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?	
Are services effective?	
Are services responsive?	
Are services well-led?	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We found:

- Staff had limited access to swipe cards and keys, reducing their freedom of movement and their ability to respond to alarms and patient need. Although we could not find evidence that this had led to an increase in assaults the potential risk was evident and a concern to staff.
- Personal alarms were not in regular use and were limited in supply. A nurse call system allowed staff to call for an emergency response in all rooms and corridors provided an alternative. However, staff responses could be limited by the inability of staff to move freely between rooms.
- Some agency staff did not have training in the use of physical restraint and could not support permanent staff in managing aggression. This meant possible delays in responding to incidents as the staff team would need to wait until enough suitably trained staff were present before being able to safely restrain the patient.
- There was a lack of governance around the monitoring of staff on shift each day, their skill profile and distribution around the hospital. Each ward maintained an individual register but there was no central register for the hospital managers to refer to.
- The cleanliness and the management of bedding was a concern and we found no system in place to support its regular review and renewal when worn or soiled.

However:

- There were reliable systems in place to support the physical health needs of patients including access to a GP, community nursing team and specialist care. There was no evidence that staff had neglected the physical well-being of patients.
- Staff operated a transparent system of recording all transactions made on a patients behalf and made an effort to maximise the financial independence of patients. There was no evidence to support the claim that staff financially exploited patients.
- Inductions for agency staff and new bank staff were robust, and included an introduction to the patient's risk profiles and individual needs.
- The majority of staff were very positive about the responsiveness of management and the quality of support they received when incidents took place.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults		Not rated

Summary of findings

Contents

John Munroe Hospital - Rudyard

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to John Munroe Hospital – Rudyard

John Munroe Hospital is an independent mental health hospital providing care for up to 57 people with long-term mental health needs. The hospital, in Rudyard, provides treatment, nursing and care to people over the age of 18 whose complex mental health and challenging behaviours prevent them from having effective treatment in less restrictive settings. Most people who use the service are detained for treatment under the Mental Health Act 1983.

The registered provider for John Munroe Hospital is John Munroe Group Limited.

There was a registered manager in post at the time of our inspection.

The regulated activities carried out at this hospital are the assessment or medical treatment for persons detained under the Mental Health Act 1983, the treatment of disease, disorder or injury and diagnostic and screening procedures.

The hospital has five clinical areas:

Rudyard Ward offers an admission and assessment service for men and women with challenging behaviour who may have a diagnosis of dementia and may have a forensic history. The ward has 15 beds. It cares for adults and older people, aged 45 plus, with organic brain damage either due to alcohol or other substance misuse, or with early or late onset dementia.

Horton Ward offers an admission and assessment service for people with extremes of challenging behaviour and a diagnosis of functional mental illness or personality disorders. The service has ten beds for male patients and six for female.

The Larches was a male-only, six-bedded intermediate rehabilitation bungalow in the hospital grounds, independent from the main hospital.

Kipling Ward offers an admission and assessment service for female patients with challenging behaviour who have a mental illness or disorder. The ward has 13 beds.

High Ash was a female-only, seven-bedded intermediate rehabilitation bungalow in the hospital grounds, independent from the main hospital.

The Care Quality Commission (CQC) inspected the hospital on 23 and 24 February 2015 as part of its pilot comprehensive independent mental health inspection programme. We issued two requirement notices in relation to Regulation 12 of the Health and Social Care Act 2008, relating to safe care and treatment.

We re-inspected on 14 January 2016 with a focus on these outstanding concerns. Reports of all previous inspections with detailed findings can be found on the CQC website. The CQC had planned a comprehensive inspection of the hospital for November 2016. Concerns from staff at the hospital shared with the CQC led to earlier inspection visits in August 2016. This report details the findings made in regard to the concerns raised about clinical care and environmental risks notified to the CQC as whistleblowing concerns.

Our inspection team

The team that inspected the service comprised CQC inspector Michael Fenwick (inspection lead, a further three CQC inspectors supporting the team leader on the first inspection with the addition of a fourth CQC inspector on the second inspection.

Summary of this inspection

Why we carried out this inspection

We carried out a series of inspections in August 2016 in response to concerns raised directly to the CQC by two whistleblowers.

A person who reports wrongdoing in the place where they work is often called a whistleblower.

In CQC, the term 'whistleblower' 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 whistleblower 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 first whistleblower contacted the CQC on the 29 July 2016. Following discussions by phone and clarification of their concerns by email, an unannounced responsive inspection was organised for the 9 August 2016.

Concerns raised included::

- That staffing levels at the hospital were low and there was a lack of staff with training in Management of Actual or Potential Aggression (MAPA). MAPA is the approach to physical restraint used at John Munroe Hospital.They also felt that the use of agency nurses who did not have training in physical restraint put an extra burden on regular staff to work with the most challenging patients.
- That short staffing meant staff had to carry out multiple clinical observations (one to ones) undermining their effectiveness and compromising safety.
- Staff manually lifted patients from the floor without using hoisting equipment or appropriate techniques.
- There was a shortage of personal alarms for staff to use. There was also a lack of swipe cards and keys for the locked doors on the wards – so that staff were often left alone in rooms with aggressive patients without a way out.
- That staff had been segregating one male patient from his peers, keeping him in a room alone apart from accompanying staff. They raised concerns a further two patients who posed a risk to others and that known risks of sexual assault or vulnerability were not taken into account when allocating of staff to their care.
- That managers failed to support a member of staff following an assault or take their complaint seriously.
- That staff failed to attend to the continence care of some patients leaving them wet and unchanged.
- Qualified staff asking healthcare assistants, untrained in medication, to give prescribed medicines to patients when caring for them on one to one observations. That staff gave some patients medication being covertly in food.
- Finally, they felt the hospital was unclean. Cleaners were limited by time and resources and that ward staff had to attend to cleaning as well as their other duties.

The CQC investigated these concerns in an unannounced inspection and made findings that upheld some of them that we shared with hospital managers for urgent action.

Within two weeks of that inspection visit, a second member of staff contacted the CQC on the 23 August 2016 with their own concerns some of which overlapped with the first whistleblower.

The most significant of the second whistleblowers concerns were:

- That the managers had neglected the physical healthcare of patients, that patients had been over medicated, and a current concern they had raised about a patient's wellbeing had not been listened to by senior staff.
- They had specific concerns about the hospital environment, a lack of ventilation and adequate heating in some areas.
- They believed that managers were not using available patients' funds to meet their basic needs e.g. clothing and washing materials.

Summary of this inspection

- They shared the concerns of the first whistleblower had about the cleanliness of the hospital, continence care for patients and a shortage of staff trained in restraint.

In response, the CQC carried out a further unannounced inspection on the 26 August 2016 to the John Munroe Hospital site. We followed this up by a visit to the providers head office on the 31 August to interview the infection control lead and review historic case notes.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the three core wards at the hospital (Horton, Kipling and Rudyard) where concerns were focused, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the registered manager and their deputy, managers or acting managers for each of the wards
- spoke with seven qualified nurses and seven health care support workers. Two of the qualified nurses and one of the health care support workers were agency staff
- received feedback about the service from two local safeguarding leads
- spoke with the infection control lead
- spoke with the human resources and training managers
- spoke with the clinical pharmacist that supports the hospital
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management on three wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

On this occasion, we did seek the views of people who used 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?

We found:

- Not all staff had access to swipe cards and keys to open internal doors; this meant staff left alone with patients in locked rooms might not be able to leave in the event of an emergency. Managers were commissioning a new security system that would provide sufficient keys and swipe cards for all. However, there had been no immediate mitigation put in place to reduce this risk.
- Staff did not use personal alarms routinely and relied on the nurse call system. There were not enough alarms available for all staff on a shift to use and no clear guidance on when they should use them.
- Managers failed to maintain accurate records of staff on shift and could not provide the assurance of an accurate fire register in case of an alarm.
- Staffing levels regularly fell below planned establishment levels. Staff had brought their concerns to the attention of managers within the service. However, it was not possible to gauge the full extent of the problem due to poor record keeping.
- A patient constantly supported by two staff (two to one observations) received all care isolated from his peers and clinical staff had not recognised this as being segregation. Managers agreed to bring the patients care plans in line with the Mental Health Act code of practice and introduce the required safeguards.
- We found duvets, pillows and their protective covers in a poor state of repair. Ward staff had no routines for checking that bedding was cleaned or maintained to reduce infection risks. .

However:

- We found evidence of good practice around observations, including inducting staff to particular patient need. Staff were committed to engaging with patients being nursed on increased observation levels rather than passively watching.
- The majority of staff were happy about management support following serious incidents.
- We observed an incident of a staff member activating an alarm following an assault and other staff responding within two minutes although the incident occurred outside main ward areas.

Summary of this inspection

- After reviewing cleaning records of all bathrooms and bedrooms we found no evidence of any gaps in the cleaning regime. We found no significant odours or evidence or dust or other debris to suggest the hospital was unclean.

Are services effective?

We found:

- Medical staff only prescribed covert medication when supported by Best Interests Decisions for patients they had assessed as lacking capacity under the Mental Capacity Act and/or the authority of the Mental Health Act.
- We found no evidence to support claims that qualified nursing staff used support workers to dispense medicines.
- There was evidence of staff making regular checks on patients continence needs and demonstrated awareness of the risks relating to patient's skin breakdown or pressure ulcers.
- There was evidence of good access to physical healthcare including access to specialists when needed. Care records were detailed and clear in reporting discussions within the multi-disciplinary team and the involvement of the local GP in planning end of life care.

Are services responsive?

We found:

- The care environment was clean, dry and well ventilated and we could find no evidence of the damp or environmental hazards reported that had prompted our responsive inspection of this service.
- Staff operated systems for recording all financial transactions made on a patients behalf and made an effort to maximise the financial independence of patients.

Are services well-led?

We found:

- A lack of governance systems to record staffing levels day to day and highlight shifts not filled. Managers did not assess the number of restraint trained staff available to each ward on a shift by shift basis. As such, they could not effectively manage their resources and ensure an even distribution of suitably trained staff across the wards in line with potential risk. This put staff and patients at potential risk of harm.
- Managers did not routinely share lessons learnt from incident reporting with ward staff.

Summary of this inspection

- The majority of staff had expressed concerns about the lack of swipe cards. Managers were aware of staff concerns and planning a permanent solution with the use of capital funding. However, they had failed to implement short term measures to mitigate and monitor risk at the time of our inspection.

However:

- The majority of staff were positive about managers being open and approachable. Only a small minority of staff did not feel they could approach managers with their concerns without risking victimisation.
- Managers agreed to improve communication with staff and create regular forums for staff to participate in discussion of service development.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw in the use of covert medications that for people who might have impaired capacity, staff assessed and recorded their capacity to consent. They did this on a decision-specific basis with regards to significant decisions, and staff gave people assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Where appropriate and when they lacked capacity, staff made decisions in a patient's best interests.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- We found duvets and pillows on Horton ward within protective covers in a poor state of repair. Although we found some bedding to be worn and some protective covers showed sign of repair none were soiled or dirty. Staff had no clear routines for checking bedding or the regular cleaning of bedding to reduce potential infection risks. There was no evidence that the quality and cleanliness of bedding was subject to any regular audit.
- We saw up to date and complete cleaning records for all the bathrooms and bedrooms inspected. We experienced no significant odours or saw any evidence or dust or other debris. Managers did report that there was guidance on the amount of cleaning materials cleaning staff should use to control costs. They also reported some occasional delays in the ordering process could result in very short term shortages of cleaning materials. However, there was no evidence that these restrictions had led to the hospital being unclean.
- We discussed concerns about cleanliness on the wards and the management of potential infection risks with the infection control lead for the John Munroe Group. Management agreed to initiate a monthly bedding audit which would be included in the infection control audit schedule. The bedding audit tool would highlight any damaged items which required replacing. The provider also agreed that along with the bedding and mattress audits she would also review monthly cleaning audits and present a report for discussion at the clinical governance meeting.
- Hospital management shared with us a plan, approved earlier in August 2016, to develop infection control champions on each ward. They would receive more in depth training in infection control, its importance and how to encourage correct procedures i.e. hand hygiene and equipment cleaning. They would also attend regular meetings with the infection control lead to discuss progress.
- All staff had training in infection control and we reviewed the training materials used. They covered all essential points on how staff would identify and manage potential infection risks and safely dispose of any soiled materials. The infection control training package also included hand washing and discussions around cleaning in relation to cross infection.
- We discussed with staff the use of personal alarms and they told us that they did not routinely use them and relied on the nurse call system or calling out for help. Only the staff providing two to one observations for a male patient who liked to walk around the hospital and its grounds routinely used the alarms. We found that there were insufficient alarms available if all staff required them and managers had issued no guidance to staff on when it might be appropriate for alarms to be used..
- We observed staff from the wards respond promptly to an alarm call set off on an upper corridor where staff had taken personal alarms to support the care of a patient on two to one observations. The nurse call system was available in all rooms and when we tested it in an occupied bedroom on Horton ward there was a response from staff with two minutes. All staff we spoke with were familiar with this use of the nurse call alarm system.

Long stay/rehabilitation mental health wards for working age adults

- We reviewed incident reports involving assaults on staff and they did not support an increasing rate of incidents as alleged in the whistleblowing alert received. The majority of incidents of assault occurred in social areas where multiple staff were present.
- Plans were in place to replace the current alarm systems. The new system would allow greater control of the distribution of alarms and allow managers to track their use. On our second inspection visit, managers told us that the contractors had agreed a plan to complete installation in October 2016.
- There were a limited number of swipe cards and keys available for agency and bank staff. Regular staff had access to an allocated set of keys and swipe cards. Therefore, the scale of the deficit was dependent on the number of bank and agency staff on each shift. Staff without a set of keys or swipe card to hold for a shift were unable to open internal doors. The impact was to limit their ability to evade an attack or respond to a call for help from others. Staff not holding keys or swipe cards would also be limited in their ability to support patient needs e.g. taking a patient to the toilet.
- Permanent staff members told us of their frustration at having to lend their swipe card and keys to bank and agency staff to allow them to move around the ward. In some cases staff told us, they felt vulnerable if left in that situation. During our inspection we talked to one agency nurse in the communal area on Horton ward who had been left to supervise four patients. They did not hold a swipe card or keys and felt trapped.
- However, in an emergency the fire alarm would open all doors allowing staff to evacuate patients to safety. During our interviews with staff no-one reported having been involved in an incident where they had been trapped and were unable to summon help. The high volume of staff on the units meant other staff members were likely to be close by and if a staff member was left without a swipe card this would most likely be in a social area of the ward.
- The new security system would provide additional capacity for swipe cards and keys as well as incorporating personal alarms for all staff as described above. Managers had not considered any immediate measures to mitigate the potential risks of staff being isolated before the installation of this new system.

Safe staffing

- Managers had set out the required levels of staffing using a formula that took into account the number of one to one or higher observations on each ward. Further staff were then allocated to the patients requiring lower levels of observation in a fixed ratio of a member of staff per two patients during the day and one staff member per three patients at night on Horton and Rudyard wards. On Kipling, ward the staffing establishment was one member of staff to three patients on during daytime shifts and one to four at night.
- Due to vacancies, sickness absence, planned leave and the high number of patients being nursed on increased observations managers made regular use of bank and agency staff. In a review of staffing rosters relating to the three wards the maximum percentage of non-permanent staff we found on any one shift was 27% (three out of 11 support workers on duty).
- We reviewed agency bookings for July 2016 across the hospital and found that managers had made requests to cover 12% of all day shifts and 25% of night shifts with agency staff.
- On the first day of our inspection there was a shortage of staff on Rudyard ward with two staff absent from the 13 planned to be on duty. This was because of sickness phoned in that morning. Staff told us that staffing levels were regularly below the levels planned. Management did not systematically monitor the incidents of staffing shortages and their records did not allow any clear analysis to be made of the rates at which the wards were short staffed. However, managers did not challenge that this was the case and cited last minute report of sickness or the absence of booked agency staff as the main causes. When this happened ward managers could urgently book agency staff for that shift or find staff from another unit, if available, to fill the shortfalls.
- Permanent staff provided an induction for bank and agency staff to the service orientating new staff to the wards and introducing them to the patients.
- Both callers reported that the use of agency nurses, who did not have training in physical restraint, put an extra burden on regular staff to take on observations with the

most challenging patients. Permanent staff that we spoke with supported these concerns. However, only seven out of the eight permanent staff who commented said they felt safe on the unit.

- Records of the training in the use of physical restraint for permanent staff at John Munroe Hospital demonstrated that 89% (142 out of 159) up to date with their annual update. The training rates for the Birch agency who were the first choice to fill gaps in the rosters were 92% (38 out of 41) were up to date with training in restraint. Other agencies used did not provide training in restraint for their staff. Managers reported that they were trying to address this problem through continued review of the nursing agencies they were using and preferring those who could provide staff with Management of Actual and Potential Aggression training.
- From the information available, the majority of staff on any shift would always have restraint training. Managers agreed to monitor levels of staff with MAPA training and continue to seek suitably trained staff as a priority through permanent recruitment and reviewing their use of agencies.

Assessing and managing risk to patients and staff

- We reviewed the risk assessments of two patients, about who a whistleblower had raised concerns, and discussed their care with medical and nursing staff. In both cases staff had completed, reviewed and updated risk assessments and care plans highlighting potential risks around sexualised behaviours and that how care should be delivered to reduce risk. There was clear care planning around the risks of male staff working with a vulnerable female patient in delivering personal and staff on the ward told us this was followed. In the case of a male patient, a risk of sexually disinhibited behaviour was recorded and the care plan required that staff supporting this patients be experienced and familiar with the patient. A Care Programme Approach review from March 2016 recorded that staff should 'preferably' be male given the unpredictable aggressive and threatening behaviour. Staff had last updated the care plan in May 2016 and evaluated it monthly since then. We reviewed the observation record sheets and could not find evidence that two woman were ever allocated to his observations.
- On Kipling ward we found good practice in place around clinical observations. Three of the four patients had been risk assessed as requiring constant one to one observation because of ongoing attempts to harm themselves. For one patient, considered at particularly high risk, experienced staff introduced new staff to her, her care plan and behaviours. The new member of staff then shadowed a peer during a period of before performing observations alone.
- The most frequent concern staff raised around observations was that shortages of staff meant that there was often a need to move from one set of one to one observations to another without any break. Staff found this tiring and stressful and delays in transferring between duties often cut into breaks.
- We asked ten permanent staff if staff shortages ever meant they had to carry out multiple clinical observations (one to ones) at once. Three reported having observed two patients at once in communal areas of the wards. One of the three reported it happening only once in their experience when snowfall overnight had delayed staff in getting to the hospital for the morning shift. The second reported having to do this only twice when the ward was short of staff. Only the third reported it as a semi regular occurrence and said it happened to allow staff to take breaks if they felt patients were settled in communal areas of the ward. They also said that they felt confident they could call on help if required in that situation. Of the remaining seven staff, none had ever performed multiple observations and five told us that they would not do multiple observations if asked as they believed it to be unsafe.
- We investigated the specific concerns about the management of one patient who was on constant two to one observations. Managers confirmed that the patient was not allowed contact with fellow patients because of an ongoing risk of harm to others. They had not recognised this as long term segregation. Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, staff do not allow them to mix freely with other patients on the ward on a long term basis. However, patients should not be isolated from contact with staff or deprived of access to therapeutic interventions. Managers felt that as the patient had access to space in hospital reception, the ability to exercise in corridors and outside in the grounds that the conditions weren't met to consider this segregation.

Long stay/rehabilitation mental health wards for working age adults

- We discussed this case with the medical director and after reviewing the revised Mental Health Act Code of Practice 2015 agreed that this patient was subject to long term segregation. The medical director instituted daily reviews of this patient to demonstrate he continued to meet the conditions to justify this restriction. Managers updated commissioners and family members, who were already aware of the care plans in place, about the change in status and safeguards now in place.
- Qualified nurses dispensed medicines to patients following the guidance of the nursing and midwifery council. We interviewed managers and staff about the use of unqualified nursing staff to administer medicines. Only one support worker out of the seven we interviewed reported that she had been asked to do so and that was by an agency nurse on one occasion at least two years before. Two other support workers reported that they had been asked to give medicines to patients who they had a good rapport with. Support workers would only do this under the direct supervision and observation of the dispensing nurse. All the qualified nurse we interviewed reported that they would not ask a health care support worker to administer medicines unsupervised and recognised that this would be a breach of their code of conduct.
- Staff gave some medicines covertly, hidden in food or drink, and without the patient's consent. Under the mental capacity act this is allowed if the patient lacks mental capacity to consent to treatment and the medicines are necessary to maintain their well-being. We found that Best Interests Decisions supporting the use of covert medication in all cases. Staff had documented the discussions that had led to these decisions and had included the involvement of relatives, carers and/or external professional as recommended.
- However, there was no local protocol in place to guide these clinical decisions in line with the MCA code of practice. We found that the medical staff needed to give more detail for of the benefits to the patients of taking the medicines prescribed covertly. They should have also evidenced the agreement of a pharmacist that the medicines were safe to administer and would retain their potency if crushed or dissolved. The pharmacist told us she had reviewed these decisions in retrospect and all medicines administered covertly would retain their efficacy. We discussed these concerns with the medical director who agreed to develop a protocol to standardise the recording and level of evidence required to support best interests decision making.
- Medical staff had prescribed anti-psychotic medications individually or in combination at doses higher than recommended in the British National Formulary for some patients. The psychiatrist was able to justify this prescribing and demonstrate to us that overall doses were decreasing since the point of admission. Patients with a long history of mental problems often have complex medication regimes with some prescribing outside of the recommended ranges. We were assured that that medical staff had prioritised simplifying and reducing the medication regimes of patients at the hospital.
- The clinical pharmacist completed monthly audits on the compliance of prescription charts with the mental health act and prescribing guidance. When doctors had prescribed medicines outside of British National Formulary (BNF) limits the pharmacist had highlighted this on the treatment form and it had been supported by the review of a second opinion approved doctor.
- Staff told us that the hospital operated a no lifting policy and patients were encouraged to get up themselves when able with the use of a chair or other aid. Staff had not reported any injuries from attempting to lift patients.
- Where equipment was used for the transfer of patients, staff were suitably trained and understood their responsibilities to assess patients prior to assisting them when fallen. Staff told us they communicated with and visually reviewed a fallen patient before making any attempt to move them. Staff evidenced this in the incident reports regarding falls we examined.
- Staff made regular checks on patients known to be at risk of incontinence. We found that staff were aware of physical health risks including pressure ulcers and took appropriate steps to monitor this. Staff assessed pressure ulcer risk using the Walsall community pressure ulcer risk calculator and regularly reviewed their ratings. There was no report of any pressure ulcers

Long stay/rehabilitation mental health wards for working age adults

amongst the patients on the wards at the time of our inspection or historically that would give cause for concerns that staff regularly neglected continence needs.

Reporting incidents and learning from when things go wrong

- Staff reported knowing how to report incidents and they reported all incidents that involved actual or potential harm or accident.
- Overall, we found incident reporting to be robust; the deputy manager reviewed reports and highlighted concerns to senior clinical staff. However, there was no process to ensure that they shared any learning with staff on the wards.
- Staff confirmed in interview that they did not regularly receive feedback from incidents. Staff meetings were irregular and hospital wide meetings focused on particular subjects rather than a regular agenda with review of minutes and actions.
- Of the permanent staff we interviewed ten reported having been involved in an incident where patients had caused them harm. Eight of the staff felt that management had been supportive and debriefed them following the incident. If the assault had resulted in an injury the hospital and human resources managers had supported staff during sick leave. Of the two staff who felt that support was lacking one said there was no immediate debriefs but managers offered other support. The other felt that managers had not provided any support or feedback from the incident.
- We interviewed the deputy manager about the management of a specific incident disclosed by the first whistleblower. In that case we found there had been a delay in managers offering support to a staff member as the original review of the incident had failed to highlight their potential needs following an assault.

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

(for example, treatment is effective)

Best practice in treatment and care

- We reviewed case notes and discussed with clinicians involved the care of patients identified in the concerns of a whistleblower. In both cases, we found that the patients care was in line with our expectations. Patient's relatives were heavily involved in planning for palliative care at the hospital and on both occasions, emergency services had been involved as appropriate. A local GP, who works closely with hospital staff, regularly reviews the physical health of all patients
- Staff performed regular physical examinations and observations of the patients and there was ongoing monitoring of physical health problems. Staff contacted medical or more senior nursing staff at points when the physical condition of a patient deteriorated.
- We had been told by whistle-blowers prior to inspection that senior staff had ignored the concerns of support workers about the well-being of a patient. We found that the qualified nurses had documented these concerns and escalated them for medical review. Following a joint medical assessment by the GP and psychiatrist, treatment had been prescribes and this was being monitored for effectiveness. The occupational therapy team had also been asked to consider if any aids would be suitable to support the safety of this patient.

Multidisciplinary and inter-agency team work

- We found that there was an effective working relationship with local primary care services to support the physical health needs of patients. A local GP visited weekly and members of the local community nursing service had input into the hospital to support complex physical health care needs and provide specialist input for end of life care.
- Ward staff could escalate concerns about a patient's physical health to be included at the GPs weekly review. Medical staff working at the hospital would attend to any more urgent concerns or in the case of emergencies the ambulance service was called.
- We also spoke to the two local safeguarding leads for adult and older adult care teams. They both reported having confidence in the current management and that they were regular contact to discuss potential and actual safeguarding concerns.

Good practice in applying the Mental Capacity Act

Long stay/rehabilitation mental health wards for working age adults

- We saw in the use of covert medications that for people who might have impaired capacity, staff assessed and recorded their capacity to consent. They did this on a decision-specific basis with regards to significant decisions, and staff gave people assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Where appropriate and when they lacked capacity, staff made decisions in a patient's best interests.

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

Start here...

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

(for example, to feedback?)

The facilities promote recovery, comfort and dignity and confidentiality

- During our inspection we found that heating was installed throughout the hospital. A regulator linked to the main boiler controlled this This included the three bedrooms on a lower floor from the main Horton ward. All three of these rooms had ensuite bathroom facilities. Within the three rooms we found no evidence of damp visible on the walls or tiles. Each room was ventilated by windows with restricted opening.
- On the top floor we found one bedroom window was screwed shut reducing ventilation. Manager explained that a decision had been made to fix closed due to safety risks. With the window open it would be possible to reach out and touch a boiler flue and risk a burn. There were opening windows in the ensuite bathroom and in the corridor immediately adjoining allowing reasonable ventilation. Managers reviewed the risk on the day of our visit and concluded that following a change in the heating system the window could now be opened with restrictors in place.
- We investigated the financial arrangements to support the well being of two patients. In each case we found that control of their finances lay with family members not the hospital management. Acting under a recognised legal authority family members provided money for personal expenses to the hospital. Ward staff contacted the relevant relative to request money for particular needs. In both cases, we saw staff had attempted to support the patients to manage some aspects of their finances. We also found both patients to have clothes and toiletries available to them
- Hospital managers had attempted to support all patients in managing their finances independently by providing safes in bedrooms and through the introduction of a patients' bank available three days a week. Care staff kept careful records of any transactions made on a patient's behalf. Some patients were wholly independent financially and managed their personal income without any staff help.
- We discussed with hospital managers our concern that care records did not clearly demonstrate who had legal responsibility for managing each patient's finances. They agreed that for all patients not directly managing their own finances the staff would record their individual personal arrangements. When another person was managing a patient's finances on their behalf through a lasting power of attorney or another relevant legal authority the hospital would keep a copy in the patient's notes.

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

Good governance

- During our first inspection, we became aware of gaps in intelligence and systems for recording and analysing staffing patterns and incidents. Managers had failed to keep accurate records of staff on shift, and they could not provide assurances that in the case of a fire alarm that all staff had evacuated the building.
- Managers were not able to identify when there had been shortfalls in planned staffing. They maintained no central record of how many staff were in the building at

any one time. Each ward maintained their own records and could account for the whereabouts of staff members but managers did not integrate this information into a central record.

- We raised this with managers as an urgent concern and they agreed to introduce a system to monitor centrally staffing levels and the number of staff trained in restraint on each shift. This would allow them to identify any patterns in shortfalls and develop action plans to resolve the problems identified.
- In regard to the problems identified with personal alarms, swipe cards and keys managers were aware and planning long term permanent solution with capital funding. However, no short term mitigation in place to manage and monitor risk day to day.
- We found no evidence that managers routinely shared lessons learnt from risk reporting with ward staff. However, incident reporting was robust and the deputy manager reviews reports daily and highlights concerns to senior clinical staff.
- There was no local risk register to bring together ongoing concerns and action plans for example alarms and doors. This meant that action plans to resolve known problems were left with individuals and not available for group discussion. We discussed this omission with the managers who agreed to collate current projects and outstanding risks into a central record that would be available for discussion at future engagement meetings.

Leadership, morale and staff engagement

- Both staff members who approached the CQC directly felt that managers at the hospital had not listened to them. Given the seriousness of their concerns, they had contacted the CQC. We discussed with the management team that these members of staff reporting similar themes might represented a greater level of concern amongst staff. Our findings supported some the concerns that the whistleblowers had raised. Managers were aware of the majority of the issues and were taking action was to resolve them. However, managers had not made staff aware of how their concerns had been recognised and actioned. This highlighted an issue regarding communication about service improvement and planned changes at the hospital between managers and clinical staff.
- Managers agreed to set up regular meetings with staff members led by directors to allow an opportunity for staff to address their concerns directly and discuss developments at a hospital wide level. These meetings would supplement the ongoing team meetings at ward level.
- The two whistleblowers had not felt able to raise concerns without fear of victimisation. However, all of the eight permanent staff we interviewed at inspection felt that they could raise concerns without any such fear. Four of these staff remarked positively on the open door policy maintained by both the hospital manger and her deputy.
- We heard a positive report from six out of the eight permanent staff we spoke with about team working and morale inside the hospital. Two felt that there was a lack of leadership at ward level and that the high number of agency staff used undermined team cohesion.
- There was no ongoing forum to allow staff the opportunity to give feedback on services and input into service development. At times managers and board members had consulted staff on particular projects. Managers agreed to ensure consultation with staff would be part of ongoing service development plans.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clinical staff on duty have access to swipe cards or keys to move freely around the wards and enable an early response to any alarm or urgent patient need.
- The provider must ensure records of staff on shift are accurate and could provide assurance of the safety of staff in case of a fire alarm.
- The provider must put in place a system to ensure that incident reporting is used to inform staff of lessons learnt.

Action the provider SHOULD take to improve

- The provider should ensure personal alarms are provided in sufficient quantity for all staff on shift
- The provider should ensure that bedding was included in future hygiene audits, the integrity of protective covers and state of wear of items in use be considered.
- The provider should ensure that staff apply the safeguards outlined in the MHA code of practice to the management of long term segregation and other restrictive practices.
- The provider should ensure that managers offer all staff a debrief and support following any incidents of abuse or assault.
- The provider should establish a local protocol to support best interests decision making around the administration of covert medicines in line with NICE guidance and the MCA code of practice.
- The provider should ensure that when patients were unable to manage their finances independently that staff clearly record their personal arrangements and a copy of the legal authority allowing another person to manage money on their behalf be available for inspection.
- The provider should seek to improve engagement with staff through regular meetings and improving communication about management action to improve the environment and care at the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no system to allow management to monitor the presence of staff inside the hospital at any one time. The management of risk incidents did not include sharing lessons learnt with clinical staff.

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 A shortage of swipe cards and keys for the use of temporary staff created the potential risk for staff to be isolated from help.