Sturdee Community Hospital

Quality Report

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Date of inspection visit: 25 April 2018
Date of publication: 18/06/2018

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 well-led?	

Overall summary

We found the following issues that the service provider needs to improve:

- The provider's medicines management practice was unsafe in relation to the storage, dispensing and medicines reconciliation. Staff made numerous errors and omissions when handling controlled drugs. These practices did not follow the services local medicines policy or NICE guidance. Managers had not addressed the issues with medicines management identified at the inspections in May 2017 and December 2017.
- Managers had not reviewed or updated the internal systems for reporting incidents.
- The majority of the staff we spoke with reported they did not feel supported or listened to by hopsital management.

However:

- Staff completed the initial assessment of the patients' risks at the pre admission assessment and the multidisciplinary team updated the risk assessment once the patient had been admitted to the service.
- Managers ensured they had the required amount of staff on the majority of shifts to meet the needs of the patients.
- Staff reported that morale was ok and that they felt supported by their colleagues.

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		No rating given as the inspection was an unannounced focussed inspection.

Summary of findings

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Summary of this inspection

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Sturdee Community Hospital

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Sturdee Community Hospital

Sturdee Community Hospital is part of the Inmind Healthcare Group. Located in Leicester, the hospital provides both locked and open rehabilitation for female patients with complex mental health needs, some of whom are detained under the Mental Health Act 1983.

At the time of the inspection, 20 patients were receiving care and treatment.

Charles Stima is the registered manager and the nominated accountable office for controlled drugs.

Since September 2016, the hospital has been operating as an all-female hospital. They have two wards:

- Rutland Ward – 16 beds
- Aylestone Unit – 9 supported self-contained flats.

The service has a third ward called Foxton ward. This ward was used as a rehabilitation therapy unit but is currently undergoing a refurbishment plan.

Sturdee Community Hospital is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury

Sturdee Community Hospital first registered with the CQC in April 2011.

Since this date there have been five Mental Health Act reviews, five CQC comprehensive inspections and one unannounced focussed inspection. The last comprehensive inspection was carried out in December 2017. Following this inspection the CQC identified actions that the provider must take to improve the service:

- The provider must ensure that the ligature audit for Sturdee Community Hospital is completed and accurate.
- The provider must ensure that blind spots across Sturdee Community Hospital are identified and mitigated.
- The provider must ensure that the medicines management policy is adhered to and includes safe prescribing, administration and storage of medications.
- The provider must ensure they have adequate oversight to ensure delivery of its Mental Health Act administration functions.

In addition to this CQC identified actions the provider should take to improve the service:

- The provider should ensure that all incident reports include records of any actions taken
- or changes to policy and procedures.
- The provider should ensure that all patients have detailed occupational therapy plans that meet the patients' motivational, social, and independent living skills needs.
- The provider should ensure they have adequate pharmacist monitoring.

Our inspection team

Team leader: Sarah Duncanson

The team that inspected the service comprised of a CQC inspection manager, one inspector, one assistant inspector and a pharmacy specialist advisor.

Why we carried out this inspection

We carried out this focused inspection following concerns flagged up by intelligence monitoring of Sturdee

Summary of this inspection

community Hospital. The concerns related to medicines management, incomplete patient records, and a reduction in the number of permanent staff and bullying and harassment.

How we carried out this inspection

This was a focussed inspection and asked the following questions of the service.

- Is it safe?
- Is it effective?
- Is it well-led?

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

During the inspection visit, the inspection team:

- spoke with the registered manager and managers for the service
- spoke with six other staff members; including doctors, nurses and unqualified nurses
- looked at five care and treatment records of patients
- carried out a specific check of the medication management on two wards; and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- The provider's medicines management practice was unsafe in relation to the storage, dispensing and medicines reconciliation. Issues with medicines management had been identified at the inspections in May 2017 and December 2017.
- Staff made numerous errors and omission when handling controlled drugs. These practices did not follow the service's local medicines policy or NICE guidance.
- Up-to-date Medicines and Healthcare Regulatory Agency (MHRA) alerts were not contained in files within clinic rooms.
- Nurses had not completed clinic room checks since the 19 April 2018.

However:

- Managers ensured they had the required amount of staff on the majority of shifts in line with their safe staffing numbers.
- Staff completed the initial assessment of the patients' risks at the pre admission assessment.
- Staff had completed all incident forms in line with the provider's policy. We reviewed 19 incident reports and found that staff had not inputted two onto the electronic system.

Are services effective?

- The majority of staff completed comprehensive assessments when patients were admitted to the service.
- Staff ensured that detention paperwork was completed correctly, up to date and stored within patients' case notes.
- Staff ensured that consent to treatment requirements were adhered to and copies of consent to treatment forms were attached to the medication charts when applicable.

Are services well-led?

- Managers did not ensure that good medicines management practice (transport, storage, dispensing and medicines reconciliation) were in place.
- Managers had not reviewed or updated the internal systems for reporting incidents.
- The majority of the staff we spoke with reported that they did not feel supported or listened to by hospital management.

However:

Summary of this inspection

- Staff reported that morale was ok and that they felt supported by their colleagues.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Well-led	

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

Safe staffing

- Prior to the inspection concerns were raised that the provider did not ensure that had the required amount of staff on duty. We found that managers had ensured that they had the required amount of staff on the majority of shifts to meet the needs of the patients. We reviewed the staffing rotas from 01 March 2018 to 25 April 2018 and found that managers had filled all shifts except three shifts for unregistered staff.
- Since January 2018, two registered nurses and four unregistered staff had resigned. Two resignations were due to health issues, two staff had other jobs, and the remainder of the leavers gave no reason.
- Managers used agency staff in order to fill additional nursing needs when patients required enhanced observations. Managers reported that they would choose agency staff that knew the service and patients, as a priority, but this was not always possible.
- We saw that a registered nurse was near the communal areas of the ward, although a support worker was present in the communal areas at all times.

Assessing and managing risk to patients and staff

- Staff used the short-term assessment of risk and treatability (START) risk assessment tool. Staff completed the initial assessment of the patients' risk at the pre admission assessment. The multidisciplinary team updated the risk assessment once the patient had been admitted to the service.
- We reviewed 10 risk assessments, five pre admission and 5 admission risk assessments. Staff had completed them fully and had identified all the patients' known risks. However, we found the time scale in which staff completed the admission risk assessments varied from five days to 15 days. Staff we spoke with said there were no set timeframes for the first risks assessment to be completed after admission. We were concerned that patients risk profiles might have changed at the point admission and these had not been assessed or documented.
- There were policies and procedures in place for the use of observation of patients. We observed staff carrying out observations discreetly during the inspection. We reviewed observation records of five patients and found that staff had completed them fully.
- Staff medicines management practice was unsafe in relation to the storage dispensing and medicines reconciliation. Issues with medicines management had been identified at the inspections in May 2017 and December 2017.
- Three large boxes of medication had been delivered to the service on the day of the inspection and this stock remained on a chair in the clinic room throughout the day and was not locked away securely. In an unlocked drawer under the clinic bench, we found prescribed ointment that should have been stored in a locked cupboard. On Aylestone ward, the medicines trolley and cupboard were located in nurses' office. During the inspection, the door to this room was left open and unattended by staff, and the window was left wide open with no additional security measures in place. We could not be assured that patients or visitors could not gain access to this medication.
- The medication trolley contained eye drops that did not have a date of opening or revised expiry date. We were not assured that it was safe to continue to use these eye drops.
- Staff monitored the clinic fridge temperature for March and April 2018. On eight occasions staff recorded that, the maximum fridge temperature was above eight degrees but staff had taken no action to address this. Due to this, the efficacy of the medication stored within the fridge could have been affected.
- The clinic was over stocked with medication. We found 18 boxes of one type of injection and 40 boxes of another injection stored in the clinic.

Long stay/rehabilitation mental health wards for working age adults

- Staff made numerous s errors and omission when handling controlled drugs. These practices did not follow the service's local medicines policy or NICE guidance.
- The provider had not ensured that the controlled drug keys were kept separated from the clinic room keys as per guidance. Therefore, protective measures were not in place to maintain the security of controlled drugs.
- Staff did not store the controlled drugs recording books in a locked cupboard in the clinic. Staff did not ensure that the recording books contained accurate index pages at the front of the book to support accurate and timely recordings. Staff did not complete the 'continues on' page and 'brought forward form page'. Due to this, there is a risk that control drugs records did not clearly reflect the amount of controlled drugs stored in the clinic or what medication had been administered to patients.
- Staff completed adhoc stock checks of the controlled drugs held within the clinic. However, we found that not all stock checks had been signed by two staff. This was in breach of local polices and the nursing and midwifery councils guidance.
- Two staff had not regularly signed the controlled drugs book to record the administration of the controlled drug, oramorph, as per policy and nursing and midwifery council guidance. Staff had crossed out administration dates for oramorph for reasons unknown.
- Staff dispensed a named controlled drug, oramorph, to patients other than the person for whom the medication was prescribed.
- We reviewed the drugs liable to misuse register stock balance. Staff had failed to complete an accurate stock tally of diazepam 5mg tablets. The register reported staff had counted 195 tablets. There were 196 tablets in stock.
- Staff had crossed out entries within the drugs liable for misuse records on several occasions including changing the names of the patient the medication had been administered to.
- We found an entry where staff had retrospectively recorded a medicines administration for a patient i.e. on the next day, and not at the time of the controlled drug - benzodiazepine medicines administration. This posed a potential risk to the patient. If the medication record was not a true reflection of what medication the patient had taken that day, there was a risk that staff could have dispensed a second dose.
- Staff did not keep clear stock checks of drugs liable for misuse. These were unclear, duplicated and did not tally. For example, we found two pages in the drugs liable for misuse register that had showed duplicated entries, for the same medication. Both entries showed stock levels and different times that staff had administered the medication to the patient.
- Whilst nurses told us they were dispensing medication for patients to take away for periods of leave in accordance with policy, we found the bottles used to dispense medication were re-cycled between patients, which increased the risk of cross contamination of tablets. In addition to this, we found three plastic boxes containing recycled 'to take away' bottles with medication inside. The labels that were attached to the bottles were not dated, did not have a second check signature and were missing patients' names. We also found two unmarked tablets loose within the plastic box. Due to this poor practice, we were not assured that staff had ensured patients had taken their prescribed medication or recorded what medication had been omitted for patients.
- We reviewed 15 paper medication charts and found that 'when required' medications had been administered as prescribed.
- Staff had not used the correct refusal codes or codes related to the non-administration of medicines as directed on the front of the prescription chart. This meant that is was unclear as to why the patient had not taken their prescribed medication.
- Staff had amended the administration times on one medication chart, it was unclear who had made the amendment as it was not signed or initialled. This practice did not meet the service local medicines policy.
- Doctors had prescribed an antibiotic for a patient but had failed to record on the patients' medication administration record the date the prescription should be stopped. This could potentially result in a patient taking a longer course of treatment than clinically necessary.
- Staff had administered medication to a patient before the start date on the patients' medication

administration record chart. The medication record clearly documented that the medication start date was 25 April 2018. However, staff had administered the medication on 24 April 2018.

- Up-to-date Medicines and Healthcare Regulatory Agency (MHRA) alerts were not contained in files within clinic room. We were not assured that staff were aware of the latest alerts when prescribing or administering medication,
- Nurses had not completed clinic room checks since 19 April 2018. These checks were in place to ensure that any errors in equipment, medication storage, recording and reconciliation and prescription charts were reported to managers so that action could be taken to address the issues found. Staff reported that they were waiting for another book to record their findings in order to resume these checks. We were concerned there was no monitoring of the clinic that medication or equipment was safe for use and stored in line with guidance.
- We saw evidence that before 19 April 2018, these checks had been completed and the issues relating to missing medicines administration signatures were found. However, staff had not recorded any action that had taken place in order to address these issues or to reduce the likelihood of them reoccurring.

Reporting incidents and learning from when things go wrong

- Staff had completed all incidents forms in line with the provider's policy. We reviewed 19 incident reports and found that two had not been inputted into the electronic system.
- Patient case notes fully recorded all incidents and highlight any changes in the patients' observation levels so staff could support the patient.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- The majority of staff completed comprehensive assessments when patients were admitted to the service. We reviewed the care plans of five patients and four were up to date, personalised, holistic and recovery orientated. Staff involved patients in the writing of their care plans. However, we found one patient's care plan was the multidisciplinary teams admission care plan and the patient had been in the service for over two weeks. We found evidence in another patient case notes that the multi-disciplinary team had requested, on two occasion, nearly a month after admission for all care plans to be completed but we found staff had only completed two. Senior staff reported this was due to staff not having the time to complete them.

Adherence to the MHA and the MHA Code of Practice

- Staff ensured that detention paperwork was completed correctly, up to date and stored within patients' case notes.
- Staff ensured that consent to treatment requirements were adhered to and copies of consent to treatment forms were attached to the medication charts when applicable.

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

Good governance

- Managers ensured that they had systems in place to meet and monitor the safe staffing levels for the service.
- Managers did not ensure that good medicines management practice (transport, storage, dispensing, medicines reconciliation) was in place. Managers reported that an external pharmacist carried out quarterly audits at the service and the last one took place in February 2018. Managers were requested to provide a copy of these audits during the inspection. However, these were not provided.
- The provider sent copies of medication audits when requested after the inspection. We reviewed this information and found, the internal audit highlighted 13 areas of improvement, staff had completed only two. The external pharmacy audits highlighted areas that the provider needed to address. However, there was no evidence that the provider had taken any steps address them.
- We interviewed the registered manager who told us that medication was only stored in one clinic within the

hospital. However, during the inspection we found that medication was stored in two separate areas. We were concerned that senior management were not up to date with medication storage arrangements within their service.

- Managers had not reviewed or updated the internal systems for reporting incidents. At the inspections carried out in May 2017 and December 2017, we found that the service used two incident form systems one paper and one electronic system. Staff completed the paper record and then the human resource administrator copied this information in to the electronic record. Whilst managers had highlighted this issue with the provider, there were still no plans to review this system and reduce the risk of errors.

Leadership, morale and staff engagement

- There were no active bullying and harassment cases at the time of the inspection. The staff we spoke with were not aware of any bullying and harassment within the service.
- Staff reported that morale was ok and they felt supported by their colleagues. However, the majority of the staff we spoke with reported they did not feel supported by hospital management. They stated they were unapproachable and they did not trust them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the medicines management policy is adhered to and includes safe prescribing, administration and storage of medications.
- The provider must ensure they have adequate oversight and governance structures in place to monitor the management of medicines within the service. This should include regular audits, with actions plans and outcomes.

Action the provider SHOULD take to improve

- Managers should ensure that all incidents are recorded fully and in line with their incident reporting policy.
- Managers should consider having a timeframe in which patients risk assessment and care plans are completed after admission.

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 • Managers did not ensure that good medicines management practice (transport, storage, dispensing, medicines reconciliation) was in place. Whilst audits had been completed not all actions had been addressed. This was in breach if Regulation 17

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured the proper and safe management of medicines. • Clinics were overstocked with medication. • Medication was not stored in line with policy or securely. • Medication was not administered as prescribed by a doctor. • Controlled drug registers did not tally and entries in the register were duplicated. • Controlled drug stock checks were not completed in line with policy and the stock checks did not reconcile with medication in the clinic. • Two staff had not regularly signed the controlled drugs book when administering controlled drugs. • Medication was administered without a valid prescription in place • TTO medication was not disposed of or stored in line policy. • Staff did not complete daily checks of the clinic rooms. • Staff did not keep up to date Medicines and Healthcare Regulatory Agency alerts in files in the clinic. • Staff had failed to complete an accurate stock tally if drugs liable to misuse. • Staff had retrospectively recorded a medicines administration for a patient. This was in breach if Regulation 12