John Munroe Group Limited

John Munroe Hospital - Rudyard

Inspection report

Horton Road
Rudyard
Leek
ST13 8RU
Tel: 01538306244
www.johnmunroehospital.co.uk

Date of inspection visit: 05 January 2022
Date of publication: 17/03/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

John Munroe Hospital – Rudyard is part of the John Munroe Group and is an independent mental health hospital that provides care, treatment and rehabilitation for up to 57 adults, aged 18 or over, with long-term mental health needs services. Edith Shaw Hospital is also part of the John Munroe Group and is located nearby.

The service was most recently inspected in August 2021. We carried out this inspection to follow up on concerns raised at a focussed inspection in January 2021 where the service was rated as inadequate and placed in special measures. We also served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within four days that described how they would address our concerns. The provider's response did not provide enough assurance that they had acted to address immediate concerns.

Due to the serious nature of the concerns we found during the August 2021 inspection, we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and imposed additional conditions on the provider's registration. This included a condition to restrict the provider from admitting any new patients to John Munroe Hospital – Rudyard without the prior written agreement of the Care Quality Commission. This inspection rated John Munroe Hospital – Rudyard as inadequate and placed it into special measures.

On 1 December 2021 John Munroe Group announced to CQC they planned to close the John Munroe - Rudyard site on 28 February 2022 due to the cost of changes and maintenance required to the building and staffing pressures due to the service's rural location. The commissioners were working with people to find suitable alternative placements.

This inspection commenced on 5 January 2022 and was an unannounced, focussed inspection to see what improvements the provider had made. Our inspection focussed on the concerns we raised to the provider following our previous inspection.

We found improvements in some areas of the service during this inspection, but some serious concerns remained. As a result, the additional conditions on the provider's registration remained in place. This included a condition to restrict the provider from admitting any new patients to John Munroe Hospital – Rudyard without the prior written agreement of the Care Quality Commission. This inspection rated John Munroe Hospital – Rudyard as inadequate and kept it in special measures.

Our rating of this location stayed the same. We rated it as inadequate because:

- The service was due to close in eight weeks and five out of seven patient records we spoke to did not know their discharge destination.
- Discharge was not adequately planned, co-ordinated and communicated to meet the safe and timely discharge of patients.
- The environment was not always fit for purpose. The building did not meet fire and electrical testing requirements.
- We found maintenance concerns had not always been raised and addressed.
- Fridge temperatures had not been recorded regularly and patient fridges consisted of food that had been opened and not labelled correctly showing when it was opened and when it should be consumed by.

Summary of findings

- Not all staff had up to date mandatory training. Training compliance levels were lower than the providers target of 80% for safeguarding training children training, health and safety training, diabetes awareness and manual handling training.
- Staff were not appropriately supervised or supported in line with the provider's policy.
- Patients did not always have a care plan in place that was detailed and personalised for all areas of care.
- Governance processes in place were not effective and performance and risk were not managed well.
- Staff did not feel respected and valued by senior people in the organisation.

However:

- Staff used approved restraint techniques and patients were not exposed to unnecessary risks of harm and abuse.
- Senior management now reviewed all incident on CCTV to ensure all incident report are an accurate reflection of incidents and all lessons learnt are identified and shared.
- The provider had a process in place to ensure all safeguarding incidents are identified, recorded and reported.
- Ligature anchor points and blind spots were identified, risk assessed and had clear mitigation in place.
- The environment was safe and free from sharp objects and fixtures were secured or removed.
- Waste was now being disposed of appropriately. There were no clinical waste bags and general waste bags stored outside wards or within patient areas.
- Staff followed infection control measures in line with the provider's policy and visitors were asked to wear clinical face masks as soon as they entered the service.
- Emergency grab bags were secured effectively and had completed checklists in place.
- Staff were aware of the rapid tranquilisation policy
- Medication was stored at the recommended temperature and guidance was in place for what actions staff should take if medication fridge temperatures were out of range.

This service remains in special measures. Services placed in special measures would usually be inspected again within six months. As the provider had decided to close the service CQC will not be going out to reinspect the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	John Munroe Hospital provides two core services: • Long stay rehabilitation mental health wards for working age adults. • Wards for older people for mental health problems. The provider states that it provides a rehabilitation service, however the model of mental health rehabilitation does not meet recognised national guidance. Wards for older people with mental health problems provide assessment, care and treatment for people whose mental health problems are often related to ageing. This may include a combination of psychological, cognitive, functional, behavioural, physical and social problems. Wards for older people with mental health problems is a small proportion of hospital activity. We have reported findings for both core services under the long stay rehabilitation mental health wards for working age adults' section.

Summary of findings

Contents

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 providers 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 – Rudyard is one of two hospitals run by the John Munroe Group Limited.

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

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

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

- Horton is a male-only ward that supports up to 16 patients with chronic or complex mental health needs.
- Kipling is female-only ward for up to 16 patients with chronic or complex mental health needs.
- Rudyard is a male-only ward that supports up to 11 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. At the time of this inspection this ward had been closed.

The board had decided to close the site by 28 February 2022 and at the time of the inspection Larches was closed and there were only 39 patients at the service.

At the time of inspection, there was a registered manager in place.

We most recently carried out a focused responsive inspection at John Munroe Hospital in August 2021, when we rated the location overall as inadequate. Following the inspection, we told the provider it must take actions to improve.:

What people who use the service say

We spoke to seven people who use the service and one relative.

People who use the service told us they felt safe, were able to raise concerns if they had any and staff treated them with respect and were caring. All seven patients knew about the hospital closing and were anxious about the changes and where they would be placed.

The one relative we spoke to was unhappy about the decision the provider had taken to close the service and was worried about the impact this would have on their relative.

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- spoke with the registered manager
- spoke with 17 other staff members including; nurses, therapy lead, activities coordinators, consultant psychiatrists, support workers, and facilities team members
- spoke with the local independent mental health advocate team
- attended one morning meeting
- looked at 12 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the provider.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to improve:

- The provider must ensure that food fridge temperatures are taken daily, and any opened food is clearly labelled stating when it was opened and when it should be consumed by. (Regulation 12 (2)).
- The provider must ensure patients physical health care needs are recorded within care records and health needs are escalated to appropriate professionals when required. (Regulation 12 (2)).
- The provider must ensure all ligature risk assessment available to staff on the wards are up to date and reviewed regularly. (Regulation 12 (2)).
- The provider must ensure visual checks of oxygen cylinder gauge or valve handle are completed during emergency grab bag checks. (Regulation 12 (2)).
- The provider must ensure the environments of dementia wards are dementia friendly. (Regulation 15(1)(2)).
- The provider must ensure effective processes are in place for staff to raise maintenance concerns and for the facilities manager to be aware of ongoing maintenance. (Regulation 15 (1) (2).
- The provider must ensure electrical testing requirements and fire safety regulations are met for the building. (Regulation 15 (1) (2).
- The provider must ensure it works effectively with clinical commissioning groups to ensure patients are safely discharged. (Regulation 17).
- The provider must ensure that patients and their families are fully engaged and informed about planned discharges. (Regulation 17).
- The provider must ensure effective systems and processes are in place to ensure all patients have a care plan in place that is personalised, and goal orientated. (Regulation 17).
- The provider must ensure effective systems and processes are in place to ensure all patients have activities plans in place developed by the occupational therapy team. (Regulation 17).
- The provider must ensure effective systems and processes are in place to ensure all patients have a discharge plan in place. (Regulation 17).

Summary of this inspection

- The provider must ensure effective systems are in place to ensure staff on the wards have access to current discharge plans. (Regulation 17).
- The provider must ensure it has effective governance systems and processes which must be established and operate effectively. These should enable the provider to assess, monitor and improve the quality and safety of their services. (Regulation 17(1)(2)).
- The provider must ensure all staff receive managerial supervision in line with the provider's policy. (Regulation 18 (2)(a)).
- The provider must ensure staff have completed all mandatory training. (Regulation 18 (2)(a)).
- The provider must ensure they carry out an effective risk assessment before employing staff members with a criminal conviction, which considers their role alongside the disclosure made and clearly states the measure they will put in place to ensure patients are safe. (Regulation 18 (2)).

Action the provider SHOULD take to improve:

- The provider should ensure that cleaning records are completed regularly. (Regulation 17).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Requires Improvement
Responsive	Inadequate
Well-led	Inadequate

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

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Not all areas of the wards were well maintained. However, improvements had been made on the safety and cleanliness of the wards.

Safety of the ward layout

Staff now completed environmental risk assessments of all ward areas, we found these removed or reduced identified risks. Ligature risks previously identified had now been mitigated and ligature reducing showers were now in place in all communal bathrooms. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. Staff we spoke with demonstrated an understanding of the ligature risks on the ward and knew where to find the ligature risk assessment. Staff confirmed there were no patients at the hospital who had been assessed as at risk of ligaturing. However, not all ward ligature risk assessments gave clear guidance on specific mitigating actions. The ligature risk assessment on Horton had not been updated and did not record the installations of the ligature reducing shower heads.

Staff could now observe patients in all parts of the wards. Blind spots were mitigated using converse mirrors so staff could observe all parts of the wards. The provider had installed convex mirrors. The mirrors mitigated blind spots identified at our previous inspection and allowed staff to observe all parts of the ward.

Maintenance, cleanliness and infection control

Equipment being used by staff and patients was safe. Hoists now appeared to be safe and maintenance checks for these had been completed. However, ward areas had not been well maintained. There was an out of order bathroom on High Ash and broken cupboard doors on Horton. Staff had not reported these on the maintenance helpdesk. The fire alarm maintenance record showed the service did have automatic fire detection devices in all cupboards and voids making it non-compliant with fire standards and regulations.

Staff disposed of clinical and non-clinical waste safely. This had improved since our previous inspection.

All ward areas were visibly clean, but staff did not keep cleaning records up to date to demonstrate regular cleaning took place. We found staff had not always completed cleaning records of all wards between 1 January and 5 January 2022. Cleaning audits identified actions and now recorded the date of when those actions had been completed. This had improved since our previous inspection where we told the provider they must ensure all audits including cleaning audits give a clear outline of actions identified, who is responsible to complete them and when they should be completed.

We continued to have concerns about the way staff managed fridge temperatures and food hygiene. Staff on High Ash continued not to label food stored in the ward fridge with details of the date opened and when it should be consumed by. No fridge temperature recordings were found for the fridges on High Ash. We found gaps in the fridge temperature recordings for Kipling, Horton and Rudyard between December 2021 and January 2022. Staff informed us the fridge thermometer on Horton had not been working since November 2021. Staff told us they had reported this to the maintenance team, but no record of this request was found. This increased the risk of patients consuming spoiled foods.

Staff followed the provider's infection control policy. Staff followed good hand hygiene practices, all staff were bare below the elbow and there was adequate personal protective equipment (PPE) available. Staff asked visitors to ensure they were wearing the appropriate PPE. We saw visitors on site wearing the correct PPE as per the providers infection control policy and guidelines which recommended everyone in the hospital wears Type IIR Fluid Resistant Surgical masks as a minimum. This had improved since our previous inspection where we told the provider they must ensure staff and visitors follow PPE guidelines outlined in their infection control policy and national guidance.

Clinic room and equipment

Staff did not always check, maintain, and clean all equipment. At the previous inspection we asked the provider to ensure emergency grab bags are secured effectively and have completed checklists in place. At this inspection we found this had improved and staff now checked and secured emergency grab bags. We found all emergency grab bags sealed and staff checked content expiry dates weekly against an attached list of contents and expiry dates. Staff only opened emergency grab bags if the seal was no longer intact. This meant there was no visual check of the oxygen cylinder gauge or a check to see if the valve handle turned easily. Staff would not know if the oxygen cylinder was always fit for use in an emergency. However, clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medication.

Safe staffing

The service had enough nursing and medical staff, who knew the patients on shift. But staff had not received all basic training to keep people safe from avoidable harm.

Mandatory training

Not all staff have the right qualifications and skills to do their job. The overall mandatory training rate was at 81% for the hospital including bank and agency staff. This reached the providers target of 80% compliance rate. However, training compliance was lower in some key areas such as children's safeguarding training at 77%, diabetes awareness training at 68%, health and safety training at 74% and manual handling training at 74%.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

At the previous inspection we had told the provider to ensure all staff had completed basic life support training and safeguarding children's training. Staff basic life support training and safeguarding children training rates had now improved. Basic life support training had improved from 62% to 85% compliance and safeguarding children's training had improved from 70% to 77% compliance. However, the children's safeguarding training compliance rate did not meet the providers target compliance rate of 80% compliance.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient and reviewed these regularly, including after any incident. We looked at 12 patient records, all assessed the patients' risks and detailed how staff should manage them. COVID-19 risk assessments were now in place including details around patient compliance with COVID-19 testing.

Management of patient risk

Staff we spoke with knew about risks associated with each patient and these were now effectively recorded in individual risk assessments. Staff completed patient observations in line with best practice. This had improved since our previous inspection. We found patient observation records were an accurate reflection of patient behaviour or activity. Staff now managed risks after an accident or incident. They completed body maps with patients if injuries had been sustained, logged if additional observations had been carried out to keep patients safe and recorded when debriefs were completed with staff and patients.

Use of restrictive interventions

Staff now made attempts to avoid using restraint by using de-escalation techniques. During a review of close circuit television (CCTV) footage, we saw patients being redirected to other areas of the wards by staff before incidents escalated.

We reviewed eight incidents with CCTV footage where we saw incident reports gave an accurate description of the incident. The provider now routinely audited the use of restraint techniques during patient incidents against corresponding CCTV footage. Each incident was now reviewed by the manager, physical restraint training instructor and quality assurance team to ensure patients were not exposed to the risk of harm and the use of restraint during incidents was necessary and proportionate. However, we saw one example of staff pointing their finger at a patient during an incident. The manager had reviewed this incident and had addressed this with the member of staff through managerial supervision. The provider had shared lessons learnt from this incident with staff through the weekly lessons learnt bulletin.

Staff were now aware of the providers policy to complete physical observations with patients following the administration of rapid tranquilisation. We could not monitor whether staff had followed the policy as the service had not administered any rapid tranquilisation since our previous inspection.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain clinical records.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

All staff including bank and agency staff had easy access to patient notes. Notes informed staff them of the patients' risks, needs and ensured staff had a good understanding of patients care needs.

The provider had implemented a new electronic care planning system in August 2021, which at the time of our previous inspection we found had not been fully embedded. Staff told us they were now confident in using the new system. All staff had received training on the system and the provider had implemented super users. Managers felt the system could deliver what was needed and was now fully embedded.

Medication management

The service used systems and processes to safely store medications.

At this inspection we did not complete a full review of medication management. We looked at specific areas of improvement identified in the previous inspection. Actions relating to medication management identified from the previous inspection had been addressed. Records showed staff took medication fridge temperatures daily and there was clear guidance displayed on actions to take if fridge temperatures were not within the recommended temperature range.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to report concerns.

Following our previous inspection, we told the provider they must ensure systems and processes are established and operated effectively to prevent abuse. During this inspection we found actions by the provider had been enough to meet this requirement. All incidents were reviewed by the service manager and quality assurance team member, and the incident record clearly stated if further actions were taken, when lessons learnt were shared or if safeguarding referrals were made.

At the previous inspection we told the provider they must ensure staff completed safeguarding children training. At this inspection we found the provider made safeguarding adults and safeguarding children training available to staff. However, staff compliance with safeguarding adults training had decreased from 88% at our last inspection to 81% but safeguarding children's training compliance had increased from 70% from our last inspection to 77%. The safeguarding children's training did not meet the providers target of 80% compliance.

We were assured staff identified and escalated concerns of abuse or improper treatment of patients in the service. Staff we spoke to were aware of how to raise concerns and felt confident to approach the service manager.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and report them appropriately. Managers investigated all incidents and shared lessons learned with the whole team and the wider service.

Staff reported serious incidents in line with the provider's policy. Staff gave an accurate description of incidents. During our review of incidents, we saw every incident had been reviewed by the service manager. The service manager recorded an overview of the findings, actions taken, lessons learnt and whether it had been reported to the CQC and local safeguarding team.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We were assured the provider investigated all incidents thoroughly. Senior staff had access to CCTV footage to support incident investigations. During our CCTV review of concerns about staff conduct with patients, we found the provider had already identified and taken action against a member of staff through focused supervisions and sharing lessons learnt.

Staff told us managers debriefed and supported staff after any serious incident. Incident records showed when a debrief was offered to staff and patients.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Inadequate

Our rating of effective stayed the same. We rated it as inadequate.

Assessment of needs and planning of care

There was very limited or no outcomes of care and treatment. Necessary action was not taken to improve patient's outcomes. Not all areas of care planning were personalised, and recovery orientated, and staff did not always follow the guidance within these plans to raise health concerns effectively.

Staff told us they completed a comprehensive mental health assessment of each patient either on admission or soon after and evidence of these were now in place within patient records.

Patients had their physical health assessed soon after admission. However, staff did not always follow patient care plans when managing the needs of patients with diabetes. Staff did not always take appropriate actions or escalate concerns when patient blood sugar levels were not within the optimum range. We saw records where staff had not followed care plans to escalate or manage when a patient's blood sugar level was not at the optimum range. This included no record of contact with a GP or 111 and no escalation to the physical health lead during the services morning multidisciplinary meeting.

Not all care plans were personalised in a consistent way and not always holistic or recovery orientated. All patient records now had personalised care plans in place for infection control, stating the individuals COVID-19 vaccination status and compliance with COVID-19 testing. However, this level of personalisation and detail was not consistent in all areas of care. We saw one patient record which stated an individual had diabetes and did not need blood sugar to be monitored daily but there was no detail on how often it should be monitored.

We found little evidence of individual patient goals within care plans. Care plans continued to lack detail and did not have patient specific occupational therapy led activities plans. The impact of the providers decision to close the service was felt by patients and staff on the wards, with a marked decrease in activities. The occupational therapy team had a plan to increase patient activities provided at the ward level but had been required support ward staffing levels during COVID-19 sickness. Records showed involvement from the therapies team varied from patient to patient. Seven of the 12 patient records we viewed showed involvement from the therapies and activities team and five did not show any involvement. Where records were in place staff recorded patient participation, and where patients had received one to one support.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff recorded patient preferences and involved patients or family members in the development of care plans. Care plans were written in the first person or from the patient's perspective. There was some detail on patient likes and dislikes specific to patient treatment and intervention.

As the provider had decided to close the service by 28 February 2022, all discharge plans and care progress assessment meetings were being managed centrally from the provider's head office. Discharge plans and records available to staff providing care to patients on the wards were not always up to date and did not include the current discharge plans. One record viewed stated a patient had not had a care progress assessment meeting since March 2021, but the records held at head office stated the last meeting was on 6 December 2021. The meeting had included a full multi-disciplinary team discussion including incidents and therapy input that would help the patient meet their goals, but this information had not been communicated to staff at ward level. This meant staff at ward level did not know the patient's holistic treatment plan.

Skilled staff to deliver care

The ward teams had timely access to the full range of specialists required to meet the needs of patients on the wards. Managers did not always support staff with supervision.

The ward teams now consisted of a full range of specialists including occupational therapist, psychologist, assistant psychologist and activities coordinators. Patients had access to therapists on site, even though the lead psychologist worked remotely, an assistant psychologist was on site to provide therapies.

At our previous inspection we had told the provider they must ensure all staff receive managerial supervision in line with the provider's policy. At this inspection we found this had not improved. There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Managers did not always support staff through regular, constructive appraisals of their work. We found 22 out of 23 support services staff including maintenance, domestic, cleaning and administrative staff had not received a three-monthly supervision in line with the providers policy.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not work together as a team to benefit patients, specifically personalised care planning and activities not being delivered. They did not support each other to make sure patients had no gaps in their care and did not always communicate this effectively to staff on the wards or to patients.

Staff from different disciplines including occupational therapists and psychologists did not always work together to benefit patients. Records we viewed showed input from different disciplines varied from patient to patient. Seven of the 12 patient records showed regular one to one time, support and activities whereas five did not. We found the level of involvement was dependant on the level of engagement the patient was able to have. Those who were less able to engage with the services had limited involvement whereas those with the capacity to participate had detailed plans in place. Therefore, patients did not have equal access to therapeutic recovery orientated treatment.

Staff held handover meetings where each patient and any incidents were discussed. There were daily morning meetings where all issues including maintenance, health and safety concerns, lessons learnt, incidents, staffing and complaints and compliments were discussed. These meetings were attended by the registered manager, nurses, physical health needs lead, maintenance and ward managers. Information from this meeting was fed back to staff on the wards through the shift handover meetings. However, we found physical health needs were not always escalated at these meetings. We

Long stay or rehabilitation mental health wards for working age adults

Inadequate

found on 4 January a patient with diabetes had blood monitoring that was not within the normal range, and this had not been raised to the physical health needs nurse at the morning meeting. After the inspection we asked the provider to ensure specific physical health concerns are raised and discussed at the morning meeting including patient blood sugar levels.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Requires Improvement

Our rating of caring improved. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness but did not always respect patients' dignity.

During the inspection we observed that staff were discreet, respectful and responsive when caring for patients. We saw many positive interactions between staff and patients including singing along with patients, assisting patients to make meals and providing reassurance when patients became anxious.

We saw staff used approved restraint techniques which were in line with the provider's Restraint Reduction Management of Aggression Policy, which promotes treating everyone with dignity, respect and compassion. We saw examples of staff engaging with patients positively during incidents to de-escalate or better understand the behaviour being presented, including re directing patients to different areas of the ward before incidents escalated. However, we saw one occasion of where a staff member displayed negative body language pointing their finger at the patient when speaking to them. The management team had reviewed the incident, identified this as an area where lessons were learnt and shared through their staff bulletin and individual focused managerial supervision.

Involvement in care

Staff involved patients in care planning and risk assessments, but views were not always reflected within discharge planning. Staff on the wards were not always able to give patients an update on discharge plans.

Involvement of patients

Staff involved patients and worked collaboratively with them to develop their care plans and risk assessments. The care records we looked at demonstrated patient or family member involvement in specific areas of care or logged if they had refused involvement. Staff now recorded patient choice and preferences within care records. Where patients were not engaging with staff, we saw plans of to build a rapport with patients. However, as the service was due to close availability of this was limited as the primary focus of the service was around patient discharge. The patients we spoke to were anxious about the service closing and the uncertainty this brought to where they would be placed. Records on the wards were not up to date around discharge plans and this increased the anxiety about the future.

Staff made sure patients could access advocacy services. The advocacy services we spoke with did not have any concerns about the service. They had been approached by the provider and commissioners to support patients and families during the closure of the service.

Involvement of families and carers

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff informed and involved families and carers with care needs.

Staff supported, informed and involved families or carers. We spoke to one family member during the inspection. They told us they were involved in meetings about their relative's care. The family member told us they felt their relative was receiving really good care at the service and was very settled. They were anxious about the closure and the impact the change would have on their relative's behaviour and health.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Inadequate

Our rating of responsive stayed the same. We rated it as inadequate.

Access and discharge

The provider did not plan discharge well with people. Discharge plans were not clear, did not meet the needs of patients and families, and were not communicated with relevant services and stakeholders to ensure safe, effective and timely discharge. Patients were anxious due to the uncertainty of their future placements.

Discharge and transfers of care

At the time of the inspection the service was preparing to close and was working closely with the placing commissioners to plan patient discharges. Staff based at head office managed patient records and meetings specific to discharge following the providers decision to close the service. We reviewed nine patient discharge records at head office and found records showed seven patients had not received a discharge planning meeting since the announcement the service would close. One patient's next discharge planning meeting was not until 7 February 2022. This increased the risk of discharge not being planned effectively and patients being placed inappropriately. Placing commissioners informed us all patients had received discharge planning meetings, but patient records did not reflect this.

Records did not demonstrate discharge conversations were being recorded effectively and being communicated to staff and patients on the wards. Six of the 12 records we viewed at ward level did not clearly state what the plan for discharge was. This increased the risk of exposing patients to unnecessary anxiety as the staff on the wards were not always able to give an update on discharge plans. All patients we spoke with were aware of the plans to close and were anxious about the closure and their discharge. Three of the seven patients did not know where they were moving to or what the discharge plans there were for them. Two patients were aware of a plan and when they were moving, and two patients knew staff were looking for a suitable placement.

Ward teams had effective working relationships with external teams and organisations. We saw evidence of Care Programme Approach (CPA) meetings involving commissioners and families. However, discharge was not always discussed at these meetings. In two of the nine patient records we viewed the discharge planning section had not been completed.

Staff did not always discuss discharge with personalised goals and patient preferences in mind at Care Programme Approach meetings. On two Care Programme Approach plans reviewed for the discharge plan stated, the patients would be discharged to a suitable nursing home but there were no goals around how this would be achieved. Staff did not record patient preferences around where the patient would like to be placed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Five of the seven patients we spoke with were unaware of where they would be discharged to even though the service was due to close within eight weeks.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom but not with an en suite bathroom.

Each patient had their own bedroom, which they could personalise. However, at the previous inspection Larches provided only one toilet and one bathroom to meet the needs of six patients. We had asked the provider to identify suitable contingencies. At the time of this inspection, we found the provider had closed Larches.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients. The environment in the dementia specialist ward was not suitable for patients with dementia.

Rudyard is a dementia specialist ward but was not dementia friendly. Staff had completed a dementia friendly assessment of the ward in July 2021 and found communal areas were sparse, lacked visual stimulation and the layout of the ward prevented all areas from being easily observed. The service had since put an action plan in place but due to the provider's decision to close the service all actions had not been completed. At the time of the inspection six patients remained admitted to the ward.

Listening to and learning from concerns and complaints

The provider had improved the complaints audit from the previous inspection and now identified when a complaint was received, the nature of complaint, the actions taken and the date of response. The audit showed if staff dealt with a complaint within timescales outlined in the provider's policy.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were discussed daily as part of the morning meeting to ensure there was recognition of good work.

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

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Culture

Staff did not feel respected or valued by the directors of the company, but they told us they felt supported by the service manager since the service had announced its decision to close. We saw evidence of the management team addressing poor culture through training, sharing lessons learnt and reviewing of CCTV.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

At the previous inspection we identified significant concerns with the culture at the service within staff teams. CCTV showed evidence of incidents of improper and ill-treatment of patients by staff on CCTV that had not been reported. We reviewed several clips of CCTV during this inspection and found staff engaged patients well and de-escalated incidents before they occurred. Where issues did arise, the management team had a process in place to review and investigate incidents and share learning.

Staff told us they felt comfortable raising issues to the Freedom to Speak Up Guardian. We saw 11 issues had been raised and addressed through the freedom to speak up guardian in the last two months.

All staff we spoke with felt the registered manager was supportive, approachable and had been available for support since the provider had taken the decision to close the service. However, staff we spoke with felt the provider's communication about job security had been poor following the closure announcement. This led to staff feeling devalued and not respected.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

There were still no effective maintenance logs in place. Staff were not using the new helpdesk log that had been developed since the last inspection. We found several maintenance jobs across the service including an out of order bathroom, a thermometer not working in a ward patient fridge and broken cupboard door handles that had not been reported. This meant the facilities manager still had no oversight over the jobs that needed completing across the service. Some staff we spoke to knew of the new helpdesk log, whereas others said they would raise issues to the nurse in charge or would email the maintenance team. As a result, there was still no clear log or way of knowing what maintenance issues were outstanding on the site as jobs that had been emailed through to the maintenance team were not transferred onto the helpdesk log.

This was highlighted as a concern when we found the patient fridge on Horton did not have a fridge thermometer for staff to record patient fridge temperatures from November 2021 onwards. The maintenance team told us the thermometer was not an issue and had been resolved, whereas ward staff stated they had emailed the issue to the maintenance team. There was no record of this job request.

During our previous inspection we found the provider did not have oversight on issues that could disrupt the service. The management team had now addressed this by ensuring all utility providers copy the facilities manager into their correspondence. However, we still found not all maintenance work and building safety work had been completed in line with regulations. The service did not have up to date fixed wiring certificates and was not deemed to be compliant with fire regulations. The maintenance team had mitigated immediate risk temporarily by regularly testing the fire alarm system in place. The building was at an increased risk of undetected fires as all cupboards and voids did not have automatic fire detection devices fitted as required by fire regulations. The board had recognised the limitations of the building and whether it was fit for purpose which had led to their decision to close the service.

The governance meetings staff held discussed a variety of provider wide topics from all locations including incidents, staffing, safeguarding and complaints and now had a process in place to review actions from previous meetings.

Meeting discussions were now an accurate reflection of the service, with a discussion around ongoing investigations. However, we found some areas such as staff supervision compliance levels were not discussed in detail and did not give the board oversight in the gap of managerial supervision levels for staff. The discussion on this area did not include the staff supervision compliance levels.

The governance meetings gave an overview of incidents that had occurred and how lessons had been learnt from them and shared with staff. They now included themes from compliments and complaints to give the board additional oversight of the services they provide.

The provider completed investigations including root cause analysis for incidents and complaints. The quality of reporting had now improved. All incidents had been reviewed against CCTV footage (where possible as the service only has CCTV in communal areas). Incidents were investigated effectively, actions had been taken and lessons learnt had been shared.

The provider now had a process in place to review and audit CCTV outside of investigations to ensure all incidents were recorded effectively. The provider's reports to CQC were now detailed and identified concerns from the incidents and CCTV. For example, reports now identified wider issues such as staff not wearing masks, or staff pointing their finger at patients or poor moving and handling of patients.

Managers had still not provided appropriate managerial supervision and support to staff. We found 22 support services staff including maintenance, domestic, cleaning, and administrative staff had not received a three-monthly supervision in line with the providers policy.

Management of risk, issues and performance

The providers electronic care planning system now provided staff with access to the information they needed to provide safe and effective care to patients. Managers had audit systems in place to check if care plans and risk assessments were in place, but these systems now checked the quality of the information record as well.

At the previous inspection we found the implementation of the new care planning record system had not been effective, meaning not all staff were confident in using the new system or accessing information. At this inspection we found the system had now become embedded and all staff we spoke with told us they were confident in using the system and had access to all information they needed. The system now had the necessary templates for all disciplines including occupational therapy.

At the previous inspection we told the provider they must ensure they carry out an effective risk assessment before employing staff members with a criminal conviction, which considers their role alongside the disclosure made and clearly states the measure they will put in place to ensure patients are safe. At this inspection we found this had not improved. The provider had not reviewed risk assessments and mitigating actions in place when employing staff with a criminal conviction. After the inspection we asked the provider to update these immediately and the risk assessments in place were now detailed and included measures the provider had taken to ensure any risks posed by the previous convictions were mitigated against. This was now in line with the provider's recruitment policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that food fridge temperatures are taken daily, and any opened food is clearly labelled stating when it was opened and when it should be consumed by. (Regulation 12 (2)). • The provider must ensure patients physical health care needs are recorded within care records and health needs are escalated to appropriate professionals when required. (Regulation 12 (2)). • The provider must ensure all ligature risk assessment available to staff on the wards are up to date and reviewed regularly. (Regulation 12 (2)). • The provider must ensure visual checks of oxygen cylinder gauge or valve handle are completed during emergency grab bag checks. (Regulation 12 (2)).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider must ensure the environments of dementia wards are dementia friendly. (Regulation 15(1)(2)). • The provider must ensure effective processes are in place for staff to raise maintenance concerns and for the facilities manager to be aware of ongoing maintenance. (Regulation 15 (1) (2). • The provider must ensure electrical testing requirements and fire safety regulations are met for the building. (Regulation 15 (1) (2).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure it works effectively with clinical commissioning groups to ensure patients are safely discharged. (Regulation 17). • The provider must ensure that patients and their families are fully engaged and informed about planned discharges. (Regulation 17). • The provider must ensure effective systems and processes are in place to ensure all patients have a care plan in place that is personalised, and goal orientated. (Regulation 17). • The provider must ensure effective systems and processes are in place to ensure all patients have activities plans in place developed by the occupational therapy team. (Regulation 17). • The provider must ensure effective systems and processes are in place to ensure all patients have a discharge plan in place. (Regulation 17). • The provider must ensure effective systems are in place to ensure staff on the wards have access to current discharge plans. (Regulation 17). • The provider must ensure it has effective governance systems and processes which must be established and operate effectively. These should enable the provider to assess, monitor and improve the quality and safety of their services. (Regulation 17(1)(2)).
Regulated activity	**Regulation**
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure all staff receive managerial supervision in line with the provider's policy. (Regulation 18 (2)(a)). • The provider must ensure staff have completed all mandatory training. (Regulation 18 (2)(a)). • The provider must ensure they carry out an effective risk assessment before employing staff members with a criminal conviction, which considers their role alongside the disclosure made and clearly states the measure they will put in place to ensure patients are safe. (Regulation 18 (2)).