and wrong medication being given as a result of a junior member not being appropriately supervised.

Summary of this inspection

- Sexual misconduct by a member of staff towards a patient. This had reportedly been observed by other staff and reported to a senior member of staff but not responded to appropriately as per the provider's policy.
- A member of staff being aggressive towards other staff and antagonising a patient. This patient's complaints about the staff member were reportedly not taken seriously by the leadership team.

How we carried out this inspection

Our focused inspection of this location was very specific to assess if the provider had taken appropriate steps to safeguard patients at the hospital. We also inspected to check if any other patients had been subjected to abuse or inappropriate treatment.

We looked at specific questions under our safe and well led domains.Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all five wards at the hospital;
- spoke with 11 patients and carers who were using the service;
- spoke with the registered manager and clinical nurse managers for each of the wards;
- spoke with 32 other staff members; including nurses, occupational therapists, psychologists and care support workers;
- spoke with an independent advocate;
- observed a multi-disciplinary meeting;
- looked at 15 care and treatment records of patients:
- carried out a specific check of the medication management on two wards; and
- looked at a range of policies, procedures and other documents relating to the running of the provider.

What people who use the service say

We spoke with two patients and nine carers who were positive about the service. They told us that they found staff were kind and friendly, asked them what they needed and listened carefully to them. Both patients said that they felt safe in the care of the hospital.

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?

Not sufficient evidence to rate

We did not rate this key question. We identified the following areas of concern:

- Staff did not make a safeguarding alert when they recognised possible abuse. However, staff had received training on how to recognise and report abuse and they said they knew how to apply it.
- Not all risk assessments were up to date.
- Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff said they were not always supported to report all incidents appropriately and felt that managers did not investigate all incidents. Lessons learned were not always shared effectively with the whole team.

However:

- The provider used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

Are services well-led?

Not sufficient evidence to rate

We did not rate this key question. We identified the following areas of concern:

- Staff did not always find leaders to be visible and approachable.
- Not all staff felt respected, supported, and valued. They did not always feel able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level.

However;

- Leaders had the knowledge, and experience to perform their roles, had a good understanding of the services they managed.

Long stay or rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

Safe	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

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

Not sufficient evidence to rate

Assessing and managing risk to patients and staff

Staff managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. However, not all assessments were up to date.

We found that staff had a good understanding of their patients and managed the risks to patients and themselves. Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers. Care and treatment on the ward demonstrated that staff considered the guiding principle of least restriction.

We reviewed eight care records and found that all had a risk assessment completed on admission. We saw that risk assessments were updated regularly on the live documents however, on Horton we found two records that were not up to date due to the named nurse being on long term leave. Not all staff had access to the live electronic documents and relied on the handover for updated information, which they said consisted of a lot of information within a short period of time. The provider was in the process of implementing a new risk assessment and we saw examples of both old and new assessments within patient folders. This did cause some confusion when reading patient files to ascertain whether risks and incidents were recorded. The older assessments contained details of incidents relating to specific risks whereby the new one had all incidents contained under one heading. This meant that incidents and therefore risks could be found in two different places however, the older style assessment was being phased out.

Support workers made up a substantial proportion of the workforce and spent the longest time with patients but were not always able to attend meetings or felt empowered to input into them. This included multidisciplinary and care programme approach meetings. This led to a lack of understanding of the clinical judgements being made and a lack of understanding of the roles of the multidisciplinary team. Staff felt that clinical decisions were sometimes made without the multidisciplinary team fully understanding the patient risk due to not having representation from support workers. In addition, staff shared concerns that the clinical nurse managers would attend patient multidisciplinary and care programme meetings and make clinical decisions in place of the named nurse. Staff felt that the clinical nurse managers were not always fully knowledgeable about individual patients, including risks, and therefore were concerned that the clinical judgements made were not always done so with all the information needed. There was also a culture of not reporting incidents or concerns to leaders, including clinical nurse managers, which meant staff did not always approach them which could lead to vital information about patient care not being discussed.

Staff said they had received a risk assessment relating to COVID-19 but were unaware of the outcomes.

Safeguarding

Staff did not always make a safeguarding alert when they recognised possible abuse. However, staff had received training on how to recognise and report abuse, said they knew how to apply it but they did not always apply it.

Multiple staff gave examples of seeing inappropriate behaviour between peers and patients but had failed to directly raise a safeguarding alert. Some had raised concerns to their manager but again a safeguarding alert was not made.

CQC raised a safeguarding alert on receipt of a whistleblowing enquiry relating to an allegation of misconduct between a member of staff and a patient. We found the provider had been slow to act on receipt of this

knowledge, only beginning an investigation when contacted by CQC despite acknowledging staff had raised similar concerns. The investigation was ongoing throughout the inspection period.

However, staff said they were trained in safeguarding and gave examples of how to make a safeguarding alert. They gave examples how they would identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The provider had an up to date safeguarding policy that staff had to read and sign to acknowledge they understood the contents.

Staff access to essential information

Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient records were kept on an electronic database, an online folder structure and within a paper folder. Not all information needed to deliver patient care was available or easily accessible to all relevant staff, including agency staff, when they needed it.

At our last inspection we said the provider should ensure that care support workers have access to the daily electronic patient record. On this inspection staff said that support workers did not have access to the electronic systems and as such relied on the paper folders being kept up-to-date. The provider kept live electronic care plans and risk assessments, documents that could be added to daily if needed, and printed them off once a month to add to the paper folder. Staff said they did not always have the most recent patient information.

Policies and procedures were kept in the ward office for staff to access, and staff signed a document to say they had read them. However, agency staff said they did not read the provider's policies or updates as they were for the permanent staff, which meant that they did not receive up-to-date information.

Staff were expected to record information in more than one system, paper and electronic, this was not always easy and could be time consuming. Staff said that information would be duplicated which meant workloads were unnecessarily increased. One such example involved handover information which was recorded separately on the handover sheet, the daily report and on the electronic system.

Medicines management

The provider used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

We reviewed three patient medications records and found all but one to be in good order. Staff followed good practice in medicines management, that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication, and did it in line with national guidance.

Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Staff completed weekly medicines audits and an external pharmacist also completed clinical audits on a bi-monthly basis for each ward. Medicines audits were discussed at the morning meetings and as part of the provider's clinical governance meetings. We reviewed 15 internal medicines audits and three external audits and found that actions were followed-up and completed.

There had been one medicines error where the pharmacy had sent the incorrect dose of medication, but this had been noticed quickly by the nurse in charge and removed from the medications room.

The organisation had a rapid tranquilisation policy that met National Institute for Health and Care Excellence guidance.

Reporting incidents and learning from when things go wrong

Staff said they were not always supported to report all incidents appropriately and felt that managers did not investigate all incidents. Lessons learned were not always shared effectively with the whole team.

There was a system in place to review incidents and a course of action following an incident. However, staff did

Long stay or rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

not feel confident to report them, were not always able to report due to lack of access to the system and when they did there was no learning fed back to most staff including those providing direct patient care. All staff knew what incidents to report and how to report them but said they were reluctant to report incidents and felt discouraged to report. Support workers did not have access to the electronic system and had to report incidents via the nurse in charge or the senior support worker. The nurse in charge would then complete the online record. Not all staff felt confident that the incident report reflected their words. However, we saw evidence of completed incident reports and no obvious theme that suggest incidents were not being reported.

The provider did not have a robust process for providing feedback and lessons learned from incidents. Staff did not receive feedback from the investigation of incidents, both internal and external to the service. Staff said this lack of feedback had fed into the reluctance to report an incident.

We saw lessons learned were discussed in the handover documents and at the daily meetings. We found managers and nursing staff had a good overview of incidents and lessons learned. However, support worker staff said they received little feedback from the daily meeting and felt the handover was too quick to absorb all the messages. Staff could read minutes from the daily meetings but felt that time to do so was limited.

We reviewed five root cause analysis reports and found the quality and level of detail to be inconsistent. In two reports it was unclear about when the incident was reported.

The providers approach to debriefs was inconsistent. We heard from staff who had received debriefs and found them to be supportive and from other staff who had not. For those staff who had not received a debrief, the support was specific to their own team of peers to check they were okay. Psychologists had undertaken reflective practice and de-briefs on the wards to try to create a safe environment but again this was not consistently used.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff understood the duty of candour.

The provider had an incident review process. Incidents were discussed and reviewed at the daily multi-disciplinary team meeting. The team then graded the incident and decided whether the incident required a referral to the local authority safeguarding team. There was ongoing monitoring of incidents via the hospital's electronic records system where additional information, actions and outcomes could be added. Additionally, incidents were reviewed within the monthly local governance meeting and monthly John Munroe Group clinical governance meetings.

The provider recognised more work was required in supporting staff to raise concerns and log incidents and were introducing more in-depth training. This training would offer more support, so staff understood the importance of reporting. Following the inspection, the provider told us they would review the systems to enable all staff to raise concerns.

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

Not sufficient evidence to rate

Leadership

Leaders had the knowledge and experience to perform their roles. However, staff did not always find them to be visible and approachable.

They had a good understanding of the services they managed and had a good clinical understanding of caring for patients with dementia and providing long term rehabilitation for a wide range of other patients. Leaders we spoke to were able to describe clearly how they worked to provide high quality care. Leadership development opportunities were available, including opportunities for staff below team manager level.

However, staff did not always find leaders to be visible and approachable. Staff gave examples of feeling unsupported and demoralised. We often heard that staff were dismissed by leaders when raising concerns and when suggesting improvement in patient care. Staff felt that a blame culture had developed that meant they were reluctant to speak with leaders.

Whilst the registered manager had encouraged and enhanced communications between staff and leaders, we found that this was inconsistent and not fully imbedded.

Culture

Long stay or rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

Not all staff felt respected, supported, and valued by peers or by managers. They did not always feel able to raise concerns without fear of retribution.

Both staff and leaders contributed to poor culture in the hospital.

We found a notable change in the culture since our last inspection in November 2019. Staff reported that morale was low and that there was a culture of bullying, gossip, and malicious complaints.

The provider did not have a robust process by which staff could raise concerns, including verbal concerns, with agreed managerial responsibilities. Since the last inspection the Freedom to Speak up Guardian had changed due to the previous Guardian leaving John Munroe. A temporary Guardian had been employed but staff including managers were unable to tell us who the Guardian was. During this inspection we were told they were in the process of recruiting a new Guardian. Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.

Whilst staff knew the whistleblowing process, not all staff felt able to raise concerns. Staff reported a culture of a reluctance to report incidents and concerns due to either a fear of retribution or due to perceived lack of action by leaders. Staff gave examples of reporting concerns, including those contained within the whistleblowing that triggered this inspection, but received no feedback and saw no change in practice. Staff said they were actively discouraged from reporting bullying if it did not directly relate to them and that concerns were not acted on when raised.

Staff said that leaders did not protect staff from bullying and harassment, only addressing concerns if they were formally put into writing. This was not in line with the provider's Freedom to Speak Up raising issues of concern policy. This left staff feeling at risk from recrimination and reluctant to raise concerns.

Managers did not always deal with poor staff performance when needed. Staff gave us example of where they had raised concerns but did not feel the provider appropriately acted upon them.

Whilst overall, we found that individual teams worked well together, we also saw a culture of silo working. Staff reported issues with informal hierarchies being in place, such as who had been working for the provider the longest.

The provider had recently employed an external consultant to audit the hospital with a remit of exploring closed cultures. However, not all staff including leaders were aware of this. A closed culture is a poor culture which has an increased risk of harm – including abuse and human rights breaches. This can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones.

Closed cultures are more likely to develop in services where people are removed from their communities, where people stay for months or years at a time, where there is weak leadership and where staff often lack the right skills, training or experience to support people. They are also more likely to develop where there's a lack of positive and open engagement between staff and with people using services and their families.

In these services, people are often not able to speak up for themselves - this could be through lack of communication skills, lack of support to speak up or abuse of their rights to.

Staff reported that they were provided with opportunities for career progression. Staff appraisals included conversations about career development and how it could be supported. Staff had access to support for their own physical and emotional health needs through an occupational health service.

Leaders recognised that there were still improvements to be made and were committed to improvement. This included planning team building exercises which were being planned to take place 2020/21.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level.

The provider was in the process of implementing a new governance structure which had led to patient information being saved in multiple locations. Patient records were not complete and when asked, staff said they struggled to get an overall view of the patient to support their care and treatment. We found various aspects of patient information

Long stay or rehabilitation mental health wards for working age adults

Not sufficient evidence to rate

kept in a paper folder, within an electronic records system and within an online folder structure. Each patient had an online folder created under their name, but we found the folder structures and usage to be inconsistent.

Not all staff had access to the electronic systems which meant they were heavily reliant on the paper records being up to date. The paper records whilst indexed were laid out as such that the most up to date information was found toward the back of the record. These records could be quite large, and this meant staff would need to navigate several sections to find information such as risk assessments and care plans. Additionally, this also meant that support workers who spent the largest amount of time with patients were unable to contribute to care notes or log incidents. We found care plans and risk assessments could be delayed in being created or updated if the named nurse was on leave and that there was no formal process in place to prevent this.

Staff reported that the electronic system was not updated consistently and was difficult to navigate. For example, it was not always easy to find multidisciplinary team meeting notes, meetings where clinical decisions were made, and staff had to rely on key word searches to find information.

On Horton we found patient bank statements within an easy to access paper folder, this was not in line with the General Data Protection Regulations. These were removed at once on notification to the provider.

The provider had a daily multidisciplinary meeting which had a clear framework of what must be discussed to ensure that essential information, such as learning from incidents and complaints, was shared, and discussed. They were committed to continuous quality improvement and clinical governance. There had been a continued emphasis on the governance of the hospital's medicines management system, and they continued to make improvements.

Not sufficient evidence to rate

Wards for older people with mental health problems

Safe	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

Are wards for older people with mental health problems safe?

Not sufficient evidence to rate

Assessing and managing risk to patients and staff

Staff managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. However, not all assessments were up to date.

We found that staff had a good understanding of patients and managed the risks to patients and themselves. Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers. Care and treatment on the ward demonstrated that staff considered the guiding principle of least restriction.

We reviewed seven care records and found that all but one had a risk assessment completed on admission. The one record related to a newly admitted patient who had specific infection control needs and when we asked to the see the assessment, we were told the assessment had been delayed due to the named nurse being on leave. This patient needed a very specific risk assessment with specific personal protective equipment (PPE) needs for various aspects of their care. The lack of assessment had caused anxiety amongst staff who were unsure as to what personal protective equipment (PPE) was needed when providing care and treatment. However, we found that the PPE provided was in line with guidance and sufficient to provide safe care and treatment.

We saw that risk assessments were updated regularly on the live documents. Not all staff had access to the live documents and relied on the handover for updated information, which they said consisted of a lot of information within a short period of time. The provider was in the process of implementing a new risk assessment and we saw examples of both old and new assessments within patient folders. This did cause some confusion when reading patient files to ascertain whether risks and incidents were recorded. The older assessments contained details of incidents relating to specific risks whereby the new one had all incidents contained under one heading. This meant that incidents and therefore risks could be found in two different places however, the older style assessment was being phased out.

Support workers made up a substantial proportion of the workforce and spent the longest time with patients but were not always able to attend meetings or felt empowered to input into them. This included multidisciplinary and care programme approach meetings.. This led to a lack of understanding of the clinical judgements being made and a lack of understanding of the roles of the multidisciplinary team. Staff felt that clinical decisions were sometimes made without the multidisciplinary team fully understanding the patient risk due to not having representation from support workers. In addition, staff shared concerns that the clinical nurse managers would attend patient multidisciplinary and care programme meetings and make clinical decisions in place of the named nurse. Staff felt that the clinical nurse managers were not always fully knowledgeable about individual patients, including risks, and therefore were concerned that the clinical judgements made were not always done so with all the information needed. There was also a culture of not reporting incidents or concerns to leaders, including clinical nurse managers, which meant staff did not always approach them which could lead to vital information about patient care not being discussed.

Staff said they had received a risk assessment relating to COVID-19 but were unaware of the outcomes.

Safeguarding

Staff did not always make a safeguarding alert when they recognised possible abuse. However, staff had received training on how to recognise and report abuse, said they knew how to apply it but they did not always apply it.

Not sufficient evidence to rate

Wards for older people with mental health problems

Multiple staff gave examples of seeing inappropriate behaviour between peers and patients but had failed to directly raise a safeguarding alert. Some had raised concerns to their manager but again a safeguarding alert was not made.

CQC raised a safeguarding alert on receipt of a whistleblowing enquiry relating to an allegation of a misconduct between a member of staff and a patient. We found the provider had been slow to act on receipt of this knowledge, only beginning an investigation when contacted by CQC despite acknowledging staff had raised similar concerns. The investigation was ongoing throughout the inspection period.

However, staff said they were trained in safeguarding and gave examples of how to make a safeguarding alert. They gave examples how they would identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The provider had an up to date safeguarding policy that staff had to read and sign to acknowledge they understood the contents.

Staff access to essential information

Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient records were kept on an electronic database, an online folder structure and within a paper folder. Not all information needed to deliver patient care was available or easily accessible to all relevant staff, including agency staff, when they needed it.

At our last inspection we said the provider should ensure that care support workers have access to the daily electronic patient record. On this inspection staff said that support workers did not have access to the electronic systems and as such relied on the paper folders being kept up-to-date. The provider kept live electronic care plans and risk assessments, documents that could be added to daily if needed, and printed them off once a month to add to the paper folder. Staff said they did not always have the most recent patient information.

Policies and procedures were kept in the ward office for staff to access, and staff signed a document to say they had read them. However, agency staff said they did not read the provider's policies or updates as they were for the permanent staff, which meant that they did not receive up-to-date information.

Staff were expected to record information in more than one system, paper and electronic, this was not always easy and could be time consuming. Staff said that information would be duplicated which meant workloads were unnecessarily increased. One such example involved handover information which was recorded separately on the handover sheet, the daily report and on the electronic system.

Medicines management

The provider used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

We reviewed five patient medications records and found all but one to be in good order. On one record we saw that there had been an instance where the record had not been completed in full but saw evidence that this had been reviewed and addressed as part of an audit programme. We reviewed the controlled drugs and the corresponding ledger and found both to be tidy and intact.

Staff followed good practice in medicines management, that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication, and did it in line with national guidance.

Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Staff completed weekly medicines audits and an external pharmacist also completed clinical audits on a bi-monthly basis for each ward. Medicines audits were discussed at the morning meetings and as part of the provider's clinical governance meetings. We reviewed 15 internal medicines audits and three external audits and found that actions were followed-up and completed.

Not sufficient evidence to rate

Wards for older people with mental health problems

There had been one medicines error where the pharmacy had sent the incorrect dose of medication, but this had been noticed quickly by the nurse in charge and removed from the medications room.

The organisation had a rapid tranquilisation policy that met National Institute for Health and Care Excellence guidance.

Reporting incidents and learning from when things go wrong

Staff said they were not always supported to report all incidents appropriately and felt that managers did not investigate all incidents. Lessons learned were not always shared effectively with the whole team.

There was a system in place to review incidents and a course of action following an incident. However, staff did not feel confident to report them, were not always able to report due to lack of access to the system and when they did there was no learning fed back to most staff including those providing direct patient care. All staff knew what incidents to report and how to report them but said they were reluctant to report incidents and felt discouraged to report. Support workers did not have access to the electronic system and had to report incidents via the nurse in charge or the senior support worker. The nurse in charge would then complete the online record. Not all staff felt confident that the incident report reflected their words. However, we saw evidence of completed incident reports and no obvious theme that suggest incidents were not being reported.

The provider did not have a robust process for providing feedback and lessons learned from incidents. Staff did not receive feedback from the investigation of incidents, both internal and external to the service. Staff said this lack of feedback had fed into the reluctance to report an incident.

We saw lessons learned were discussed in the handover documents and at the daily meetings. We found managers and nursing staff had a good overview of incidents and lessons learned. However, support worker staff said they received little feedback from the daily meeting and felt the handover was too quick to absorb all the messages. Staff could read minutes from the daily meetings but felt that time to do so was limited.

We reviewed five root cause analysis reports and found the quality and level of detail to be inconsistent. In two reports it was unclear about when the incident was reported.

The providers approach to debriefs was inconsistent. We heard from staff who had received debriefs and found them to be supportive and from other staff who had not. For those staff who had not received a debrief, the support was specific to their own team of peers to check they were okay. Psychologists had undertaken reflective practice and de-briefs on the wards to try to create a safe environment but again this was not consistently used.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff understood the duty of candour.

The provider had an incident review process. Incidents were discussed and reviewed at the daily multi-disciplinary team meeting. The team then graded the incident and decided whether the incident required a referral to the local authority safeguarding team. There was ongoing monitoring of incidents via the hospital's electronic records system where additional information, actions and outcomes could be added. Additionally, incidents were reviewed within the monthly local governance meeting and monthly John Munroe Group clinical governance meetings.

The provider recognised more work was required in supporting staff to raise concerns and log incidents and were introducing more in-depth training. This training would offer more support, so staff understood the importance of reporting. Following the inspection, the provider told us they would review the systems to enable all staff to raise concerns.

Are wards for older people with mental health problems well-led?

Not sufficient evidence to rate

Leadership

Leaders had the knowledge, and experience to perform their roles. However, staff did not always find them to be visible and approachable.

They had a good understanding of the services they managed and had a good clinical understanding of caring for patients with dementia and providing long term

rehabilitation for a wide range of other patients. Leaders we spoke to were able to describe clearly how they worked to provide high quality care. Leadership development opportunities were available, including opportunities for staff below team manager level.

However, staff did not always find leaders to be visible and approachable. Staff gave examples of feeling unsupported and demoralised. We often heard that staff were dismissed by leaders when raising concerns and when suggesting improvement in patient care. Staff felt that a blame culture had developed that meant they were reluctant to speak with leaders.

Whilst the registered manager had encouraged and enhanced communications between staff and leaders, we found that this was inconsistent and not fully imbedded.

Culture

Not all staff felt respected, supported, and valued. They did not always feel able to raise concerns without fear of retribution.

Not all staff felt respected, supported, and valued by peers or by managers. Both staff and leaders contributed to poor culture in the hospital.

We found a notable change in the culture since our last inspection in November 2019. Staff reported that morale was low and that there was a culture of bullying, gossip, and malicious complaints.

The provider did not have a robust process by which staff could raise concerns, including verbal concerns, with agreed managerial responsibilities. Since the last inspection the Freedom to Speak up Guardian had changed due to the previous Guardian leaving John Munroe. A temporary Guardian had been employed but staff including managers were unable to tell us who the Guardian was. During this inspection we were told they were in the process of recruiting a new Guardian. Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.

Whilst staff knew the whistleblowing process, not all staff felt able to raise concerns. Staff reported a culture of a reluctance to report incidents and concerns due to either a fear of retribution or due to perceived lack of action by leaders. Staff gave examples of reporting concerns, including those contained within the whistleblowing that triggered this inspection, but received no feedback and saw no change in practice. Staff said they were actively discouraged from reporting bullying if it did not directly relate to them and that concerns were not acted on when raised.

Staff said that leaders did not protect staff from bullying and harassment, only addressing concerns if they were formally put into writing. This was not in line with the provider's Freedom to Speak Up raising issues of concern policy. This left staff feeling at risk from recrimination and reluctant to raise concerns.

Managers did not always deal with poor staff performance when needed. Staff gave us example of where they had raised concerns but did not feel the provider appropriately acted upon them.

Whilst overall, we found that individual teams worked well together, we also saw a culture of silo working. Staff reported issues with informal hierarchies being in place, such as who had been working for the provider the longest.

The provider had recently employed an external consultant to audit the hospital with a remit of exploring closed cultures. However, not all staff including leaders were aware of this. A closed culture is a poor culture which has an increased risk of harm – including abuse and human rights breaches. This can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones.

Closed cultures are more likely to develop in services where people are removed from their communities, where people stay for months or years at a time, where there is weak leadership and where staff often lack the right skills, training or experience to support people. They are also more likely to develop where there's a lack of positive and open engagement between staff and with people using services and their families.

In these services, people are often not able to speak up for themselves - this could be through lack of communication skills, lack of support to speak up or abuse of their rights to.

Staff reported that they were provided with opportunities for career progression. Staff appraisals included

conversations about career development and how it could be supported. Staff had access to support for their own physical and emotional health needs through an occupational health service.

Leaders recognised that there were still improvements to be made and were committed to improvement. This included planning team building exercises which were being planned to take place 2020/21.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level.

The provider was in the process of implementing a new governance structure which had led to patient information being saved in multiple locations. Patient records were not complete and when asked, staff said they struggled to get an overall view of the patient to support their care and treatment. We found various aspects of patient information kept in a paper folder, within an electronic records system and within an online folder structure. Each patient had an online folder created under their name, but we found the folder structures and usage to be inconsistent.

Not all staff had access to the electronic systems which meant they were heavily reliant on the paper records being up to date. The paper records whilst indexed were laid out as such that the most up to date information was found toward the back of the record. These records could be quite large, and this meant staff would need to navigate several sections to find information such as risk assessments and care plans. Additionally, this also meant that support workers who spent the largest amount of time with patients were unable to contribute to care notes or log incidents. We found care plans and risk assessments could be delayed in being created or updated if the named nurse was on leave and that there was no formal process in place to prevent this.

Staff reported that the electronic system was not updated consistently and was difficult to navigate. For example, it was not always easy to find multidisciplinary team meeting notes, meetings where clinical decisions were made, and staff had to rely on key word searches to find information.

On Horton we found patient bank statements within an easy to access paper folder, this was not in line with the General Data Protection Regulations. These were removed at once on notification to the provider.

The provider had a daily multidisciplinary meeting which had a clear framework of what must be discussed to ensure that essential information, such as learning from incidents and complaints, was shared, and discussed. They were committed to continuous quality improvement and clinical governance. There had been a continued emphasis on the governance of the hospital's medicines management system, and they continued to make improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risk assessments and the resulting care plans are created without delay and shared with all staff members. These should include good cleaning regimes, that any wounds are regularly swabbed to ensure there are no signs of open infection, that appropriate body washes are used, and that staff always use personal protective equipment when doing personal care and changing bedding. Regulation 12.
- The provider must employ a Freedom to Speak Up Guardian and ensure staff have the confidence to raise concerns and be confident they will be acted upon. Regulation 16.
- The provider must ensure they have a robust process by which staff can raise concerns, including verbal concerns and incidents, with agreed managerial responsibilities, and this should be implemented consistently. Regulation 17.
- The provider must ensure that there is a clear process for learning lessons from incidents and complaints, that staff are aware of it and it is consistently followed. Regulation 17.

Action the provider SHOULD take to improve

- The provider should ensure they are compliant with the principles of the General Data Protection Regulations. Regulation 17.
- The provider should ensure that all voices of staff are heard at multidisciplinary team meetings and care programme approach meetings, including registered nurses and staff who spend the most time with patients. Regulation 17.
- The provider should ensure all staff are treated with respect when suggestions are made regarding changes to clinical care and their thoughts reflected at clinical meetings. Regulation 17.
- The provider should ensure that support workers understand the work of the multidisciplinary team and what they do when not on wards to ensure patients receive specific treatment. Regulation 17.
- The provider should ensure that there is a formal process for de-brief, and this is followed. Regulation 17.
- The provider should ensure that managers are consistent in their approach to staff. They should be visible, open and known to all staff. Regulation 17.
- The provider should consider exploring silo working to ensure that there is a cohesive approach to team working that engages all teams, and that supports staff who do not feel they have a voice outside of their peer group.
- The provider should consider assessing the potential risks of a closed culture and address any identified actions as a result to drive improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider must ensure they have a robust process by which staff can raise concerns, including verbal concerns, and incidents with agreed managerial responsibilities and this should be implemented consistently.** **The provider must ensure that there is a clear process for learning lessons from incidents and complaints, that staff are aware of it and it is consistently followed.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure that care plans and risk assessments are created without delay and shared with all staff members. These should include good cleaning regimes, that any wounds are regularly swabbed to ensure there are no signs of open infection, that appropriate body washes are used, and that staff always use personal protective equipment when doing personal care and changing bedding.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

The provider must employ a Freedom to Speak Up Guardian and ensure staff have the confidence to raise concerns and be confident they will be acted upon.