

John Munroe Hospital – Rudyard

Quality Report

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Rudyard
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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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



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.

Summary of findings

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.

Overall summary

We rated John Munroe Hospital – Rudyard as requires improvement because:

- There were some gaps in checks of emergency resuscitation equipment in High Ash bungalow, there were no records confirming checks of portable equipment on Kipling ward, and clinical equipment such as the medicines cutter on Kipling/Rudyard wards was not clean.
- Staff delayed replacement of a patient's mattress that was not fit for use and posed an infection control risk.
- Staff found it difficult to access the nurse shared between High Ash and Larches because of a lack of adequate means of communication.
- There were a number of blanket restrictions on Horton, Kipling and Rudyard wards. Patients could not make their own drinks or snacks or keep food in their rooms or elsewhere, and staff did not allow relatives on Horton, Kipling and Rudyard wards or in the patients' bedrooms.
- The ward environments of Horton, Kipling and Rudyard wards were sparsely furnished and had poor décor.
- The design, layout and facilities on Rudyard ward did not promote the safety, comfort and wellbeing of patients living with dementia. The ward had no handrails, orientation aids, signage or other furnishings to support people living with organic conditions.
- There was a lack of meaningful and recovery-orientated activities on the three main wards. On Rudyard ward, staff engagement and communication with patients with cognitive impairment was limited.
- Staff were not up-to-date with their mandatory training, and there were gaps for specialist training such as dementia-focused care.

- Three relatives we spoke with raised concerns about poor communication with the hospital generally, including a lack of updates and difficulties getting through when they phoned.
- Patients on Horton, Kipling and Rudyard wards did not have access to kitchen facilities. Patients complained about the quality and choice of food available to the three wards (Horton, Kipling and Rudyard). There were no menus displayed.
- On the three wards, patients' belongings were not looked after well and went missing.

However:

- The provider had installed a new alarm system that would allow all staff access to mobile alarms and swipe cards to enter or leave the wards.
- The hospital had access to a wide range of disciplines that provided clinical input to the wards and patients. This included a skilled and experienced therapies team and occupational therapy service.
- All staff received supervision regularly.
- Staff personnel files contained appropriate up-to-date documentation, and fit and proper person declaration forms were in order.
- The provider had implemented a monitoring system that ensured there were sufficient staff on each ward that could carry out physical interventions safely.
- The hospital had a strong focus on patients' physical healthcare needs, and patients had regular and timely access to physical healthcare support.
- All wards had regular, effective and well-coordinated multidisciplinary team meetings and handovers.
- The provider had good incident reporting systems and processes that included a central database, daily ward reports and good links with the local authority safeguarding team.
- The hospital had a risk register that set out risks to the business and service delivery, and described the contingency plans.

Summary of findings

- The provider had improved its governance systems and processes for monitoring all aspects of care. Managers and staff had access to information that helped them assess service delivery and identify areas for improvement.

Summary of findings

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Requires improvement 

John Munroe Hospital - Rudyard

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 – Rudyard 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, 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. During our inspection, Horton ward changed from being a mixed-gender ward to a male-only ward.
- Kipling ward is 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 unit for up to seven patients and provides locked rehabilitation.
- Larches is a male-only unit for up to six patients and provides locked rehabilitation.

Our inspection team

Team leader: Si Hussain

The team that inspected the service comprised four CQC inspectors, a CQC pharmacy inspector, a specialist

professional advisor (registered mental health nurse) and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who has used mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. We had previously inspected (but not rated) John Munroe Hospital on four occasions and completed three Mental Health Act monitoring visits.

We undertook Mental Health Act monitoring visits to High Ash unit on 30 November 2015, Larches unit on 27 April 2016, Kipling Ward on 5 May 2016 and Horton ward on 17 June 2016.

We completed a comprehensive inspection in February 2015, a focused inspection in January 2016 and two focused inspections in August 2016 following whistleblowing concerns. Following the inspection in August 2016, we told the provider that it must:

- ensure that all clinical staff on duty have access to swipe cards or keys to move freely around the wards and enable an early response to any alarm
- ensure records of staff on shift are accurate and provide assurance in case of a fire alarm
- hold a risk register that shows ongoing concerns and action plans
- ensure that risk reporting is used to inform staff of lessons learnt
- ensure that systems are in place to record shifts that are not filled.

We also told that provider that it should:

- ensure personal alarms are provided in sufficient quantity for all staff on shift

Summary of this inspection

- ensure that bedding is included in future hygiene audits, and check the integrity and condition of protective covers
- ensure that staff apply the safeguards outlined in the MHA Code of Practice to the management of long-term segregation and other restrictive practices
- develop a local protocol to support best interests decision making for the administration of covert medicines in line with the national institute of health and care excellence (NICE) guidance and the Mental Capacity Act Code of Practice

- ensure that where patients are unable to manage their finances independently, their personal arrangements are clearly recorded and a copy of the legal authority allowing any other person to manage money on their behalf is available for inspection.

We issued two requirement notices at the last inspection in August 2016 for breaches of:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance.

At our most recent inspection, we checked if the provider had addressed these issues.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about 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, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 18 patients and seven relatives
- spoke with the registered manager for all the wards
- spoke with 30 staff members including doctors, nurses, healthcare support workers, the occupational therapist and the psychologist

- spoke with four other staff including the human resources manager, the mental health law manager, the training officer and the maintenance supervisor
- received feedback about the service from care co-ordinators and commissioners
- spoke with an independent advocate
- attended and observed a multidisciplinary team meeting
- observed a GP round for five patients
- conducted nine short observational framework for inspection (SOFI) exercises
- reviewed 14 comments cards from patients
- looked at care and treatment records for 29 patients
- carried out a specific check of the medication management on all wards and looked at 14 prescription charts
- looked at human resources files for five employees
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 18 patients, seven relatives and an advocate. We reviewed 14 comments cards. We conducted nine short observational framework for inspection (SOFI) exercises on Horton, Kipling and

Rudyard wards. A SOFI involves close observation of staff and patient interactions for short periods of time. We used SOFIs because we were unable to speak with some patients because of the severity of their dementia.

Summary of this inspection

Overall, patients gave positive views about how staff treated them. Patients on High Ash unit spoke highly of the staff and described them as ‘angels’. Patients described a good rapport with staff on Kipling ward. Some patients commented on the clean environment and complimented the friendly domestic staff.

However, patients on Kipling and Horton wards raised a number of issues including a lack of meaningful activity and community access, cancelled activities, a lack of recovery and rehabilitation focused care, and feelings of isolation and boredom. Patients from all wards complained about the high turnover of staff and the high use of temporary staff. Patients on the wards in the main hospital site (Horton, Kipling and Rudyard) complained about the poor design and layout of the wards, the lack of choice and poor quality of the food, and missing personal items.

Relatives gave mostly positive views about staff. Some relatives described them as welcoming and friendly. Relatives praised the staff on Larches unit and said they

“couldn’t fault it” referring to the staff and care. Another relative said, “I can’t praise them enough” referring to staff on Kipling ward. A relative described staff as reassuring towards a patient on Kipling ward and commented on their attention to detail.

However, three relatives felt there was poor communication between staff about patients’ specific needs and risks and poor compliance with patients’ risk management plans. Relatives felt that temporary staff lacked information about patients. Two relatives felt that staff showed little regard for patients’ belongings, and expressed concern about patients’ personal items such as glasses, clothes and shoes going missing.

From our SOFI exercises, we observed mostly caring and respectful interactions between staff and patients although we also saw occasions where staff ignored patients. We noticed an absence of meaningful engagement with patients on Rudyard ward where most of the patients had organic conditions such as dementia.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because:

- Rudyard ward had no handrails, orientation aids, signage or other furnishings to demonstrate a safe, dementia-friendly environment to support patients living with organic conditions.
- The provider delayed in replacing a mattress that was not fit for use and posed an infection control risk.
- Staff did not regularly clean and maintain clinical equipment so that it was safe from the risk of cross-contamination.
- Staff in High Ash unit did not consistently carry out checks on emergency resuscitation and there were no records confirming checks of portable equipment on Kipling ward.
- The hospital had a high staff turnover and vacancy levels, which meant they relied heavily on temporary staff to cover shifts. This affected the continuity and consistency of care received by patients.
- Staff found it difficult to access the nurse shared between High Ash and Larches because of a lack of adequate ways to communicate.
- Not all staff had received all of their mandatory training.
- There were a number of blanket restrictions on Horton, Kipling and Rudyard wards.
- There was an absence of guidance for some PRN (pro re nata – as required) medication.

However:

- The provider had installed a new alarm system that would allow all staff to have access to mobile alarms and swipe cards for entering and leaving the wards).
- Staff personnel files contained the appropriate up-to-date documentation, and fit and proper person declaration forms were in order.
- The provider had implemented a monitoring system that ensured there were sufficient staff on each ward that could carry out physical interventions safely.
- The provider had a comprehensive risk assessment tool that covered a range of risks, and staff completed risk assessments for each patient and updated these regularly.
- The provider had good incident reporting systems and processes that included a central database, daily ward reports and good links with the local authority safeguarding team.

Requires improvement



Summary of this inspection

- Staff assessed patients' physical health risks such as falls and pressure ulcers and planned appropriate care for their specific needs.
- During our inspection, the hospital successfully implemented emergency business continuity measures to ensure patients were safe and warm.

Are services effective?

We rated effective as good because:

- All patients received timely and comprehensive assessments of their mental and physical health needs. Patients had a range of up-to-date, personalised care plans that reflected their needs.
- The hospital's paper and electronic files were in good order, clearly set out and stored securely.
- The hospital had access to a wide range of disciplines that provided input to the wards and patients.
- The hospital had a strong focus on patients' physical healthcare needs, and patients had regular and timely access to physical healthcare support.
- All wards had regular, effective and well-coordinated multidisciplinary meetings and handovers.
- Staff received supervision regularly. Specialist disciplines such as psychology and occupational therapy had access to professional and peer supervision.
- Mental Health Act (MHA) documentation was up-to-date and completed accurately. There were effective systems and processes in place to ensure compliance and good practice with MHA requirements.
- Most staff had a good understanding of the principles underpinning the Mental Capacity Act (MCA). The hospital applied the MCA appropriately and followed best interest processes for significant decisions, where necessary.

However:

- The hospital did not use a recovery-focused model of care. Many care plans lacked a rehabilitative or recovery focus.
- There was an absence of dementia-focused care on Rudyard ward where most patients had organic conditions.
- At the time of our inspection, staff did not receive specific training in dementia care.
- Not all staff had received their annual appraisal.
- Not all eligible staff had received training in the Mental Health Act, the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Good



Summary of this inspection

Are services caring?

Good



We rated caring as good because:

- There was a positive and friendly atmosphere between staff and patients on High Ash and Larches units, good rapport between staff and patients on Kipling ward and caring and respectful interactions between staff and patients on Horton and Rudyard wards.
- Patients and relatives we spoke with described most of the staff as friendly and caring, and spoke highly of the doctors.
- Patients had access to local advocacy services and other forums for raising concerns and giving feedback about the service.
- Staff had a good understanding of most patients' needs. Staff involved patients and their relatives, where appropriate, in assessment and care planning. On High Ash unit, staff encouraged patients to develop their own crisis management plans.

However:

- On Rudyard ward, we observed limited staff engagement and communication with patients with cognitive impairments and an absence of dementia-focused care. The care provided mainly focused on practical tasks such as personal care and help with eating and drinking.
- Some relatives we spoke with raised concerns about poor communication with the hospital generally including a lack of information and updates and difficulties getting through when they phoned.

Are services responsive?

Requires improvement



We rated responsive as requires improvement because:

- The facilities on Rudyard ward did not promote the comfort and wellbeing of patients living with dementia.
- There was an absence of signs and information on Rudyard ward to help with navigation around the wards and orientation to time and place.
- The ward environments of Horton, Kipling and Rudyard wards were sparsely furnished and had poor décor.
- Patients on Horton, Kipling and Rudyard wards did not have access to kitchen facilities so they could make hot drinks and snacks.
- There was a lack of meaningful and recovery-orientated activities on the three main wards. There was a lack of activities tailored to specific patient groups, for example, people living with dementia.

Summary of this inspection

- Patients complained about the quality and choice of food available to the three wards (Horton, Kipling and Rudyard). There were no menus displayed.
- On the three wards, staff did not adequately look after patients' belongings and they went missing.

However:

- The bungalows (High Ash and Larches units) were pleasant, homely and well-furnished.
- All patients had access to ample, secure outside space.
- Patients in receipt of occupational therapy received recovery-focused support tailored to their needs.
- Staff made adjustments to accommodate the needs of individual patients.
- The multidisciplinary team on High Ash unit provided appropriate, gender-sensitive care and treatment for patients who had experienced trauma.

Are services well-led?

We rated well led as good because:

- The provider had engaged with staff to share the organisation's values and vision, and invited feedback.
- The provider had improved its governance systems and processes for monitoring all aspects of care. Managers and staff had access to information that helped them assess service delivery and identify areas for improvement.
- The hospital had a risk register that set out risks to the business and service delivery, and described the contingency plans.
- Staff who had worked for the hospital for some years reported improvements in the staff culture and quality of the service.
- The provider had set up a range of methods such as staff engagement meetings and a questions and suggestions box to invite feedback from staff.

However:

- Staff were not up-to-date with their mandatory training, and did not receive specialist training for their roles.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to help reach an overall judgement about the provider.

We undertook Mental Health Act monitoring visits to High Ash unit on 30 November 2015, Larches unit on 27 April 2016, Kipling ward on 5 May 2016 and Horton ward on 17 June 2016. The provider sent us action plans that showed how they planned to address the issues identified from the visits. At this inspection, we found that the provider had addressed the issues.

At the time of our inspection, there were 45 patients detained under the Mental Health Act 1983. Staff explained patients' rights to them on admission and regularly thereafter.

Forty-eight per cent of clinical staff had received training in the Mental Health Act. There were further sessions planned to ensure all staff received the training.

We found that detention paperwork was up-to-date and completed accurately. The hospital kept clear records of

leave granted to patients. The hospital had the appropriate treatment certificates for patients detained under the Mental Health Act. Staff kept these with the prescription charts so they could check that the medicines administered were legally authorised.

The provider had a range of up-to-date policies associated with the Mental Health Act. These included policies on absence without leave, the transfer of detained patients and guidance on specific sections of the Mental Health Act.

The mental health law manager completed regular audits on MHA practice and documentation. The mental health law manager shared any issues identified in the audits with staff and drew up action plans to address them.

Patients had access to local independent mental health advocacy services provided by Asist Advocacy. The ward manager routinely referred patients detained under the MHA to the IMHA. The advocacy service visited the hospital weekly.

Mental Capacity Act and Deprivation of Liberty Safeguards

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Detailed findings from this inspection

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Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

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

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

Requires improvement 

Safe and clean environment

- The design and layout of the building that held Horton, Kipling and Rudyard wards did not allow staff to observe all parts of the wards. The wards had narrow corridors and blind spots throughout. However, staff mitigated the risks by their presence in these areas or by increased observations of patients.
- There were a number of ligature points such as wardrobes, window handles, and taps in the wards and bungalows. The provider completed a ligature risk assessment on each ward in September 2015. These identified that all wards had high levels of risk. The provider had an action plan to help address the risks, including replacing or modifying the furniture and items that posed risks. Staff reduced the risks through risk assessments and close observations, where required.
- Kipling ward was poorly maintained with chipped paint on the walls, door frames and skirting boards, and exposed pipework. The ward environment had narrow corridors and felt confined. There were no signs to orient patients around the ward.
- Rudyard ward had patients living with organic conditions such as dementia. However, the design and layout of the ward was not dementia-friendly. The ward had long, narrow corridors at angles to each other with sharp corners. There were tight corners, limited entry and exit areas, and a confusing layout. The corridors held the bedrooms and provided access to the communal areas and other wards. The ward had a large dining area that looked out onto the garden. There was a small lounge attached to the dining room that did not have any external views or natural light. The ward had no handrails, orientation aids, signage, contrasting colour schemes or other furnishings to support patients living with dementia. However, the bathrooms were spacious but did not contain mobility aids such as handrails although we saw a frame around one toilet.
- Rudyard ward layout presented numerous risks to patients that staff managed with increased observations. In addition to physical risks such as obstacles, trips and falls, the ward presented a confusing and, at times, chaotic environment for patients with dementia. The ward created an increased risk of distress and agitation for patients. At the time of our inspection, six patients received one-to-one care and one patient received two-to-one care. This meant there were often lots of people in confined spaces.
- The wards complied with the Department of Health gender separation requirements. Kipling, Larches and High Ash wards were single-sex wards. Horton ward became a male-only ward during our inspection. Rudyard ward was a mixed-gender unit although at the time of our inspection, most of the patients were male. The ward had separate bedroom areas for men and women. There were two bedrooms for female patients located on the first floor of the ward. Female patients had access to a female-only lounge.
- There were two clinic rooms in the hospital. Horton ward had a clinic room that was clean but cluttered. There was a clinic room on Rudyard ward that was shared with Kipling ward. Kipling ward held a supply of emergency drugs and a ligature cutter in a cupboard in

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

one of the hallways. The bungalows (High Ash and Larches) did not have clinic rooms. However, the staff offices had medicines cupboards and emergency equipment. Staff attended patients in their bedrooms, where necessary. Alternatively, staff and patients had easy access to the clinic rooms in the main hospital building, if needed.

- The hospital did not have a seclusion room and did not practise seclusion.
- Staff mostly adhered to infection control principles. Staff carried anti-bacterial hand gel and there were dispensers located throughout the hospital. The provider completed comprehensive infection control audits on a regular basis. These comprised five standards including hand hygiene, management of the environment and patient equipment, domestic and laundry areas, personal protective equipment, and sharps, medication and waste management. However, the audit for Rudyard ward, dated March 2016, showed scores below the provider's target of 85% for three out of the five areas (hand hygiene (77%), management of the environment and patient equipment (57%), and sharps, medication and waste management (79%).
- We found a urine-soaked bed in a patient's room on Kipling ward. On further inspection, we found that the mattress was damp from urine. There was a waterproof cover on the mattress, which prevented moisture from the mattress seeping out. The top of the cover was wet from urine. We raised the issue with the staff and a cleaning team started to clean it immediately. We expressed concern about the condition of the mattress. We found that the mattress audits completed on 14 September and 17 October had identified the need for a replacement mattress, and the provider had ordered new mattresses at that time. Staff contacted the provider's store and found there were plenty of mattresses in stock, and they arranged for a replacement mattress that day. The same patient's bedroom had stains on the wall above the bed and a bag that contained soiled linen on the window sill.
- Most equipment was clean, well maintained and had visible stickers showing the dates of checks. Staff checked the first aid box monthly on Kipling ward. However, records showed gaps in checks on the resuscitation equipment in High Ash. We had raised this as an issue in past inspections, and although the provider had introduced systems to address it, and staff stated they checked the equipment daily, we found that

staff did not always record it. We found that some clinic equipment on Kipling ward was not clean. The medicines cutter and crusher contained residue of medicines, which posed a risk of cross-contamination of medicines. The sharps disposal box was dirty. Staff commented on delays in ordering and receiving new or additional equipment such as syringes and pads. There was an emergency oxygen cylinder in the bungalow but the nurse did not know how much to administer in case of emergency. There was no record of portable equipment cleaning such as the blood pressure monitor and thermometers on Kipling ward although staff assured us they cleaned them every weekend. High Ash and Larches bungalows shared a defibrillator that was kept on High Ash. This presented a risk of delay should it be needed for a patient on Larches. Rudyard ward had a defibrillator that staff checked daily. There was an emergency bag and emergency oxygen on Rudyard ward. The wards and bungalows had the appropriate safety equipment such as fire blankets, fire extinguishers, and fire alarms that were in-date. Electronic appliances had received safety tests.

- High Ash and Larches wards were clean, well furnished and well maintained. Horton, Kipling and Rudyard wards were clean and contained basic furniture and furnishings. Each ward had its own domestic staff, and their cleaning records showed they cleaned the wards regularly. However, we found some gaps in the cleaning charts on Kipling ward that suggested gaps in cleaning the ward or in keeping the charts up-to-date. The provider planned to introduce a cleaning audit on Kipling ward, to help monitor standards.
- Most staff had access (swipe) cards and mobile alarms. However, during our inspections in August 2016, we found that not all staff had access to swipe cards to allow them to enter and exit wards, and not all staff had access to mobile alarms to call for help. The provider explained that their system had reached full capacity and there were no spare swipe cards or alarms to issue. This meant staff relied on other staff who had swipe cards and alarms to move around the unit or call for help. All bedrooms had nurse call alarms. The hospital had a nurse call system that all staff and patients had access to, which partly mitigated the risks to staff and patients. During this inspection, we found that the provider had installed a new system that meant all staff would have access to keys and alarms. The system was in working order and tested in our presence. The system

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

also logged which staff were in work but not their exact whereabouts. The ward managers kept a manual register of staff on shift on their units in case of a fire alarm. The provider had implemented a plan to ensure safe transition from the old to the new system. The provider had arranged to issue keys and alarms to staff the following week on 30 November 2016.

- At the time of our inspection, Larches' staff had access to one alarm, which they usually left in the office. High Ash staff had access to personal alarms should they need them, and which they mostly used when they went outdoors.
- The provider allocated one registered nurse to work across the two bungalows, High Ash and Larches. The bungalows were next to each other, which made access easy. The nurse moved between the bungalows frequently, for example, to complete medication rounds. However, we found that the lack of mobile telecommunications (for example, mobile phone, pager) hampered urgent access to the nurse. The provider had ordered a new phone, which was due to be installed soon after our inspection.

Safe staffing

- Most shifts ran from 8am to 8pm. Staff worked 13 shifts over four weeks. Full-time and part-time staff worked 12-hour shifts (11 hours, 45 minutes excluding breaks). Some staff found the long shifts difficult while others preferred them. There were some shorter shifts (9am to 5pm) available to activity workers to support community access. Bank and agency staff had more flexibility in the hours they worked. The main concern for some staff working in the bungalows was that they did not receive their breaks.
- As of 31 July 2016, John Munroe Hospital had 205 whole time equivalent (WTE) staff that comprised registered nurses, healthcare support workers (known as clinical practitioners or clinical support workers), medical staff, therapists (occupational therapy, psychology, art therapy), activity coordinators, domestic staff and maintenance staff. The hospital had 17 WTE qualified nursing posts and 159 healthcare assistant posts. As of 31 July 2016, there were 3.5 WTE vacancies for nurses and 33 vacancies for healthcare assistants. Horton and Rudyard wards had vacant posts for nurses and all wards had vacancies for healthcare assistants with Rudyard and Horton wards holding 13 and 9 vacancies respectively.

- The provider reported the following WTE staffing establishments as of 31 July 2016:
 - Horton ward, 6.46 qualified nurses, 44 healthcare support workers
 - Kipling ward, 4.3 qualified nurses, 32 healthcare support workers
 - Rudyard ward, 3 qualified nurses, 48 healthcare support workers
 - High Ash and Larches, 4.3 qualified nurses, 35 healthcare support workers.
- The staff turnover rate was high at 42% for the 12 months to 1 July 2016. Horton ward had the highest rate of 45% followed by Kipling ward with 40% and Rudyard ward with 27%. For the same period, the vacancy level was 11% and the average sickness rate was 5.5%. The provider had a continuous recruitment programme that helped manage the vacancy levels.
- We asked the ward manager and human resources manager about the high staff turnover levels. They gave a number of reasons including burnout, working in a challenging environment, the patient mix and working hours. Some staff moved on once they gained experience. In addition, there were a number of local factors that affected recruitment and retention such as the hospital's rural location, and competition with local trusts for staff. In response, the provider had reviewed its terms, conditions, salaries, shift rotas and leave arrangements. The provider offered a long-term service initiative, and access to a range of national vocational qualification (NVQ) courses. The provider had also offered nursing training to unqualified staff but received low response rates. It helped the hospital that when staff left, some staff stayed on the provider's bank rota. The provider offered staff exit interviews to understand the reasons why staff left but staff were reluctant to engage in this process.
- The hospital had a basic minimum staffing ratio of one staff member for every three patients for day shifts, and one staff member for every four patients for night shifts. The provider estimated the number of additional staff required according to the needs of the patients, for example, for one-to-one care and enhanced observations. As such, the number of healthcare assistants on the wards frequently varied. Some staff complained that on some days, there were staff with little to do while on other days, there were shortages.
- The ward manager relied on temporary staff to ensure sufficient staffing levels to take account of patients'

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

changing needs. The hospital had an internal bank system, an agency affiliated to the company, and access to a number of external agencies. Wherever possible, the hospital used staff familiar with the hospital and patients. However, it used external agency staff regularly, which some patients found difficult. In particular, patients in High Ash unit struggled to cope with unfamiliar staff and the impact this had on their sense of security and continuity of care. The lack of stability in staffing also had an impact on delivering psychological interventions consistently. The provider ensured temporary staff read information about patients and signed to say they had done so. Some staff expressed concern about the shortage of regular, permanent staff and the heavy reliance on external agency staff who were not trained in handling violence and aggression.

- The provider employed a human resources manager who helped ensure good practice and compliance with human resources procedures. We reviewed five employees' human resources files and six fit and proper person declaration forms, and found them to be in order. Staff files showed identity checks, enhanced disclosure and barring service checks (known as DBS), references and evidence of registration.
- There was a qualified nurse present in the communal areas of Horton, Kipling and Rudyard wards at all times. High Ash and Larches shared a qualified nurse who spent time on each of the units. However, the lack of an adequate method of communication limited urgent access to the nurse. Staff said it could be difficult to access the nurse when they were in the other bungalow. The manager had ordered new cordless phones for the bungalows some months earlier but there had been delays. We saw an email that showed they had arrived at the provider's head office and were due to be installed in the coming week.
- On Kipling ward, staff reported that there were not enough staff to allow for one-to-one time with patients, especially at weekends. On Horton ward, staff said that patients received one-to-one time with their name nurse. Rudyard ward had many patients on one-to-one observation levels but even so, we observed a lack of meaningful engagement and activity.
- Staff occasionally cancelled escorted leave and activities because of a lack of drivers or because of limits on what temporary staff could do safely. This was

an issue on Larches, Horton and Kipling wards although this had improved. Staff explained the reasons for any cancellations to patients and offered alternatives, where possible.

- Most staff had received training in the management of actual or potential aggression (MAPA). In addition, all staff registered with the agency affiliated with the company received the same training as substantive staff, which included MAPA. However, this was not the case for external agency staff. The provider had implemented a monitoring system that ensured there were sufficient staff on each ward that could carry out physical interventions safely. Where necessary, managers moved staff between wards taking into account the risk profile of the patient groups. Staff trained in MAPA felt confident in using it.
- There was adequate medical cover during the day and night, and a doctor could access the ward quickly in an emergency. Doctors could access patients' electronic care records from home, which helped them assess patients' needs quickly. Staff contacted the patient's own doctor in the first instance.
- Not all staff had received all of their mandatory training. The figures below show the average training rates for clinical (ward) staff:
 - Safeguarding, 65%
 - Statutory in-house training (incorporating health and safety, fire, manual handling, infection control and basic life support), 89% for clinical staff, 72% for all staff
 - Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS), 48%
 - Food Safety, 51%
 - MAPA, 91%.
- However, the provider had made progress with its mandatory training programme. For example, the provider had recruited a dedicated training coordinator. There were sessions ongoing for MHA, MCA and DoLS, and the training rate had increased from 15% for clinical staff on 31 July 2016 to 48% by the time of our inspection. Three provider staff had trained in level three food safety, which meant they could deliver level one food safety training. The provider had arranged four fire marshal training sessions during the following three months, and a recurrent programme of first aid training including basic life support, emergency first aid at work, first aid at work and automated external defibrillation and oxygen therapy. The provider had developed a new

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mandatory training programme that offered 'supplementary' training to qualified staff, for example, a legal documentation, systems and procedures workshop.

Assessing and managing risk to patients and staff

- There were no episodes of seclusion at John Munroe Hospital as the hospital did not use seclusion.
- There was a designated long-term segregation suite on Rudyard ward. At the time of our inspection, there was one male patient placed in the suite because of his specific needs and risks. Staff made the appropriate checks and kept up-to-date records on observations.
- The hospital had 186 incidents of restraint in the six months to 31 July 2016, which involved 29 different patients. The highest proportion of incidents of restraints took place on Horton ward (94, 51%) followed by Kipling ward (48, 26%) and Rudyard ward (36, 19%). There were no incidents of restraint in prone position. There was very little restraint used in Larches.
- Staff undertook a risk assessment of every patient on admission, and reviewed and updated these regularly. Staff used positive behaviour support plans alongside risk assessments and care plans to help apply the least restrictive interventions.
- The provider had developed a holistic person-centred risk assessment tool that covered six key areas - risk to self, risk to others, physical risk, risk of self-neglect, vulnerability and quality of life risks. Our review of care records for 29 patients showed risk assessments in place, up-to-date and reviewed at least monthly.
- The hospital had a managing violence and aggression policy and a positive behaviour management policy that underpinned its approach to physical intervention. Staff received training in physical interventions (MAPA) but in the first instance, staff used less restrictive techniques such as de-escalation, distraction, verbal redirection and a move to a quiet, calm area. In particular, on High Ash, knowledge of the patients' warning signs and triggers alongside consistently applied strategies helped manage risks.
- There were a number of blanket restrictions on Horton, Kipling and Rudyard wards. For example, patients could not make their own drinks or snacks. Patients could not keep food in their rooms and there was no other facility provided. There were no visitors allowed on the wards or in the patients' bedrooms. Most relatives we spoke with expressed concern that they could not see their

relatives' rooms and living environment. The hospital imposed the restrictions based on the layout of the wards, the lack of facilities and occasionally the risks presented by a patient. However, overall, the hospital did not apply the restrictions for these wards based on individually assessed risks. There were no blanket restrictions on High Ash and Larches and staff assessed and managed risks on an individual patient basis. For example, staff intervened if a patient purchased an item that posed a danger to them. Throughout the hospital, room searches only took place where risks were high. At the time of our inspection, no patients received room searches.

- A patient on High Ash complained about staff leaving their bags containing their personal medication in the communal environment, which meant vulnerable patients had sight of, and access to, medicines that posed a risk to them. We informed the manager of this straightaway. The manager agreed to remind staff to store their personal items in the locked office.
- Staff informed informal patients of their right to leave the ward. However, on Kipling ward, there was no information at locked doors and exits to indicate that informal patients could leave.
- The provider had policies and procedures for the use of observation based on the patients' risks and vulnerability. A high proportion of patients received one-to-one care. Staff recorded observations hourly. On High Ash, staff rotated the observations hourly.
- At the time of our inspection, 66% of clinical staff had received training in safeguarding. Historically, the provider had been a low reporter of safeguarding incidents. We reviewed the safeguarding process. We found that most staff knew how to recognise and report incidents and when to escalate issues to qualified nurses, the ward manager or the safeguarding lead. The hospital had developed an internal database for logging all incidents. The safeguarding lead reviewed all incidents and referred safeguarding concerns to the local authority in line with locally agreed thresholds. For example, the safeguarding lead made 11 safeguarding referrals to the local authority between 1 January 2016 and 31 October 2016. However, the provider did not notify the CQC of safeguarding incidents but this improved significantly immediately after our inspection.
- The provider had good medicines management practice. The provider commissioned pharmacy support and services from a pharmacy experienced in mental

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health care. The pharmacist undertook audits and visited each ward. There were appropriate arrangements for recording the administration of medicines. Staff recorded patients' allergies on their prescription charts. However, we found there were delays in obtaining physical health medicines for two patients, which posed a risk to their health. We discussed this with the ward manager who explained that the delays resulted from a miscommunication with their regular pharmacy. She described how the pharmacy had added the requests for the physical health medicines to the routine monthly medication deliveries instead of dispensing them immediately. The ward manager assured us she had resolved this through clearer pathways and processes.

- The provider had a policy on rapid tranquillisation that was underpinned by the national institute of health and care excellence (NICE) guidelines such as those for prescribing in acute disturbance, prescribing of oral antipsychotics, and short-term management of disturbed/violent behaviour in adult psychiatric inpatient settings and accident and emergency settings. However, the provider had not updated the policy to reflect the NICE guidelines published in May 2015 but all 14 of the prescriptions we examined complied with current rapid tranquillisation guidelines.
- The provider had guidance for the administration of most PRN (pro re nata – as required) medication but not for all. For example, on Rudyard ward, there were protocols for seven out of nine patients prescribed PRN medication. The absence of guidance meant that patients could receive medication inappropriately.
- On Horton ward, there were some gaps in daily checks on temperatures of fridges used to store medicines. On Larches, staff monitored and recorded the fridge and room temperatures daily although there were some gaps during September and October 2016.
- Staff we spoke with knew how to report errors. However, there was no medication error database available to help identify trends and share learning. Staff received some online training on medicines management and the provider had plans to introduce competency checks for staff administering medication. The provider had a self-medication policy although at the time of our inspection, there were no patients who managed their own medication.
- Staff assessed patients who were at risk of falls and planned for their specific needs. Staff completed

moving and handling risk assessments. Staff assessed pressure ulcer risk using the Waterlow pressure ulcer risk calculator. As well as physical support, staff offered patients walking frames and wheelchairs to help with mobility issues. The provider did not allow family members to go onto Horton, Kipling and Rudyard wards to visit their relatives. Family members and children had access to a visitors' room near reception. Family members could enter High Ash and Larches to visit their relative.

Track record on safety

- The provider reported no serious incidents and one unexpected death in the 12 months to July 2016.
- For the duration of our inspection from 7 to 10 November 2016, John Munroe Hospital's main heating system was broken and the back-up boiler needed repair. This affected Horton, Kipling and Rudyard wards. The hospital implemented emergency business continuity measures to ensure patients were safe and warm. Patients shared the communal facilities that had alternative heating systems, which meant these areas were busier than usual. By the time of our return to the hospital on 22 November 2016, the heating was in good working order and we observed the wards in their normal states.
- The provider had made improvements to safety issues highlighted in a previous inspection. The provider had installed a new alarm system that meant all staff would have access to keys and alarms. The system was in working order and tested in our presence. The provider had implemented a plan to ensure safe transition from the old to the new system.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise incidents and report them. They completed incident forms and escalated any concerns or issues to qualified nurses, the ward manager or the safeguarding lead. The hospital had an internal database for logging all incidents. The clinical governance group used this to monitor the incidents and identify any themes and trends.
- The incident log for the hospital showed 74 incidents reported from 1 January to 31 October 2016. These

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included safeguarding incidents, patient-to-patient altercations and episodes of self-harm. Fifty-three incidents related to 15 patients across the hospital site. Ten incidents of self-harm related to one patient.

- The provider had a newly drafted Duty of Candour policy that encouraged an open and transparent culture.
- Staff received feedback from investigations that included lessons learnt and any changes implemented. We found examples of changes made from learning and feedback such as rotating MAPA trained staff to manage risks. Staff received feedback at team meetings, handovers and one-to-one sessions. Staff received debriefs following serious incidents.

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

(for example, treatment is effective)

Good



Assessment of needs and planning of care

- We reviewed care records for 29 patients. Patients received assessment prior to admission to determine whether the hospital could meet their needs and identify the most appropriate ward. Patients received a comprehensive and timely assessment after admission that included their full range of needs.
- Patients had up-to-date care plans that reflected their needs but many care plans lacked a recovery or rehabilitative focus except where patients had received a psychological formulation. For example, care plans on Kipling ward were up-to-date and personalised, but they were not holistic or recovery oriented and there was poor evidence of the recording of consent. However, patients on High Ash unit had very detailed care plans that matched the complexity of their needs and included their views. Most of the patients on High Ash unit had received a psychological formulation and care plans were person-centred, holistic and recovery-focused.
- Patients had a physical health file that contained care plans associated with their specific physical health needs. The files were accessible, in good order and up-to-date. Patients' prescription files contained details

of general observations such as weight, blood pressure and heart rate. The hospital had recently introduced the modified early warning score (MEWS) system to monitor patients' vital signs. However, in one case on Horton ward, we found that staff were not familiar with MEWS and had not completed it for a patient who had presented as physically unwell.

- The hospital had a diverse range of patients in terms of age, cognitive ability, mental and physical health, complexity and behaviour. The hospital did not use a formal recovery-focused and rehabilitative model of care such as recovery star. Rehabilitative, recovery-focused care was evident for some patients, for example, on High Ash unit where patients had conditions such as personality disorders and dissociative identity disorder but not evident on Kipling ward. Focused care was less evident for people with organic conditions and cognitive impairments. For example, even though most patients on Rudyard ward had progressive dementia-type illnesses, there was little dementia-focused care to help them maintain their skills, stay active and stimulate their minds and senses in line with good practice in dementia care.
- The hospital used both paper and electronic records. All records were in good order, coordinated and set out clearly. All staff with the exception of the level two healthcare support workers had access to the electronic files. Staff stored records securely and systems ensured that information was readily available

Best practice in treatment and care

- The hospital followed national institute for health and care excellence (NICE) guidance when prescribing medication. For example, medication such as lorazepam, haloperidol and promethazine prescribed for rapid tranquillisation was in line with the appropriate NICE guidance NG 10: Violence and aggression: short-term management in mental health, health and community settings. Prescribing practice was mostly in line with recommended limits set out in the British National Formulary (known as BNF). However, we found two incidents of prescribing over the maximum levels. The psychiatrist addressed these issues immediately.
- Patients had access to psychological therapies on a referral-only basis. The therapies team comprised a part-time consultant clinical psychologist (0.8 whole time equivalent (WTE)), a full-time assistant psychologist and a part-time art psychotherapist (0.6

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Requires improvement 

WTE). Only a small number of patients in the hospital received psychological therapies due to the size of the team and the diverse patient profile. The small therapies team mainly worked with patients with bi-polar conditions, personality disorder and traumatic histories. Most of the patients on High Ash received psychological interventions while none of the patients on Kipling ward received therapies at the time of our inspection.

- The therapies team followed the relevant guidance issued by the national institute for health and care excellence (NICE), for example, the pathway for the recognition and management borderline personality disorder. The team's interventions drew from systemic therapy, dialectical behaviour therapy (known as DBT), schema-focused therapy, cognitive behavioural therapy (known as CBT), and cognitive analytical therapy. Art therapy was underpinned by a psychodynamic approach. The psychology team applied a three-phase model of care and recovery to their patients covering stabilisation, skills and trauma. The formulation approach followed the British Psychological Association's good practice guidelines.
- We saw examples of psychological formulations and action plans that were comprehensive, detailed and person-centred. The therapies team completed a range of functional and cognitive assessments and provided therapy as appropriate. As well as one-to-one and group therapies, patients' action plans included advice to staff about how they could improve their communication with, and responses to, patients as part of an overarching behaviour modification and treatment strategy. Patients on High Ash described the therapies as "fantastic".
- The hospital had a strong focus on patients' physical healthcare needs. The provider commissioned a local GP practice to provide a dedicated general medical and nursing service to the hospital. The GP and nurse attended the hospital and held separate clinics weekly. The GP saw all patients routinely on a 12-weekly basis. The GP and nurse ensured patients received physical healthcare checks, screening and investigations as required. All patients received routine blood tests annually. Patients had access to specialists where required, for example, diabetic nurses, district nurses and podiatrists. The hospital had access to other local secondary care health services via GP referrals.

- Staff assessed and met patients' nutrition and hydration needs. One patient at risk of excessive drinking received restricted hydration. Although staff recorded the patient's fluid intake on one-to-one observation sheets, there was no specific care plan for this issue.
- The hospital used recognised ratings scales to assess and monitor outcomes, for example, the health of nation outcome scales (HoNOS). They used the Beck depression inventory to assess the severity of a patient's depression. The therapies team gave examples of positive outcomes from their work with patients. They described a young patient with complex needs who made good progress and was now lived in the community.
- Clinical staff participated in a range of audits. We saw copies of audits on infection control, patients' legal rights and care plans. Staff also completed audits on patients' records, physical health checks, screening and monitoring, and medication. We saw a pharmacy audit for Larches unit completed by a visiting pharmacist that highlighted errors and areas for improvement. Staff developed and monitored action plans to address any issues identified.

Skilled staff to deliver care

- The hospital had a range of disciplines that provided input to the wards. As well as psychiatry and nursing, these included psychology, art therapy and occupational therapy. The medical team comprised four consultant psychiatrists. There were two older adults psychiatrists and two general adults psychiatrists, one of whom specialised in complex female patients. In addition, the provider commissioned GP services, pharmacy support and chiropody services. The provider struggled to get speech and language therapy support for local patients. For patients from out of area, the provider requested funding from their respective commissioners.
- Nursing staff included nurses with specialisms in mental health, learning disability and general nursing. Most staff were experienced and qualified for their roles but they did not always receive the necessary specialist training for the service areas and patient groups they worked with. For example, there was no training offered on rehabilitation and recovery-focused care. There was no evidence of any specific training on working with people with organic conditions even though most of the patients on Rudyard ward and some of the patients on

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Requires improvement 

the other wards had types of dementia. However, staff on High Ash had received relevant specialist training on dissociative identity disorder, eating disorder, post-traumatic stress disorder and personality disorder. These helped staff understand and gain insight into their patients, interpret their behaviours and react appropriately. One general nurse had received training in doing chest examinations. Other courses offered included venepuncture, tissue viability, and the national vocational qualification (NVQ) in care. The mental health law manager had a certificate in mental health law and had access to external training to keep her knowledge up-to-date.

- The small therapies team was highly skilled and experienced in working with women with traumatic histories, self-harm and personality disorder. Treatment and intervention was gender-focused, person-centred and collaborative and gave positive results.
- The hospital had a skilled and experienced occupational therapy team that patients accessed by referral from the multidisciplinary team. Occupational therapists completed functional assessments, ascertained the patients' likes and developed programmes to help meet their needs. The occupational therapy resource was targeted to key groups, for example, patients stepping down who needed to develop their independent living skills. There was a targeted person-centred approach to some of the patients on High Ash unit, which had resulted in improved outcomes for the patients. The occupational therapists helped patients recognise negative coping strategies and used positive risk-taking approaches to help them make changes.
- All staff received induction that included mandatory training. The hospital had designed a new induction programme that involved four days of classroom training and a one-day orientation in the hospital. The provider offered healthcare assistants training in line with the Care Certificate. The training coordinator trained to deliver some courses such as food safety and manual handling.
- Staff received supervision regularly. The provider's policy indicated supervision should take place at least every three months. The supervision rate for January to March 2016 was 94% and from April to June 2016, it was 79%. For July to September 2016, the rate was 84%. This represented a significant improvement on staff supervision levels in the previous year of 28% (October

to December 2015). The different disciplines had arrangements for professional supervision, for example, the OT staff received regular peer group supervision, and the OT lead received peer supervision with other lead therapists. The psychologist received clinical supervision from an external psychologist every two or three months and had opportunities for continuous professional development. However, registered nurses had infrequent access to clinical supervision.

- Staff on Horton ward did not have regular staff meetings or reflective practice sessions. Staff meetings happened regularly on Larches unit. There were occasional team meetings on High Ash unit. However, staff benefited case conferences held by the therapies team at which they discussed a patient's presentation and appropriate strategies and interventions.
- As of August 2016, 60% of ward staff had received their annual appraisal.
- Managers addressed poor staff performance promptly and effectively. The ward manager gave us examples of situations in which staff members had been subject to disciplinary action.

Multidisciplinary and inter-agency team work

- All wards had regular, effective and well-coordinated multidisciplinary team meetings. Any staff member was welcome to attend their ward's multidisciplinary team meeting. All staff had the opportunity to share their views on patients from their respective disciplines. Patients attended if they wished to. They also had access to one-to-one meetings with their doctor before or after their MDT, if they preferred. Staff, patients and therapy staff gave positive comments about their MDT meetings.
- We observed an MDT on High Ash. This comprised a full range of professionals including a nurse, a psychiatrist, a psychologist, an art therapist, an OT, and an assistant psychologist. The team discussed patients with respect, sensitivity and understanding, however challenging their presentations. The team recognised the need for and adopted a long-term approach to rehabilitation and recovery for patients with personality disorder and dissociative identity disorder. We observed full and detailed discussions about each patient that covered physical and mental health needs, treatment strategies and interventions, reviews of progress and risks, any capacity issues and need for best interests decision-making, and any practical issues such as

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finances. It was evident that staff knew the patients well and placed great emphasis on building trust with them. The MDT celebrated their patients' progress, however small. We saw that the team tried to find a solution to problems that were outside of their remit in the interests of patient care.

- There were effective handovers that took place twice daily between shifts. All staff attended handovers. The nurse-in-charge on each ward usually led the handovers with the exception of Larches unit, where a senior healthcare support worker led the handover meetings and gave feedback to the nurse-in-charge (shared with High Ash unit). The nurse in charge produced daily reports at the end of each shift that contained information about patients' risks, incidents and other unusual events. The nurse passed these onto the lead for the next shift and the ward manager. Staff on High Ash unit used a communication book to note changes and information throughout the day. However, some relatives expressed concern that staff did not share vital information between shifts or that new staff did not receive briefings on patients' risks and needs.
- The managers had good working relationships with the local safeguarding authority. The provider had privately contracted arrangements with a local GP practice for the provision of services on the hospital site. The GP worked closely with the psychiatrist, shared medical information, and acted as the link for other primary and secondary care services.
- The provider had strong links with their patients' commissioners and care coordinators, and invited them to MDT and care programme approach (CPA) reviews. However, the provider struggled to obtain timely responses to requests for support or equipment that it was not commissioned to provide, for example, a specialist wheelchair, a neck brace and specialist physiotherapy.

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

- Qualified staff received and checked all Mental Health Act (MHA) paperwork on a patient's admission, and the mental health law manager checked the documents again. We found that detention paperwork was up-to-date and completed accurately. The hospital stored original copies at their head office, which was offsite but nearby. The hospital held copies of MHA documentation onsite for reference. Each ward and unit

also had a list of important dates for their patients including CPAs, managers' hearings, tribunals and formulation review dates. The hospital had an easy to access summary onsite that showed the legal status of each patient (MHA and Deprivation of Liberty Safeguards).

- The provider had a range of up-to-date policies associated with the Mental Health Act. These included policies on absence without leave, IMHA, transfer of detained patients and guidance on specific sections of the Mental Health Act. Staff knew who the mental health law manager was and how to contact her. There was regular contact between the hospital and the administrator.
- The hospital kept clear records of leave granted to patients. Staff advised patients and their relatives of the parameters of the leave granted, and of what to do in an emergency.
- At the time of our inspection, 51% of clinical staff had received training on the Mental Health Act. This represented a significant increase from 15% on 31 July 2016. There were further sessions planned to ensure all staff received the training. We saw a copy of the revised training booklet, which was comprehensive, particularly in covering changes to the Code of Practice.
- The hospital had the appropriate treatment certificates for patients detained under the Mental Health Act. Staff kept these with the prescription charts so they could check that the medicines they needed to administer were legally authorised. However, we found one patient's treatment certificate completed inaccurately. In this case, the amount of medication prescribed was higher than the limit advised in the British National Formulary.
- Care records for a patient in long-term segregation showed that the patient received daily reviews from the psychiatrist and weekly multidisciplinary reviews in line with the Mental Health Act Code of Practice.
- Records showed that staff explained patients' rights to them on admission and regularly thereafter. There were leaflets about legal rights available to patients.
- The mental health law manager completed regular audits on MHA practice and documentation. We saw audits that checked for accurate completion of MHA records, section 17 leave records, records of rights given to patients and section 58 forms. The mental health law manager shared any issues identified in the audits with staff and drew up action plans to address them. The

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mental health law manager gave us examples of changes made following issues identified from audits such as new forms for noting the outcome of leave and the recording of rights on the electronic care record system.

- Patients had access to local independent mental health advocacy (IMHA) services provided by Asist Advocacy. There were posters about advocacy displayed in the reception area, and in nurses' offices. The advocacy service visited the hospital weekly. The ward manager routinely referred patients detained under the MHA to the IMHA. At the time of our inspection, they worked with 15 patients detained under the MHA.

Good practice in applying the Mental Capacity Act

- At the time of our inspection, 51% of clinical staff had received training in the Mental Capacity Act (MCA). This represented a significant increase from 15% on 31 July 2016. There were further sessions planned to ensure all staff received the training.
- Most staff we spoke with had a reasonable understanding of the principles underpinning the MCA and assessed capacity to consent on a decision-specific basis. For example, staff on High Ash unit and Kipling ward said they knew when a patient could make a decision and when they should question capacity and request further discussion. Most patients on Rudyard ward had conditions that affected their cognitive abilities, and hampered their independent decision-making. We found that some staff assumed that these patients lacked the capacity to make any decisions and the cognitive ability to participate in any activities. However, we also found that staff presumed that a diabetic patient had the capacity to refuse appropriate treatment even though the patient's condition made him believe he had no illnesses.
- The hospital applied the MCA appropriately and followed best interest processes for significant decisions, where necessary. We saw examples of cases in which the multidisciplinary team had made best interest decisions taking into account the patient's wishes, culture and history, and the views of their relatives. For example, seven patients on Rudyard ward had best interests decisions for the administration of covert medication. The patients had covert medication protocols in place that described how to give the medication safely.

- The provider had an up-to-date policy on MCA and DoLS that set out how it met its legal obligations. Six patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection. The hospital had made five DoLS applications in the six months to 23 August 2016. There were delays in local authorities processing DoLS applications but there was evidence of ongoing correspondence about these between the hospital and the local authorities. Staff knew where to seek advice on the MCA, if needed.
- The provider had arrangements in place for monitoring adherence to the MCA. The provider had a mental health law manager who oversaw systems and processes associated with the MCA. The manager undertook audits and dealt with any issues identified. The manager had plans to improve MCA governance by adding further checks to the audits, for example, checks on best interest decisions.

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

Good 

Kindness, dignity, respect and support

- As well as observing staff and patient interaction and engagement during our inspection, we also completed nine short observational framework for inspection exercises (SOFI). We observed positive interaction, engagement and communication between staff and patients on most of the wards. This was more evident on wards where the patients had good cognitive abilities, for example, High Ash, Larches, Kipling and Horton. For patients with cognitive impairments, the interactions between staff and patients were mainly practical, for example, personal care tasks and help with eating and drinking.
- There was a positive and friendly atmosphere between staff and patients on High Ash and Larches units. There was good rapport between staff and patients on Kipling ward and staff responded to patients' request for specific activities, for example, painting nails. There was caring and respectful interaction between staff and patients on Horton ward.

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Requires improvement 

- Most patients on Rudyard ward had organic conditions such as dementia and significant cognitive impairments. During our inspection visit from 7 to 10 November 2016, patients on Rudyard ward had access to only one of its two lounges because of the heating issues in the hospital. This meant that nearly all of the patients were gathered in a small lounge on the ward. We observed 14 staff in the lounge and adjoining dining room because many patients received one-to-one care. However, we observed little interaction between staff and patients. We saw that most staff did not speak to the patients or request their preferences when giving out drinks and snacks. Staff did not speak to patients when preparing them for lunch, for example, when putting aprons on them. Staff completed paperwork or talked to each other. There were no activities underway although for a short time, an activity worker played some music from a mobile phone.
- We returned to the hospital on 22 November and conducted another SOFI on Rudyard ward in the main lounge and the men's lounge. The main lounge had a lot of 'traffic' as it was a thoroughfare to other wards, and other wards used some of its facilities. We saw some positive interactions, for example, hand holding for comfort and assurance, support with holding a drink, and greeting a patient when he woke up. Another patient was supported carefully from a walking frame into a chair. However, we also saw a patient come into the room, sit down and cough for some time continuously before someone acknowledged him. We saw a patient transferred into a wheelchair with the brakes off so the chair moved about. The staff member applied the brakes once the patient was seated. The same patient was left facing the wall for some time, there was no communication given to the patient about where he was going. There were no activities taking place in the lounge although there was a one-to-one music session in the adjoining dining room.
- We spoke with 18 patients. Patients gave mixed views about how staff treated and supported them. Patients on High Ash unit spoke highly of the staff and described them as 'angels'. Patients described a good rapport with staff on Kipling ward. Some patients commented on the clean environment and complimented the friendly domestic staff.
- We spoke with seven relatives. Relatives gave mixed views about staff. Some relatives described them as welcoming and friendly. Relatives praised the staff on

Larches unit and said they "couldn't fault it" referring to the staff and care. Another relative said, "I can't praise them enough" referring to staff on Kipling ward. A relative described staff as reassuring towards a patient on Kipling ward and commented on their attention to detail. However, some relatives felt there was poor communication between staff about patients' specific needs and risks and poor compliance with patients' risk management plans. Relatives felt that temporary staff lacked information about patients.

- Most staff knew their patients well and had a good understanding of their needs. In particular, the staff and multidisciplinary team supporting the patients in High Ash unit had a very good understanding of their patients, their histories, behaviours and risks. They worked proactively to support and treat patients with complex needs, personality disorders and challenging behaviours in a respectful and responsive manner. On Horton ward, we saw that staff knew patients' likes and dislikes when serving drinks and snacks.

The involvement of people in the care they receive

- Patients received orientation to the hospital and their ward prior to, or, on admission. Staff gave patients information about the hospital, showed them around and introduced them to staff and other patients.
- Staff involved patients and their relatives in assessment and care planning. Staff invited patients and their relatives to multidisciplinary meetings and reviews. On Horton ward, staff made comments in notes where patients were unable to contribute to their care plans or refused to sign them. Not all patients had copies of their care plans. Staff on High Ash unit fully involved patients in their care and all patients had copies of their care plans. However, no patients on Kipling ward had copies of their care plans. Care records on Larches showed where patients refused a copy of their care plan. Staff encouraged patients placed on Larches and High Ash units to maintain and develop their independent living skills. This was less evident on Horton and Kipling wards, and not evident on Rudyard ward.
- Family members gave mixed views about their involvement in their relative's care. All family members we spoke with regarded the doctors highly, valued their contribution and enjoyed the communication they had with them. One family member felt involved and received lots of information. However, several family members raised issues about poor communication with

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

the hospital generally. They expressed concern about the lack of information and updates they received from ward staff, poor communication and contact even where there was an agreement for frequent contact, and difficulties getting through when they phoned. One family member described contact as 'irregular and sporadic'. Not all relatives felt that staff involved them in assessing and managing risk, and some said that staff did not always use agreed risk management strategies. Several family members expressed concern about insufficient meeting facilities and restricted access to their respective relative's bedroom.

- Patients had access to local independent mental health advocacy services provided by Asist Advocacy. There were posters about advocacy displayed in the reception area, and on the wards. The advocacy service visited the hospital weekly. They received referrals from nursing staff, doctors and patients. They met patients on the wards or in the designated meeting rooms.
- Patients gave feedback on the service through a range of forums. Each ward held patients' meetings on a monthly basis where patients could raise any issues. The hospital completed a patient survey in November 2015 to ascertain patients' views on the care and treatment they received. The patient activity lead had surveyed patients about the activities they enjoyed and consulted their relatives. However, we saw notes from two patients' meetings held on Horton ward. They lacked details and actions to follow up any issues raised.
- Some patients had advance decisions in place. For example, some patients had their views on how they would like to be cared for in a crisis incorporated into their care plans. In one case, a patient wrote her own crisis plan. We saw examples of formulations for patients on High Ash that included the patients' views. Some patients had 'do not attempt to resuscitate' (DNAR) decisions in place that the GP reviewed, as appropriate.

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

Requires improvement 

Access and discharge

- As of 1 July 2016, John Munroe Hospital had a bed occupancy rate of 95%. The average length of stay for patients on each of the wards ranged from 20 to 24 weeks.
- Most patients at the hospital came from outside of the local area.
- Patients returning from Section 17 leave always returned to their bedroom. Occasionally, staff moved patients between wards for clinical reasons or for other appropriate reasons. For example, some patients moved to the bungalows (Larches and High Ash) when they required less intensive support and would benefit from step-down facilities that further promoted their recovery and independence. In another case, three female patients moved to other wards when their predominantly male ward became male-only.
- The hospital reported no delayed discharges. The average length of stay for patients discharged in the 12 months to July 2016 was 213 days, and the average length of stay of the remaining inpatients was 716 days. Most discharged patients moved to community-based placements although occasionally, patients moved to acute inpatients or intensive care beds. The hospital reported a number of discharges into the community following a successful programme of tailored rehabilitation, recovery and therapy for patients with complex needs, high levels of risk and behaviours that challenged. For example, three female patients moved into community-based settings following years of care in various hospital settings. At the time of our inspection, a patient on High Ash unit was in the process of moving to a community-based placement.
- At the time of our inspection, there was no waiting list for psychological therapies. Access to psychological therapies was based on patients' suitability for psychological interventions and required a referral from

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Requires improvement 

the multidisciplinary team. As such, not all patients received psychological interventions. Discharged patients received aftercare from the psychology team comprising one or two follow up visits.

The facilities promote recovery, comfort, dignity and confidentiality

- The self-contained bungalows, High Ash and Larches, had a full range of rooms and equipment to support rehabilitation and recovery-focused care and treatment. The bungalows did not have clinic rooms but staff attended patients in their bedrooms, when required. The bungalows were homely and comfortable, and patients who lived in them liked their accommodation. The other three wards, Horton, Kipling and Rudyard were located in the main hospital building. The wards had a range of facilities such as clinic rooms, mixed and single-sex lounges, dining rooms and multi-purpose rooms. However, the wards were sparsely furnished and had basic décor. Staff, patients and those relatives who had seen the wards complained about their poor design, layout and décor.
- Rudyard ward environment did not promote the comfort and wellbeing of patients living with organic conditions. Rudyard ward was a mixed-gender ward although at the time of our inspection, it had only two female patients. The bedrooms were located over three floors but there was a lift. There were bedrooms for three male patients and two female patients on the first floor. There were bedrooms for eight male patients on the second floor, and two male patients on the ground floor. All patients' bedrooms had sinks and toilets, and one bedroom had a shower. The ward had a sloping floor from the lounge to dining room. The ward environment was sparse with simple, basic décor. There was chipped or fading paint in places. Rudyard ward presented a poor environment for dementia care. The ward environment and atmosphere was unstimulating with very little activity. There were no quiet areas on ward although patients had access to single-sex lounges located in pleasant conservatories that looked out onto the garden. The ward had a constant flow of people as it was a thoroughfare to other wards and facilities. The small lounge had no tables to put drinks on. There was no clock in the lounge or dining room. There were no calendars or date signs to help orient patients to time and place.
- Horton ward was sparsely furnished and cramped with little communal space but was about to undergo improvements. There were plans for an activity room, a new bathroom and a meeting room. The ward had 16 bedrooms, three of which had ensuite facilities. There were communal bathroom facilities.
- Kipling ward was a female-only ward for up to 13 patients. The bedrooms were located on one floor and the ward had a lift. The bedrooms did not have ensuite facilities but all contained toilets and sinks. There were shared bath and shower rooms that had supervised access because of the risks that some patients presented. Kipling ward had a lounge and a dining room housed in a large conservatory. However, the dining room was not big enough to accommodate all the patients, and there were not enough chairs for all patients to sit down. The ward had poor décor and the furniture looked in poor condition. Staff had removed the television from the conservatory.
- Larches unit was a male-only unit for up to six patients. None of the bedrooms had ensuite facilities and there was only one shared shower room. The bungalow did not have a bath but patients could use the bathrooms in the main hospital. The accommodation and environment was pleasant, homely, and well equipped. There were plans to improve the environment further by creating more communal space and easier access to the garden.
- High Ash unit was a female-only unit for up to seven patients. The bungalow had seven bedrooms located on the ground floor and the mezzanine floor. Four bedrooms had ensuite facilities. There was a communal bathroom and two shared shower rooms. The bungalow was homely, warm and well equipped. There was a quiet room. Patients had access to a lockable food cupboard for items they purchased. Patients had access to a pleasant and private courtyard that had a smoking shelter, outdoor furniture and a barbecue. The main complaint from staff and patients was about the fridge, which was too small for their needs.
- Family members of patients on Horton, Kipling and Rudyard were unable to comment on the ward environment because the hospital would not allow them to visit the wards or their relatives' bedrooms. Family members expressed concern about not seeing where their relatives lived. Some family members had seen photos of their relatives' rooms.

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Requires improvement 

- Some patients owned mobile phones and so could make private phone calls in their own bedrooms. The hospital did not have a pay phone but staff facilitated requests from patients for private phone calls. Patients had access to office phones and privacy to make calls, on request. Patients had access to WIFI.
- John Munroe hospital was situated in a rural setting, which had ample secure outdoor space. The wards and the bungalows had their own designated outdoor areas that had smoking facilities. Rudyard and Horton wards shared a garden. The outside space was a real benefit to patients and staff given the constricted and busy environment on the three hospital wards.
- In October 2015, John Munroe Hospital received a food hygiene rating of five (very good) from Staffordshire Moorlands District Council. Patients in High Ash and Larches units had separate arrangements for meals to the other three wards and were happy with these arrangements. The units managed their own budgets. With the support of staff, patients decided their meals for the week, went shopping and cooked meals. The three hospital wards had an in-house cook who planned the menus and cooked all the meals. Patients gave mixed views about the food on the wards. Most patients we spoke with complained to us about the poor food quality and lack of choice. They mentioned a set menu with little, if any alternatives, a lack of fresh food and a lack of attention to specialist needs and diets. Some patients complained about the attitude of the kitchen staff and said they found them unhelpful. We did not see any menus or meal plans on the wards.
- Patients in High Ash and Larches units had access to hot drinks and snacks throughout the day and night. However, there were no kitchen facilities for patients on the other wards. There was a kitchen for staff use on Horton ward, and the other two wards shared a kitchen located on Rudyard ward. Staff gave patients water whenever they asked staff for it. Staff prepared drinks and snacks at regular intervals and brought them out on trolleys. We observed the trolley service on Horton ward. There were a range of hot and cold drinks, biscuits and a fruit plate. Staff offered patients a choice of drinks and snacks, and knew what the patients' preferences were.
- Patients personalised their bedrooms if they wished. We saw that some patients' bedrooms in High Ash and Larches reflected their tastes and preferences. There were fewer personalised bedrooms on the other wards. Family members of patients on the other wards expressed concern that they could not visit their bedrooms to assess if they were personalised or to help personalise them. Each patient on Larches and High Ash units had a locker for personal or valuable items. Patients on the three main wards could ask for a lockable safe in their bedrooms. Patients on Kipling ward had keys to their rooms subject to risk assessment. Some patients we spoke with complained about missing personal items. Some family members felt that staff showed little regard for patients' belongings, and reported that patients' personal items such as glasses, clothes and shoes went missing.
- The hospital site had a separate occupational therapy unit located near the wards and bungalows. This contained a large, well-equipped crafts room, a kitchen for 'activities of daily living' (ADL), offices, therapy rooms and a sensory room. Each ward had an activities cupboard that contained arts, crafts, materials and equipment. Staff locked the cupboard for safety reasons but held a set of keys and accessed them when needed.
- The hospital ran annual events for all patients. These included a summer garden party ('John Stock'), a firework display and a Christmas party. Patients also attended local events such as a flower festival and a Christmas tree display. Examples of regular or seasonal activities included a Christmas card competition, a Macmillan coffee morning, a monthly church service, a monthly social group and an evening group.
- Each ward had an activity lead who planned activities on a two-weekly basis. This was a new role. We saw copies of activity schedules for each of the three wards that covered Monday to Fridays. These were new and not fully operational. The activity schedule for Horton ward included group walks, film club, arts and crafts, a football score predictions session, gardening club, magazine club, karaoke, baking and decorating, current affairs, music and games. The activity timetable for Kipling ward included sensory sessions, baking club, pamper sessions, arts and crafts, music sessions, bingo, walking, games and quizzes. The activity schedule for Rudyard ward included activities such as walks, music, reminiscence, chair aerobics and pamper sessions, and we observed a brief music session during our inspection. However, overall, we saw very few patients engaged in activities during our inspection although the heating issues would have had an impact on them. On our return inspection visit on 22 November, we saw patients engaged in some activities on Horton and

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Requires improvement 

Kipling wards but there remained an absence of activities tailored to the needs of patients on Rudyard ward. The patients we spoke with on Horton and Kipling wards said they were bored and commented on a lack of meaningful, recovery-focused activities and poor community access. They reported feelings of isolation and boredom. Staff on Kipling ward remarked on the lack of meaningful and age appropriate activities for their patients

- There were no planned activities at weekends on Horton, Kipling and Rudyard wards although the provider planned to introduce a seven-day activity programme. Staff and patients had access to the crafts cupboards at weekends but otherwise, patients had access to television and radio. There was a television in the lounge on Kipling ward but the radio was broken. The provider allocated an activities budget of £72 per week for all patients at the hospital. It is likely that this influenced the type and frequency of activities available to patients, alongside other issues.
- Staff could refer patients to OT for specific interventions. The OT team comprised three qualified therapists and three assistants. The activity leads for the wards were not part of this service. The team covered John Munroe hospital and another location (Edith Shaw hospital). At the time of our inspection, there was one vacancy for a qualified occupational therapist. Patients accessed the service by referral from the multidisciplinary team. Patients in receipt of occupational therapy received a consistent, tailored and person-centred service that gave positive outcomes. Examples of support tailored to individual patients' needs included a range of life skills such as road safety, shopping, cooking and laundry. However, this service was not available to all patients. In particular, there was limited input for older patients and patients with organic conditions.
- Patients living in the bungalows, High Ash and Larches, engaged in activities of daily living such as planning meals, shopping, cooking and laundry with support from staff as needed. Patients also had access to activities such as baking and arts and crafts. There was a range of activities available including board games, art materials, music and films. Patients had home visits and overnight stays, and went to the cinema.
- The hospital operated a bank on site that was open three times a week. A staff member helped patients

manage their accounts and supported any appointeeship and deputyship arrangements (legal arrangements for people who cannot manage their finances patients because of their mental incapacities).

- The hospital had a number of vehicles to support community access and activities. The hospital employed two drivers. In addition, there were a number of permanent staff over 25 years of age registered as drivers. The provider had several vehicles including a minibus, a ramp assisted car, and a four-wheel drive car, which helped in the winter. Staff booked cars for planned activities.

Meeting the needs of all people who use the service

- At the time of our inspection, the hospital had a diverse patient population with severe and enduring mental. For example, High Ash had seven female patients, aged 20 to 59 years old with conditions including personality disorder, dissociative identity disorder, severe self-harm, enduring mental illness, combined with a wide range of physical health needs. Most of Rudyard ward's patients had organic conditions such as dementia, and Kipling ward had 11 female patients with severe and enduring mental health needs.
- A number of patients on Rudyard ward had mobility issues and needed wheelchair transport or physical assistance to move around the ward. Patients' bedrooms were located over three floors but there was a lift on the ward. The ward had an assisted bathroom.
- On High Ash and Larches units, we saw examples of adjustments made for individual patients with specific needs. Staff requested a special bed and commode for a patient who was bed bound and received additional bedding items to increase her comfort. However, occasionally, the hospital experienced delays in obtaining items for which commissioners had to agree the funding.
- On Larches, a patient had become a wheelchair user following surgery, which presented some practical difficulties for him in the bungalow. The patient had a complex history involving numerous failed placements and appeared settled at Larches. Staff discussed their concerns about the suitability of the environment for his changed needs with the patient's care coordinator. The consensus reached was that it was best for the patient to remain at the hospital rather than experience another move. The hospital arranged for appropriate

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Requires improvement



adjustments and mobility aids to help the patient's mobility. Furthermore, there were plans to modify the bungalow, which would offer more space around the bungalow and easier access to the garden.

- The hospital used mattress sensors and door alarms to raise alarm for patients vulnerable to wandering or falls. However, all the seating we saw on the three main wards was of a standard type. We saw no examples of specialist seating tailored to the needs of specific individuals yet we saw patients with different levels of frailty sat in uncomfortable and unhealthy positions. In one case, we saw a patient dozing while bent forward to the floor, about to fall. Staff did not notice so we informed them.
- The multidisciplinary team supporting the High Ash unit provided appropriate gender-sensitive care and treatment to female patients with personality disorders and complex presentations. Staff recognised the traumatic histories of some of the female patients on High Ash and their specific needs, and offered therapies tailored to their needs.
- However, the hospital did not always meet the specific needs of all its patient groups. In particular, patients living with organic conditions such as dementia did not have access to a dementia-friendly environment, dementia-sensitive activities or dementia-focused care. The environment on Rudyard ward was not suitable for the client group, and the staff did not receive specialist training in dementia care. There were plenty of staff on the ward but we saw limited communication and engagement between the staff and the patients. Two family members we spoke with expressed concern about the standard of personal care their relatives received. The issues they mentioned mostly related to the three main wards, Horton, Kipling and Rudyard. They described seeing their relative not shaved or showered, not having had a haircut, not wearing glasses, and not dressed appropriate to the weather.
- Family members also gave examples of good, person-centred care they had observed such as attention to detail in supporting the personal care of a patient in Larches unit, and the use of prompt cards to help reduce a patient's anxiety about going out on leave. Staff helped a patient cope with a move to another room by encouraging her to visit and prepare

the room before the move. Staff repainted the bedroom monthly of a patient who like to draw and paint on the walls. We also found that a patient on Larches unit who had dementia received some dementia-focused care.

- There was a range of information available to patients but it was not always visible or easily accessible on all wards. There was information displayed on advocacy services and the CQC throughout the hospital. There was a range of patient information displayed in High Ash unit. There was easy-read information available on rights and the Mental Capacity Act in the Horton ward nurses' office. Patients received information about their rights. We did not see any leaflets in different languages but at the time of our inspection, all patients had English as their first language.
- Most of the patients we spoke with on Horton, Kipling and Rudyard wards complained about the choice of food available to them. Staff confirmed concerns about the lack of choice for patients, especially to meet specific dietary needs and preferences.
- Staff supported patients with their spiritual needs, for example, one patient attended a local church regularly. The hospital held a monthly church service.

Listening to and learning from concerns and complaints

- John Munroe Hospital received four complaints in the 12 months to end July 2016. Of these, one was upheld. None were referred to the Ombudsman. The hospital received eight compliments in the same period.
- Most patients knew how to complain and most said they received the outcomes of their complaints. Staff helped patients make complaints, if needed. Relatives knew how to make complaints but some said they had not received a response when they complained.
- Staff knew how to handle complaints and tried to deal with informal complaints straightaway.
- We found some evidence that the provider acted on the findings of complaints. Staff received feedback on the outcome of complaints and investigations at team meetings, handovers and one-to-one sessions.

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

Good 

Vision and values

- Staff knew and agreed with the organisation's values. The provider's values included valuing patients and their individuality, creating a safe community, equality of treatment, quality care, empowerment and choice, and employing and investing in quality staff. The provider had engaged with staff to share the organisation's values and vision and invite feedback. The wards' objectives reflected the organisation's values and objectives.
- The provider had a quality plan that described its plan and objectives for the year but no overall strategy or vision for the organisation. However, the leads for specific areas such as human resources, training and ward management had their own improvement strategies and plans.
- As a small independent healthcare provider, John Munroe Hospital had a small senior management team. Staff knew who the senior managers and directors were. Members of the corporate team and the directors visited the hospital regularly.

Good governance

- The provider's governance systems were set out in its board assurance and escalation framework, developed in 2015. The systems included regular 'ward to board' meetings such as patients' meetings, senior clinicians' meetings (two-weekly), hospital managers' meetings, monthly clinical governance meetings, health and safety meetings, and board meetings. Managers presented the outcomes of audits and updates on action plans to clinical governance meetings.
- The provider had improved its governance systems and processes for monitoring all aspects of care. This meant managers and staff had access to information that helped them assess service delivery and identify areas for improvement. For example, not all staff had received all their mandatory training but information on gaps was readily available, and there was a clear plan to address this.
- The provider ensured that staff received supervision regularly. However, as of August 2016, only 60% of staff had received their annual appraisal. Shifts had sufficient

numbers of staff but there was a high reliance on bank and agency staff, which some patients found disruptive to their care and recovery. On some wards such as Rudyard ward, we found that staff had not received any specific training on working with people living with organic conditions such as dementia. Staff maximised their time on direct care activities but there was a lack of person-centred, meaningful engagement and activities on some wards. Staff participated in audits, as appropriate. They identified and reported incidents appropriately and received feedback on serious incidents. Staff understood and followed procedures for safeguarding, assessing capacity and complied with the Mental Health Act. However, some staff assumed patients living with dementia lacked the capacity and motivation to engage in activities.

- The provider had clear processes for collating data on a range of operational matters, for example, incidents, safeguarding, staffing, recruitment and training that enabled it to review and monitor the safety and effectiveness of service delivery via the appropriate governance meetings.
- The ward manager had sufficient authority and support to manage the service. The ward manager had a full-time staff member who helped her manage and monitor annual leave, sickness and staffing levels.
- The hospital had a risk register that set out risks to the business and service delivery, and described the contingency plans. The manager submitted items to the risk register, where appropriate.

Leadership, morale and staff engagement

- The provider held a staff survey in December 2015, which had a low response rate. No further details were available on the findings of the survey. The provider planned to repeat the survey in December 2016.
- Some staff felt confident to raise concerns with their managers while others felt less confident. Staff knew how to use the whistle blowing process. The hospital had received unannounced inspections in August 2016 following whistleblowing concerns.
- The average sickness absence rate for staff was 5.5%. Staff gave mixed views about morale and job satisfaction but most staff enjoyed their work. Staff who had worked for the hospital for some years reported improvements in the staff culture and quality of the service. Staff who worked in the bungalows spoke

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Requires improvement 

positively about their work, their colleagues, the multidisciplinary team and their role in patient care. Staff on Horton, Kipling and Rudyard wards described good team working and mutual support. However, most staff found the long shifts difficult and tiring with limited opportunities for shorter or alternative shift patterns. Staff on Larches unit said they would like more access to the nurse-in-charge. Staff on High Ash unit expressed concern about the high reliance on temporary staff who did not know the patients and hospital systems well. This contributed to lack of continuity and consistency in the care provided.

- Staff had access to a wide range of training and development yet not all staff were up-to-date with their mandatory training, and there were gaps for specialist training such as dementia-focused care.
- The provider had set up staff engagement meetings that board members attended to share information with staff, invite feedback and contribute to service development. However, attendance was low (10%) even though managers said they were well advertised and scheduled to catch staff between shifts. Managers asked

each ward to nominate a representative to attend regular staff engagement meetings and discuss issues and concerns. The provider had a staff questions and suggestions box, which was popular. Key themes identified from staff comments were insufficient activities for patients and staff pay and conditions.

Commitment to quality improvement and innovation

- The provider was aware of some of the limits presented by the hospital's design and layout but had submitted plans to modify and expand the hospital within its grounds. However, the provider had struggled to obtain planning permission to address these. This meant that the provider had to develop new plans to improve the existing environment, where feasible. For example, there were redesign plans for Horton ward that gave it more facilities such as an activity room, a new bathroom and a new meeting room.
- At the time of our inspection, the provider did not participate in any national quality improvement or accreditation programmes.

Outstanding practice and areas for improvement

Outstanding practice

The hospital had a highly skilled and experienced therapies team. Alongside the multidisciplinary team, they provided appropriate, gender-sensitive care and treatment for patients who had experienced trauma on High Ash unit. This included aftercare following discharge.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that clinic equipment is kept clean.
- The provider must ensure timely replacements of mattresses that are unfit for purpose.
- The provider must ensure that all staff receive mandatory and appropriate specialist training for their roles.
- The provider must ensure that care is person-centred and meets the specific needs of the different patient groups.
- The provider must ensure that patients have access to a range of therapeutic, rehabilitative and social activities specific to their needs.
- The provider must ensure that Rudyard ward environment is dementia-friendly and all wards contains the appropriate facilities.

Action the provider **SHOULD** take to improve

- The provider should ensure that staff fully comply with checks on resuscitation and other equipment.
- The provider should ensure that staff on High Ash and Larches units can contact the nurse immediately in an emergency.

- The provider should ensure that blanket restrictions are in place only where these are the least restrictive means of managing specific risks.
- The provider should update its rapid tranquillisation policy to reflect the national institute for health and care excellence (NICE) guidelines (May 2015).
- The provider should ensure there is guidance for all medication prescribed for PRN (pro re nata – as needed) purposes.
- The provider should continue to address staffing recruitment and retention issues.
- The provider should ensure that staff receive their annual appraisals.
- The provider should ensure that patients are offered a choice of good quality food, and that menus are displayed for information.
- The provider should ensure that all staff have a good understanding of capacity to consent and that it is applied appropriately.
- The provider should ensure that patients' belongings are kept safe.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Not all staff were up-to-date with their mandatory training, and there were gaps for specialist training such as dementia-focused care.

This was a breach of regulation 18(2)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- There were some gaps in checks of emergency resuscitation equipment in the High Ash unit, and there were no records confirming checks of portable equipment on Kipling ward.

This was a breach of regulation 12(2)(e)

- The provider delayed in replacing a mattress that was not fit for use and posed an infection control risk.
- Some clinical equipment was not clean, for example, on Kipling ward, the sharps disposal box was dirty and the medicines cutter and crusher contained residue of medicines, which posed a risk of cross-contamination of medicines.

This was a breach of 12(2)(h)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

- There was a lack of meaningful and recovery-orientated activities on the three main wards.
- **There was a lack of activities tailored to specific patients groups, for example, people living with dementia.**

This was breach of regulation 9(3)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- The facilities on Rudyard ward did not promote the comfort and wellbeing of patients living with dementia.
- **There was an absence of signs and information on Rudyard ward to help with navigation around the wards and orientation to time and place.**

This was a breach of regulation 15(1)(e)