Shrewsbury Court Independent Hospital

Quality Report

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

Overall summary

We did not rate this location as it was a focused inspection.

During our inspection in August 2016 we focused on the key areas of safe and well led out of the five domains that we inspect against and found a number of concerns. We visited the provider again in December 2016 and found that the provider had made a number of significant changes and improvements. Both inspections are described within this report.

When we undertook the inspection in August 2016, the areas that required improvement were as follows:

- Risks caused by ligature points on the wards and outside spaces were not identified and mitigated.
- No action had been taken to reduce the internal ligature risks identified at our previous inspection.
- We had concerns regarding medication management. We found 15 medication errors in the 50 medication charts we reviewed.
- The provider had received weekly pharmacy audits which identified medication errors. However, no action had been taken to address the issues identified.
- Staff supervision was not followed in line with the organisational policy. Supervision meetings were very sporadic and inconsistent. Of the 24 personnel files we reviewed, we found five files which had no record of supervision meetings being carried out at all.
- Mandatory training attendance was inconsistent. Training rates in the Mental Health Act, health and safety and risk management were all below the target of 75%.
- The provider had up to date policies but there were few systems in place to ensure policies were complied with and processes were safe.

As a result of our serious concerns about the service we served two warning notices on the provider. We asked them to make urgent improvements to the service and take steps to protect clients from avoidable harm. The provider produced an action plan to address our concerns and kept us updated regarding the progress made.We returned to the service on 9 December 2016 for an unannounced follow up inspection to look at the specific concerns relating to the warning notices.

Summary of findings

The provider had made many effective changes and it was evident that a lot of work had been carried out in order to make improvements to the service, most notably:

- The wards all had ligature identification tools that were completed weekly. These tools linked with ligature risk assessment and management forms and stated the hazards, risk level and control measures in place.
- All medication errors that had been identified in the previous inspection had been recified and measures had been put in place to prevent further reccurence.
- Each ward now had a named responsible clinician which made patient care and communication more consistent.
- We reviewed 20 personnel files and 16 files showed that staff had attended supervision meetings within the last month. The supervision template had been reviewed and was evidenced in the files and the policy had been reviewed and updated.

Summary of findings

Contents

Summary of this inspection

Background to Shrewsbury Court Independent Hospital

Shrewsbury Court Independent Hospital is owned by the Whitepost Health Care Group and is situated in Redhill, Surrey. Most of the residents are from London, Surrey and the surrounding Counties.

Shrewsbury Court Independent Hospital is a hospital providing locked rehabilitation services for adults with a mental health diagnosis.

Mulberry Ward is a five bedded ward for females, specialising in slow stream rehabilitation and complex needs.

Lavender Ward is a seven bedded intensive recovery and rehabilitation ward for females.

Maple Ward is a nine bedded male ward specialising in complex needs.

Aspen Ward is a slow stream rehabilitation ward with beds for seventeen males.

Oakleaf Ward is a nine bedded male intensive recovery and rehabilitation ward.

Fern Cottage is a three bedded step down ward.

Shrewsbury Court Independent Hospital was registered with CQC in 2013 for the following regulated activities:

• assessment of medical treatment for persons detained under the Mental Health Act,

• treatment of disease, disorder or injury

• diagnostic and screening procedures.

The hospital director and registered manager for the service has been in post since May 2016.

We last inspected this service as part of a comprehensive inspection in August 2015. During that inspection we found that the provider had breached regulations regarding ligatures, medication management and staffing levels. We asked the provider to take steps to address this and the provider responded by putting action plans in place.

We found that most of the requirement notices set in our previous inspection report for the safe and well-led domains had been completed except the continued breach of regulation 12. Ligature points on the ward and outside spaces were not all identified and risks mitigated.

Our inspection team

The team that inspected the service was comprised of Kelly Pain, lead inspector, a CQC inspection manager, two CQC inspectors and a specialist mental health nurse advisor.

Why we carried out this inspection

We carried out an unannounced, focused inspection in response to concerns raised from a whistleblower.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all five wards and Fern Cottage at the service
- spoke with two patients who were using the service
- spoke with the hospital director, clinical services manager and the four managers for each of the wards

Summary of this inspection

- spoke with five other staff members
- attended and observed one handover meeting and one multidisciplinary meeting
- looked at 35 patient risk assessments
- looked at 24 staff personnel files
- looked at 50 medication charts
- carried out a check of four clinic rooms
- carried out a specific check of the medication management on five wards
- looked at a range of policies, procedures and other documents relating to the running of the service

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?

When we undertook the inspection in August 2016, we found:

- The ward layout did not allow for staff to observe all areas of the wards.
- Not all ligature risks had been identified, assessed, or mitigated adequately.
- During the inspection, staff and management did not adhere to the infection control policy.
- Mandatory training attendance was below the 75% target for training in the Mental Health Act, health and safety and risk management.
- Medical cover was inadequate. There were locum staff covering certain days and no named doctor covering some wards which resulted in inconsistent medical support for patients.
- Environmental risk assessments were inconsistently completed across all wards.
- We reviewed 50 patient medication charts and found medication errors in 15 of them.
- The provider had received regular audits of the prescription charts by their pharmacy provider. These audits had identified many of the errors that we found but no action had been taken by the hospital to address them.

Are services well-led?

When we undertook the inspection in August 2016, we found:

- The service had inadequate systems in place to ensure staff received regular supervision meetings with a line manager. We reviewed 24 staff files. In five staff files we could not find any record that staff supervision meetings had been carried out at all. Only three records met the organisational target of six sessions of supervision a year.
- There were no supervision audits or systems in place to monitor supervision records or highlight to management that supervision meetings were not being carried out.
- The provider had up to date policies but there were no effective systems in place to ensure policies were complied with and processes were safe.

Detailed findings from this inspection

Mental Health Act responsibilities

During this inspection we did not look at the Mental Health Act responsibilities but we did find that:

Only 52% of staff had attended the mandatory Mental Health Act training.

Staff had not completed records correctly regarding patients' consent to treatment under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

During this inspection we did not look at the Mental Capacity Act but we did find:

Mental Capacity Act and Deprivation of Liberty Safeguards training were part of the organisation's mandatory training and 88% of staff had completed the training at the time of our inspection.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Well-led	

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

Safe and clean environment

- In all wards we visited the ward layout did not enable staff to observe patients at all times and have clear lines of sight throughout the ward environment.
- On Lavender ward the quiet room opposite the staff office was unobservable from the office and had multiple ligature points not identified on the ward's ligature risk assessment.
- During the inspection, two patients were taken ill on the same ward within a 24 hour period. Staff and management failed to recognise the risks of infection, failed to follow the hospital's own infection control policy of closing the ward and failed to ensure that patients were kept safe from the risk of infection.
- We saw on Maple ward that an unoccupied bedroom, which had been made ready for a new patient, had a heavily soiled and stained mattress. This had not been identified in the ward environmental checking systems and we were unable to get confirmation with staff if mattress audits were carried out.
- A fire/heat sensor on Aspen ward had been covered with a surgical glove in a patient area because building work was being completed on the ward. We were told this was a working practice to stop dust from triggering the fire alarm. This meant that an unobserved area of the ward that gave access to two patients' bedrooms was not covered by the hospital's fire alarm system. We brought this issue to the attention of the ward manager and the hospital director immediately. However the glove remained in place until the end of the second day of the inspection.

Safe staffing

- In the annex on Maple ward, the patients told us they were regularly left without staffing when the staff had to visit the main ward. They were given a fob to enable them to leave this area if they required support from staff.
- There were no full time permanent consultants in post who covered specific wards. At the time of our inspection, there were locum consultants covering certain days but the staff and patients did not have a named doctor providing consistent medical support.
- There was no medical director in post and the hospital management informed us that this vacancy was frozen for six months. Doctors had supervision from the hospital director during this time. The hospital director was not a doctor.
- At the time of inspection 52% of staff had completed mandatory training in the Mental Health Act, which was under the hospital's target of 75%.
- At the time of inspection 66% of staff had completed mandatory training in health and safety, below the hospital's target of 75%.
- At the time of inspection, 64% of staff had completed mandatory training in risk management, below the hospital's target of 75%.

However:

- Staffing levels on the wards have improved since our last inspection. The previous breach of regulations against staffing levels had been met.

During our follow up inspection in December 2016, we found:

- There were three consultants who were the responsible clinicians for specific wards which provided consistent medical support

Assessing and managing risk to patients and staff

Long stay/rehabilitation mental health wards for working age adults

- Environmental risk assessments were inconsistently completed across all wards. We reviewed the clinical services manager's records of environmental risk assessments and found months where ward staff had not completed the paperwork.
- Ligature assessments had been carried out but there were many areas which had not been assessed adequately. There was an activity room that was accessible to patients and had no clear visibility from the nurses station, there were metal brackets on the wall and a suspended ceiling that allowed us to see exposed wires through the panels, staff had not assessed the risk regarding these. Therefore patients were not kept safe from the risk of harm from ligatures.
- We saw a copy of the hospital's current ligature risk audit. We identified many risks that had not been recognised by staff and were not listed on the ligature risk audit like wardrobe doors, magazine rack fixtures, alarm pulls and toilet roll holders.
- No action had been taken to reduce the internal ligature risks identified at the previous inspection.
- We reviewed 50 patient medication charts and found medication errors in 15 of them. These errors included medication that had been prescribed but not given with no explanation given on the chart and included occasions when clients had refused medication but no reason was documented.
- One patient on Oakleaf ward was prescribed glicazide. Glicazide is a medication that lowers the blood sugar (glucose) level. It is used to treat diabetes which is not managed by diet. On 1 September the prescription chart showed that the patient had not been given his prescribed glicazide for the last four days. On two occasions it was recorded that the medication was out of stock, on one occasion it was recorded that the patient was asleep and no reason was given on one occasion. The patient's blood sugar levels had been monitored regularly and had increased to 13 millimoles per litre (mml/l). National Institute for Health and Care Excellence guidance recommends that an adult with type 2 diabetes should have a blood glucose level of between 4 and 7 mml/l before meals and under 8.5mml/l two hours after meals. Therefore the patient's health had been put at risk because he had not been given the medication he needed to reduce his blood glucose levels.
- The provider had received regular audits of the medication charts from their pharmacy provider. These audits had identified many of the errors that we found. There had been no action taken by the provider to address the issues identified in the pharmacy audits. Therefore patients were placed at risk of receiving incorrect medication.
- Three prescription charts showed medication had been prescribed and administered without being authorised on a T2 or T3 Mental Health Act treatment authorisation form when it was required under the Mental Health Act.
- There were seven prescription charts which showed there were unexplained gaps in the administration of prescribed medication. The charts had not been updated to advise why the medication had not been administered.

However:

- In all 35 treatment records reviewed, there were current risk assessments in place, and there was evidence that the risks were reviewed with dated entries on the electronic patient record system.
- We reviewed the previous breaches regarding medicines management. The issues raised at the last inspection had been met

During our follow up inspection in December 2016, we found:

- The wards all had ligature identification tools that were completed weekly, all staff had been trained to understand and identify ligatures and this was reflected in the very thorough ligature risk assessment and management form that all wards had, stating the hazards, risk level and control measures in place.
- We reviewed 44 medication charts and all errors that had been identified in the previous inspection had been recified and measures had been put in place to prevent further reoccurance.
- All staff had received a refresher in medicines management and guides had been issued to all nurses administering medication.

Long stay/rehabilitation mental health wards for working age adults

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

Good governance

- The service had inadequate systems in place to ensure staff received regular supervision meetings with a line manager. The organisational policy stated that all staff must have a minimum of six sessions of supervision a year with their line manager. Of the 24 records we reviewed, in five records we could not find any evidence that staff had received supervision meetings with their line manager at all and only three staff files met the target of six sessions of supervision a year.
- There were no supervision audits or systems in place to monitor supervision records or highlight to management that this was not being done.
- We saw evidence that the infection control policy was not being followed after two patients were taken ill within 24 hours on a ward. No control measures were put in place until the inspection team informed management to do so.
- There were inadequate systems in place to ensure that ligature audits were fully completed and actions were taken to mitigate all risks identified.
- There were insufficient systems in place to ensure that pharmacy audits which highlighted medication errors were actioned by hospital managers. The hospital managers received weekly pharmacy reports that highlighted medication errors found in pharmacy audits. No action had been taken to address the issues or stop it being repeated.

During our follow up inspection in December 2016, we found:

- We reviewed 20 personnel files and 16 had attended supervision meetings within the last month, the template had been reviewed and was evidenced in the files and the policy had been reviewed and updated.

Leadership, morale and staff engagement

- Since September 2015, 38 out of 117 members of staff had left the hospital's employment. There were no interviews held with the staff to identify issues around retention.
- Staff had been internally promoted to ward managers but no specific training or support had been put in place to upskill them or aid their transition to their new roles.

At the time of our inspection there was no medical director in post to support the clinical staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must implement effective systems to ensure ligature risks are comprehensively assessed, recorded and mitigating actions taken to reduce the risk.
- The provider must ensure that all staff are trained to correctly identify and mitigate all ligature risks.
- The provider must ensure that there are robust systems in place to recognise the risks of infection, to ensure staff follow the infection control policy and ensure that patients are kept safe from the risk of infection.
- The provider must ensure all staff have regular supervision.
- The provider must put in place effective medicines management systems
- The provider must take immediate action to address the issues identified in the pharmacy audits.

The providers have taken all the relevant actions to address all of the above.

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way for service users. Ligature risks were not identified on the hospital's ligature risk audit: Lavender ward dining room – glove dispensers, fire alarms and magazine rack. Lavender ward quiet room – door entry box on wall, wardrobe/cupboard door, bracket on wall, and suspended ceiling with clear light panel revealing accessible wires. Lavender ward bedrooms – wardrobe doors. Lavender ward wet room – alarm pull. Lavender ward toilets – windows, toilet roll holder, handwash dispenser, towel dispenser and alarm pull cord. Aspen ward dining room – soap dispensers and towel dispensers. Aspen ward bedrooms – wardrobe doors Aspen ward rooms 5 and 6 – opening windows in en suite bathroom, towel rails and door closures. Aspen ward annex – medicine cupboards on walls, taps, light fittings.

This section is primarily information for the provider

Enforcement actions

The provider had not identified these ligature risks on their ligature audit, had not assessed the risk they posed in relation to the patient group using the service and had not identified or taken mitigating action to reduce or eliminate the risk. Therefore the hospital had not ensured that patients were kept safe from the risk of self-harm because all the ligature points had not been assessed or mitigating action taken to reduce the risk.

This was a breach of regulation 12 (1) (2) (a) (b) (d).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

The provider had not ensured that care and treatment was provided in a safe way for service users.

The provider failed to follow its infection control policy when two patients on Mulberry ward experienced vomiting within a 24 hour period. The provider failed to recognise the risks of infection, failed to follow its own infection control policy and failed to ensure that patients were kept safe from the risk of infection.

This was a breach of regulation 12 (1) (2) (h).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Safe care and treatment

The provider had not ensured that care and treatment was provided in a safe way for service users. The provider had not ensured the proper and safe management of medicines.

There were errors in 15 of the 50 patients' prescription charts.

Staff had administered 48 doses of sodium valproate, three doses of hyoscine hydrobromide, four as required doses of lorazepam and two doses of orphenadrine to a patient on Aspen ward without the appropriate MHA treatment authorisation.

Three prescription charts showed medication had been prescribed and administered without being authorised on a T2 or T3 treatment authorisation form.

One patient on Oakleaf ward was not given his prescribed glicazide for four days. During this period his blood glucose levels rose to levels considerably higher than those recommended by the National Institute for Health and Care Excellence. Therefore the patient's health had been put at risk because he had not been given the medication he needed to reduce his blood glucose levels. The provider had not taken action to ensure the patient received his medication and had not taken action to respond to his increasing blood glucose levels.

This section is primarily information for the provider

Enforcement actions

Seven prescription charts showed there were unexplained gaps in the administration of prescribed medication. The charts had not been updated to advise why the medication had not been administered. This was contrary to the hospital's medication policy.

This was a breach of regulation 12 (1) (2) (g).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Good governance

Systems were not in place to adequately monitor the safety and quality of the service.

The provider failed to put in place systems to ensure ligature risks were comprehensively assessed, recorded and mitigating actions taken to reduce the risk. Therefore the hospital had not ensured that patients were kept safe from the risk of self-harm because all the ligature points had not been assessed or mitigating action taken to reduce the risk.

The provider failed to put in place monitoring systems to ensure staff received regular management supervision meetings.

This section is primarily information for the provider

Enforcement actions

The provider failed to put in place effective medicines management systems and had failed to ensure staff took action following the regular audits provided by their pharmacy provider, which had identified medication prescribing and administration errors. Therefore patients were placed at risk of receiving incorrect medication.

This was a breach of regulation 17 (1) 2(a) (b).