John Munroe Hospital – Rudyard

Quality Report

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

Ratings

Overall rating for this location

Are services safe?

Overall summary

- This inspection was a focussed unannounced inspection in response to medicines safety concerns raised by a whistle-blower to the Care Quality Commission. During the inspection we found issues around the management of medicines across all wards.
- The provider's safe and secure handling of medicines policy was not being followed by staff. We found there were systematic failures in the management of medicines that included:
- Medicine stocks not ordered in a timely manner that resulted in patients not receiving medicine as prescribed. Of the 53 patients in the hospital, 23 patients were affected by medication being out of stock on 207 occasions in the three months before our inspection.
- Medicines that had been opened or removed from the fridge did not have the patient name or new expiry date recorded on the packaging. This meant that staff could not be confident in the continued effectiveness of the medicine
- Procedures for the safe disposal of medicines were not followed, which is required for audit purposes and the protection of staff.
- Staff nurses had not received annual training on medicines competency in line with local policy.
- The actions from internal medicines audits and external pharmacy audits were not implemented to address non-compliance.
- There was a lack of equipment to monitor the physical observations of patients where an abnormal reaction may have been suspected.

Summary of findings

- Staff did not routinely report the absence of medicines as incidents on the provider's system and were unclear of the incident reporting criteria. Staff told us they raised incidents verbally with managers, who did not report them on the incident reporting system. This meant that the senior leadership team did not have oversight of emerging trends and themes for medicines incidents.
- Staff raised safeguarding concerns with the deputy hospital manager or registered manager, who spoke with the local safeguarding board. However, we found this was not a consistent process and not all safeguarding concerns had been raised to the safeguarding board in a timely manner.

However, we found:

- All the wards monitored and recorded the room and fridge temperatures, and records of these checks were completed daily by staff.
- Resuscitation equipment and emergency drugs were available in the clinic rooms and staff regularly checked the contents.
- The multidisciplinary team discussed patients and put risk management plans in place, which staff followed to keep patients safe from harm.
- Staff were able to describe how they identified safeguarding issues and how they received yearly safeguarding training.

Summary of findings

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Services we looked at

Long stay/rehabilitation mental health wards for working-age adults; Wards for older people with mental health problems;

Summary of this inspection

Background to John Munroe Hospital – Rudyard

John Munroe Hospital is an independent mental health hospital that provides care, treatment and rehabilitation services for up to 57 adults, aged 18 or over, with long-term mental health needs. Patients may be informal or detained under the Mental Health Act 1983.

John Munroe Hospital is one of two hospitals run by the John Munroe Group Limited. The Edith Shaw Hospital is located nearby and both hospitals share the same registered manager.

John Munroe Hospital is registered to carry out the following regulated activities:

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

• treatment of disease, disorder or injury, and

• diagnostic and screening procedures.

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

• Horton ward is a male ward that supports up to 16 patients with chronic or complex mental health needs.

• Kipling ward is female-only ward for up to 13 patients with chronic or complex mental health needs.

• Rudyard ward is a male only ward that supports up to 15 patients with organic conditions such as dementia.

• High Ash is a female-only ward for up to seven patients and provides locked rehabilitation.

• Larches is a male-only ward for up to six patients and provides locked rehabilitation.

The hospital was previously inspected by the Care Quality Commission on the 13-15 February 2018 and was rated requires improvement overall. The domains of safe, effective and well-led required improvement whilst caring and responsive were rated as good.

Our inspection team

Team leader: Julie Bains

The team that inspected comprised of a CQC pharmacist, a CQC inspection manager and an assistant inspector.

Why we carried out this inspection

We carried out an unannounced responsive inspection, which focussed on specific areas within the safe domain, so was not rated. The inspection was in response to concerns raised directly to the CQC by a whistle-blower. A person who reports wrongdoing in the place where they work is often called a whistle-blower. In the CQC, the term 'whistle-blower' means someone making a disclosure who is directly employed by, or provides services for a provider who is registered with CQC. Examples of a worker who provides services to a registered provider include, but are not limited to, agency staff, visiting community health staff, GPs, independent activities organisers and contractors. A whistle-blower may also be someone who has left their job after they have made a disclosure and is raising it again, perhaps because they remain concerned about vulnerable people or wrongdoing, and are not confident that the management has dealt with it. The whistle-blower contacted the CQC on the 04 June 2018. Following discussions by phone and clarification of their concerns by email, an unannounced responsive inspection was organised for the 18-19 June 2018. Concerns raised included:

- Procedures in the safe storage and dispensing of medicines were not followed, which allowed an unobserved patient to remove medicine from the

Summary of this inspection

clinic room and administer the medicine, which resulted in the patient attending the local emergency department. This incident was not reported to the local safeguarding board.

- Medicines were not ordered in a timely manner resulting in the wards running out of medicines for patients. Qualified nurses were told by the prescribing doctor to cover the shortfall by dispensing medicines prescribed to other patients to the patients whose medicines had run out until stocks were replenished. The senior management team were aware of this practice but did not challenge it.
- Medicines counts had showed discrepancies in the records between medicines dispensed and those left in stock.
- The policy for dispensing, checking and observing a patient taking their medicines was not being followed. Instead a qualified nurse would dispense the medicines and hand it to unqualified healthcare staff to take to patients.
- The care plan and risk management plan were not being followed for a patient, who required continuity of care from staff who knew them. Using unknown staff raised their risk of self-harming.
- Managers had investigated incidents of patients being bullied by staff.

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 during a comprehensive inspection:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

A copy of the comprehensive inspection can be found by following this link:

https://www.cqc.org.uk/location/1-2214110620

This inspection focussed on the safe domain only.

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

• visited all five wards at the hospital

• spoke with the registered manager, the nominated individual and a consultant psychiatrist

• spoke with seven qualified nurses and one health care support worker

• spoke with one patient

• looked at the current and previous prescription charts of all (53) patients

• carried out a specific check of the medication management on all wards

• looked at a range of policies, procedures, audits 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?

Are services safe?•

The provider's safe and secure handling of medicines policy was not being followed by staff.

The hospital's incident reporting system was not being used in line with local policy to record when medicines were not available. Staff had not reported incidents on the provider's system and were unclear of the incident reporting criteria.

• Staff nurses had not received annual training on medicines competency in line with the provider's local policy.

• The process for raising safeguarding concerns with the local safeguarding board were not consistent.

- All required equipment to monitor the physical observations was only present on only two of the five wards.

• High Ash and Larches wards did not have cleaning rotas or records in place for the clinic rooms.

However, we found:

• All the wards monitored and recorded the room and fridge temperatures and records of the checks were completed daily by staff.

• Resuscitation equipment and emergency drugs were available in the clinic rooms and staff regularly checked the contents.

• The multidisciplinary team discussed patients and put risk management plans in place, which staff followed to keep patients safe from harm.

• Staff were able to describe how they identified safeguarding issues and how they received yearly safeguarding training.

Long stay/rehabilitation mental health wards for working age adults

Safe

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

Clinic rooms and equipment

- The clinic rooms for the High Ash and Larches wards were small, cluttered and cleaning rotas were not in place for either clinic room. They did not have hand washing facilities. However, staff had access to hand gels in both clinics to maintain hand hygiene. The clinic rooms on Kipling and Horton wards were clean, tidy and surface areas were available to work on. The hatches were not in use following a recent incident. Cleaning rotas and records were in place and evidenced routine cleaning of both rooms. This meant there were inconsistency between the wards on the cleaning of clinics and the documentary evidence of cleaning records.
- High Ash and Larches wards had blood pressure monitors. One of the blood pressure monitors on High Ash was not working but not labelled as such. High Ash ward clinic room did not have a thermometer or a pulse oximeter. Horton ward had a blood pressure monitor, thermometer and pulse oximeter. Kipling ward reported they did not have any of the equipment and would use the equipment on Horton ward. Overall, this meant there was a lack of equipment to monitor the physical observations of patients, in a timely and responsive way. All the wards monitored and recorded the room and fridge temperatures, and records of the checks were completed daily by staff.
- The sharps waste disposal bin on High Ash was sealed and dated but the blue waste bin, used for the disposal of medicines, was not sealed or dated and not locked in a cupboard. This meant the disposed medicines could be accessed by non-nursing staff. The Larches clinic room sharps waste disposal bin was sealed but not dated and there was no blue waste bin. On Kipling ward, we found the waste disposal bin full of medicines awaiting destruction that included bottles, packets and tubes of medicines. The provider's Safe and Secure handling of Medicines policy was not followed regarding the disposal of medication. There was no documentation available as to the contents of the waste disposal bin, such as, who had disposed of the medicines or a secondary witness signature to the disposal, which is required for audit purposes and the protection of staff.
- On Kipling ward, we witnessed the clinic room door was propped open whilst being cleaned by the cleaner. This meant non-nursing staff but not patients, had access to medicines in a waste disposal bin stored in an unlocked cupboard.
- The first aid kit on High Ash contained bandages that had exceeded the out of date detailed on the packaging. This was reported to the nurse and were removed immediately.
- Resuscitation equipment and emergency drugs were available in the clinic rooms and staff regularly checked the contents.

Management of patient risk

- We saw documentation of a patient's risk being discussed during a multidisciplinary team meeting. The risk management plan was being followed by ward staff to keep the patient safe. However, staff told us the need to use staff known to the patient for observation often meant they had to swap staff with other wards for this to happen. This meant nurses had to spend time each shift making arrangements for swapping staff, which took them away from their other tasks.
- A patient on Horton ward was without prescribed medicines for four days. The absence of the medicines had not been noted in the clinical records. On the prescription charts the absence had been recorded appropriately. However, there was no escalation to the responsible clinician for three days. There was no recognition of the risk effects of withdrawal from the medicine or any evidence that the patient had been monitored for signs of withdrawal. This meant there was no oversight of the clinical monitoring and safety of patients medicines.

Safeguarding

- Staff were able to describe how they identified safeguarding issues and how they received yearly safeguarding training. However, staff told us they did not raise safeguarding alerts or concerns to the local safeguarding board but reported them to the deputy hospital manager. Staff said they did not receive

feedback from the deputy ward manager on the outcome. This meant the safeguarding procedures were not robust, as it relied on one person to raise concerns with the local safeguarding board.

- A patient on Horton ward was able to take medicines from the clinic room without staff knowing and consequently required hospital treatment due to over sedation. This incident was raised by ward staff to senior management. However, the provider had not reported this incident to the local safeguarding board in a timely way and it was the Care Quality Commission that contacted the local safeguarding board when the provider notified us of the incident. This meant the provider's safeguarding systems were not consistently being followed in reporting safeguarding concerns without delay. Senior managers did not have robust oversight of the monitoring of safeguarding concerns and the responsibility for reporting was not clear in the absence of the deputy manager. However, we did find evidence that other safeguarding concerns had been reported appropriately to both the CQC and safeguarding authority.

Medicines management

- During the inspection, we reviewed the previous three months prescription records for all the patients currently on the wards. On High Ash ward we found that three out of the seven patients admitted had been without medicines, with eight medicines not being available for administration on 47 occasions. On the Larches ward we found that two out of the six patients admitted had been without medicines, with two medicines not being available for administration on two occasions. On Horton ward we found that 10 out of the 16 patients admitted had been without medicines, with twelve medicines not being available for administration on 97 occasions. On Kipling ward, we found that seven out of the 13 patients admitted had been without medicines with ten medicines not being available for administration on 46 occasions. This meant patients were put at potential significant risk of harm by not receiving their medicines as prescribed.
- The provider's policy for safe and secure handling of medicines and the nursing and midwifery council (NMC) standards were not followed when High Ash ward used a bank staff nurse, with limited mobility, administered medicines to patients through use of health care workers, who took medicines to the patients. The care workers had not received the relevant training to undertake the task. This issue was raised with the senior nurse and registered manager who stopped the practice. At the time of the inspection, this incident was being investigated by the provider.
- There was inconsistent use of recording codes on the medicines administration records. For example; a patient records showed they had not received their medication on 19 occasions due to being off the ward. When raised staff confirmed the patient had been on leave and had taken their medicine with them to self-administer and a different code should have been used to record this.
- The medication administration charts on High Ash ward showed the doctor had authorised two patient's medications to be stopped but had not dated the records in the correct place.
- The medication audits carried out between March and May 2018 on High Ash and Larches wards recorded noncompliance for 'all medication administration records have clear initial/indicators for reason for omission'. The audits for Kipling and Horton wards recorded consistent non-compliance in the following areas: all medication administration records have clear initial/indicators for reason for omission, medication with a used by date/expiry date has opened date on label (liquids, creams eye drops). The disposal of medicines was not appropriately documented. The audits had actions to be taken to address the non-compliance. However, it was clear from the findings of this inspection that these actions had not been completed.
- On Horton ward we found three medicines that had been opened or removed from the fridge without a patient name or new expiry date. This meant staff could not be confident in the continued effectiveness of the medicine.
- The existing systems to manage the stock of medicines within the hospital had proven to be inadequate. This meant nurses were unable to maintain adequate stock levels of medicines at all times. Medicines were ordered for individual patients and there was no general ward stock of common medicines available to provide a contingency in case of a shortage of any one individuals supply of medicines.

- The hospital managers had circulated an updated stock reconciliation audit on the morning of the inspection in attempt to address these problems. Systems were not in place to ensure increased medicines were ordered in a timely manner, after ward round and the multi-disciplinary meeting. Staff described that night staff were responsible for ordering increased stock. However, they told us when agency staff were used this did not always happen and the day staff did not always check if additional stock had been ordered.
- During the inspection, we found evidence that failure to stock adequate amounts of one medicine led to the consultant psychiatrist instructing a staff nurse to use another patients medicine. The medicine involved was one that is limited to a single person prescription because of significant side effects. This was not reported as an incident and no follow up action was taken to address the cause or concerns of staff concern about dispensing in this way. This practice is against both national guidelines and the provider's policy.
- Staff nurses had not received annual training on medicine competency in line with local policy. The provider had a contract with an external pharmacy to provide staff nurses with individual training, which was effective from July 2017. Only three staff nurses out of 17 whole time equivalents were trained to the date of our inspection, of which two were on High Ash and Horton wards.

Track record on safety

Reporting incidents and learning from when things go wrong

- The John Munroe Group policy on the safe and secure handling of medicines states that staff administering medicines should: 'Take note where any medication has been omitted more than once, investigate the reasons why this has been recurring and take appropriate action by discussing with the patient and reviewing the prescription with the Consultant, or GP as appropriate." We found no evidence in incident reports or case notes of this policy being followed and any reliable mechanism to monitor and manage the reliable supply of medicines. Staff told us they did not complete incident reports when medication was omitted.
- The staff we spoke with told us that they would raise incidents with the deputy hospital manager or the registered manager, in the deputy's absence. Staff told us the provider produced a monthly lesson learned bulletin and they also discussed managing patient risk within the team. However, staff said shared learning was inconsistent across the wards due to staffing issues, the high use of bank or agency staff and infrequent team meetings across all the wards.
- The monthly governance meeting minutes for March to May 2018, attended by the senior leadership team, showed evidence of reported incidents being reviewed. No incidents discussed referred to medicines, the lack of stock medicines or administration issues. This showed the incident reporting procedure around medicine management was not embedded in practice and the system of reporting incidents, to the deputy hospital manager, was not effective in escalating concerns. This meant themes and trends around medicine management were not identified and so no lessons learned or changes in practice implemented. This meant the governance group had a lack of oversight of the safe governance of the hospital.

Wards for older people with mental health problems

Safe

Are wards for older people with mental health problems safe?

Clinic rooms and equipment

- The clinic room on Rudyard ward was clean, spacious and newly opened as part of the refurbishment of the ward.
- Physical health equipment was limited in the clinic room. The electronic blood pressure monitor on Rudyard was broken so they used a manual monitor. The ward did not have a thermometer or pulse oximeter. This meant that the monitoring of patient's physical health on Rudyard ward relied on the use of equipment from other wards.
- The Ward monitored and recorded the room and fridge temperatures and records of the checks were completed daily by staff.
- Resuscitation equipment and emergency drugs were available in the clinic room and staff regularly checked the contents.

Safeguarding

- Staff were able to describe how they identified safeguarding issues and how they received yearly safeguarding training. However, staff told us they did not raise safeguarding alerts or concerns to the local safeguarding board but reported them to the deputy hospital manager.

Medicines management

- During the inspection, we reviewed the previous three months prescription charts. On Rudyard ward we found that three out of the 11 patients admitted had been without medicines, with six medicines not being available for administration on 15 occasions. This meant patients were put at potential risk of harm by not receiving their medicines as prescribed.
- We reviewed three medication audits carried out between March - May 2018. The audits recorded consistent non-compliance in the following areas: all medication administration records have clear initial/ indicators for reason for omission, medication with a used by date/expiry date has opened date on label (liquids, creams eye drops). The disposal of medicines was not appropriately documented. The audits had actions to be taken to address the non-compliance. However, it was clear from the findings of the inspection these actions had not been completed.
- The nurses we spoke with stated they did not complete medicine stock reconciliation consistently due to staffing issues and the continuity of staff on the wards. However, we were told by staff that on the morning of the inspection nurses had received updated stock control reconciliation forms to be used with immediate effect. This meant that up until the inspection, nurses were unable to accurately record levels of medicine stock.
- Systems for ordering additional medicines in a timely manner, after any changes to the prescription, were not being followed up in the absence of permanent staff.

Track record on safety

Reporting incidents and learning from when things go wrong

- The John Munroe Group policy on the safe and secure handling of medicines states that staff administering medicines should: 'Take note where any medication has been omitted more than once, investigate the reasons why this has been recurring and take appropriate action by discussing with the patient and reviewing the prescription with the Consultant, or GP as appropriate." We found no evidence in incident reports or case notes of this policy being followed and any reliable mechanism to monitor and manage the reliable supply of medicines. Staff told us they did not complete incident reports when medicine was omitted.
- The staff we spoke with told us that they would raise incidents with the deputy hospital manager or the registered manager, in the deputy's absence. We saw evidence of two incidents with medication errors in the previous three months reported by the staff nurse involved. Staff told us the provider produced a monthly lesson learned bulletin and they also discussed managing patient risk within the team. However, staff said shared learning was inconsistent across the wards due to staffing issues, the high use of bank or agency staff and team meetings not taking place.
- The monthly governance meeting minutes for March to May 2018, attended by the senior leadership team,

showed evidence of reported incidents being reviewed. No incidents discussed referred to medicince, the lack of stock or administration issues. This showed the incident reporting procedure around medicine management was not embedded in practice and the system of reporting incidents, to the deputy hospital manager, was not effective in escalating concerns. This meant themes and trends around medicine management were not identified and so no lessons learned or changes in practice implemented.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure sufficient quantities of prescribed medicines for people using the service.

The provider must ensure the safe management and administration of medicines in accordance with the provider's Safe and Secure handling of Medicines policy.

The provider must ensure the incident reporting system is used in line with provider's policy to record when medicines are not available, as staff had not reported incidents on the provider's system and were unclear of the incident reporting criteria.

The provider must ensure staff nurses complete the competency assessment to administer and manage medicines.

The provider must ensure there is oversight of the clinical monitoring and safety of patients medicines.

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

Action the provider SHOULD take to improve

The provider should ensure the process for raising safeguarding concerns with the local safeguarding board are consistent and reported in a timely way.

The provider should ensure equipment to monitor the physical observations is available on all wards.

The provider should ensure High Ash and Larches wards have cleaning rotas or records in place for the clinic rooms.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed to provide sufficient quantities of prescribed medicines for people using the service. Overall 25 out of 53 (47%) of patients present at the hospital had been affected by the absence of medicines prescribed to them on 207 occasions in the three months prior to the inspection visit. There was no oversight of the clinical monitoring and safety of patients medicines. The provider failed to provide the safe management, administration and disposal of medicines in accordance with the provider's Safe and Secure handling of Medicines policy. We found no evidence in incident reports or case notes of this policy being followed and any reliable mechanism to monitor and manage the reliable supply of medicines. We found the policy was not followed for the safe disposal of medication. The provider failed to provide the staff nurses with assessment training to demonstrate their competency to administer and manage medicines. The provider failed to provide oversight of the reporting of incidents to identify themes and trends around medicine management and lessons learned or changes in practice are implemented. This was a breach of regulation 12 (1) (2) (a) (b) (c) (e) (f) (g)