John Munroe Group Limited

Edith Shaw Hospital

Inspection report

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Date of inspection visit: 9 August to 23 August 2021
Date of publication: 28/10/2021

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?	Inadequate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Edith Shaw Hospital is part of the John Munroe Group and is an independent mental health hospital that provides care, treatment and rehabilitation for up to 14 females, aged 18 or over, with long-term mental health needs. John Munroe Hospital - Rudyard is also part of the John Munroe Group and is located nearby.

The service was previously inspected in January 2021. We carried out this inspection based on concerning information received about poor infection prevention and control practice and the impact on patient and staff safety. The inspection looked only at safe and well-led key lines of enquiry. We rated the service inadequate for safe and well-led, and an overall inadequate rating. The inspection placed the service into special measure.

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for Edith Shaw Hospital on our website at www.cqc.org.uk.

This inspection which commenced on 9 August 2021 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.

Following our 9 August 2021 site visit, we issued the provider with a requirement to provide documentation and closed circuit television recordings (CCTV) specific to incidents of restraint, physical redirection and where there was a record of a patient displaying challenging behaviour between May 2021 and August 2021. We made this request because we identified a concern in relation to the way staff used physical interventions with patients. The requirement was issued under Section 64 of the Health and Social Care Act 2008. The provider responded with descriptions of 21 incidents and supporting CCTV recordings where available. The provider included details of three incidents where their own review had identified concerns with staff practice and resulted in staff suspensions.

Due to the seriousness of the concerns we identified during this inspection and through our review of the provider's Section 64 response, on 18 August 2021 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 Edith Shaw Hospital without the prior written agreement of the Care Quality Commission. This action also applied to the provider's other location, John Munroe Hospital -Rudyard.

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

- The service did not always provide safe care. Staff did not understand how to protect patients from abuse, they did not always use recognised restraint techniques with patients and staff actions to manage risk was not always proportionate to the risk presented. We saw staff pulling, pushing, dragging and lifting patients when responding to incidents or behaviour that challenged.
- The provider did not always manage patient safety incidents well. Staff did not always recognise incidents and report them accurately. The provider did not routinely use closed circuit television camera footage to investigate all incidents or monitor staff practices during incidents involving physical restraint. Not all necessary actions following the investigation of incidents were taken to communicate concerns and reduce risks of reoccurrence.

Summary of findings

- The provider had failed to risk assess for the presence of a closed culture in the service. Staff did not always treat patients well during incidents and staff did not speak up when they observed inappropriate or abusive practices by colleagues.
- The provider had introduced a new electronic record system without the necessary applications to meet the needs of all staff in the service. The understanding of staff and ability to use the new system did not support detailed, personalised and recovery oriented care and treatment plans.
- It was not always clear staff from different disciplines worked together to benefit the needs of patients or provided sufficient therapeutic activity with patients.
- Staff had not completed the ligature risk assessments with the necessary detail it required to keep patients safe.
- The provider did not complete a document specifically to record the physical health checks to monitor patients prescribed antipsychotic medication greater than recommended by the British National Formulary.
- Staff completion of basic life support training fell below the providers target completion rate.
- Not all staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Governance processes did not always work well. The provider's action plan to concerns raised at our previous inspection did not demonstrate sufficient improvements.
- The provider's existing systems and processes did not always work effectively to ensure safety and quality in the service. The included the management of incidents and staff recruitment practices.

However:

- Staff practices to adhere to infection control principles had improved since our previous inspection. Including good hand hygiene, access to personal protective equipment and information about social distancing. The service was visibly clean and cleaning records demonstrated regular cleaning.
- The provider had introduced electronic prescriptions to the service, and this provided a more complete record of medications administered.
- Staff now ensured patients could access advocacy services.
- Patients knew how to raise a complaint. The provider had changed their complaints process to ensure staff investigated and learned from complaints.
- The provider had changed leadership in the service and taken action to promote the role of the Freedom to Speak Up Guardian with staff.

This service remains in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 	Long stay or rehabilitation mental health wards for working age adults provide care and treatment for people whose needs are more complex, which require them to stay in hospital for longer. People may be referred here after a period on an acute ward when they have not recovered enough to be discharged home. Rehabilitation wards may also provide step-down for people who are moving on from secure mental health services.

Summary of findings

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Summary of this inspection

Background to Edith Shaw Hospital

Edith Shaw Hospital is a 14 bedded, female only, community based locked unit. The service provides mental health rehabilitation services for women with complex mental health needs. Admissions are taken for women over 55 years of age. Patients may be informal or detained under the Mental Health Act 1983. The service is a locked rehabilitation unit with secure perimeter fencing.

When we inspected, the hospital had 12 patients admitted. Of these, 10 were detained by the Mental Health Act 1983 and two by Deprivation of Liberty Safeguards. There was a CQC registered manager in post.

Edith Shaw Hospital is registered to provide the following regulated activities:

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

What people who use the service say

We spoke with two patients admitted to the service. They told us the service was clean and staff took measures to prevent and control the spread of infections. Patients could personalise their rooms. They felt the service provided little structured activity, but they could access periods of leave. Patients we spoke with knew how to raise a concern or complaint.

How we carried out this inspection

This was an unannounced focussed inspection to see how the provider had improved the service since our previous inspection in January 2021. Our inspection focussed on the concerns raised at our previous inspection. We did not look at all the key lines of enquiry.

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 service MUST take is necessary to comply with its legal obligations. Action a service 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 service MUST take to improve:

- The provider must ensure multidisciplinary staff presence and involvement in meetings to discuss and plan patients care. (Regulation 9(3))
- The provider must ensure ligature risk assessments describe the risk identified, details the level of potential harm presented by the risk and describe actions to manage or reduce the risk. (Regulation 12(2)(b)).

Summary of this inspection

- The provider must ensure staff use recognised interventions and techniques with patients to manage incidents and behaviour that challenges. (Regulation 12(2)(b)).
- The provider must ensure incidents that affect the health, safety and welfare of people using the service are thoroughly investigated. (Regulation 12(2)(b)).
- The provider must ensure staff understand their individual responsibilities to prevent, identify and report abuse or ill treatment of patients in their care. (Regulation 13(2)).
- The provider must ensure governance systems work effectively to ensure safety and quality in the service. (Regulation 17(1)).
- The provider must ensure effective systems and processes are in place to ensure all patients have a care plan in place that is detailed, personalised, goal orientated and from the patient's perspective. (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 monitor progress of the introduction of the electronic patient record to deliver safety and quality improvements in the service and take appropriate action where this is not achieved as expected. (Regulation 17(2)(a)).
- The provider must develop and implement a record of physical health monitoring for patients prescribed high dose antipsychotics. (Regulation 17(2)(b)).
- The provider must ensure they carry out an effective risk assessment before employing staff members with a criminal conviction. (Regulation 17(2)(b)).
- The provider must ensure they assess and monitor the service for indications of a closed culture and make a timely response to reduce or remove any concern identified. (Regulation 17(2)(b)).
- The provider must ensure staff practice to report incidents is accurate and a true account of an incident as it took place. (Regulation 17(2)(c)).
- The provider must ensure sufficient numbers of staff have completed basic life support training. (Regulation 18(1)).

Action the service SHOULD take to improve:

- The provider should ensure the practice of staff to wear personal protective equipment to prevent and control the spread of infection is embedded and consistent. (Regulation 12 (2)(h))
- The provider should ensure staff have access to templates and resources to support discharge care planning with patients. (Regulation 17 (2)(c))

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	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Insufficient evidence to rate
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 environment

Although we found the hospital to be clean, staff had not always completed environmental assessments with the necessary detail they required to keep people safe.

Access to the hospital was through a locked door. Patients had access to two communal lounges, and each had their own bedroom and ensuite bathroom, with a toilet and sink. The hospital accommodated patients across three floors.

The service accommodated female patients only. This complied with national guidance and expectations about governing the provision of single sex accommodation.

Staff completed regular assessments of the hospital environment. Since April 2021, a maintenance staff member had been in place for the service. Records demonstrated regular assessment for fire, portable electrical equipment and Legionella water testing.

In March 2021, staff completed a ligature risk assessment of the service. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. However, the ligature risk assessment appeared incomplete. We saw no description of identified risk; the level of potential harm presented by the risk and no actions to manage or reduce the risk identified.

The provider had closed-circuit television cameras (CCTV) in communal areas of the hospital and externally. Only staff from the provider's human resources department had access to CCTV recordings. Staff told us CCTV recordings could be requested and viewed to support patient safeguarding investigations. However, the provider was not routinely using CCTV footage to audit staff practices or to investigate all incidents.

Staff had access to alarms and patients had access to nurse call points from their bedrooms. Records showed staff checked alarms and call points regularly to ensure they remained in working order.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Maintenance, cleanliness and infection control

Following our previous inspection, we told the provider they must ensure all premises and equipment is clean and suitable for the purpose for which they are being used. We saw there had been improvement, all areas of the hospital and equipment appeared clean.

The hospital had dedicated housekeeping staff who were on site daily. We saw cleaning records were up to date and demonstrated regular cleaning of the hospital environment.

Staff completed an infection prevention and control audit of the service in May 2021. The audit identified environmental improvements and an action plan was in place to support this. Actions included a new floor to be fitted in the main communal area and redecoration of many patient bedrooms.

Staff practices to adhere to infection control principles had improved. Following our previous inspection, we told the provider they must ensure care and treatment is provided in a safe way to assess the risk of, and prevent, detect and control the spread of, infections.

During the inspection we saw staff were bare below the elbows and maintained good hand hygiene. There was a hand hygiene sink on entry to the hospital and staff prompted visitors to wash and sanitise their hands. The provider completed monthly hand hygiene spot checks with staff. Records from July 2021 demonstrated good practice.

The provider had a COVID-19 outbreak management plan in place. On arrival to the hospital, staff asked the inspection team for evidence of a negative COVID-19 test completed that day and recorded each member's temperature. Staff had access to sufficient supplies of personal protective equipment (PPE) and there were sufficient clinical waste bins for the disposal of used items. The provider displayed information about using PPE correctly. We also saw social distancing and safe room occupancy information. The provider required staff to wear a surgical face mask when on site, during the inspection we saw staff wearing face masks correctly. The provider's PPE audit with staff in July 2021 supported this. However, our review of CCTV footage between May and August 2021 did not confirm staff always wore face masks correctly when delivering patient care. For example, on one occasion we saw one staff member with a face mask worn under their chin and on another a staff member with a facemask not covering their nose.

The provider required staff to produce evidence of regular testing for COVID-19 and completed monthly testing with patients. During our inspection, the provider reported no COVID-19 infections in the hospital's patient or staff group.

Clinic room and equipment

The hospital had a clinic room for the storage and administration of medications. We found the clinic room clean and well ordered.

Staff made daily checks of clinic room and medication fridge temperatures, this provided assurance medicines were stored within their recommended temperature range. The quality and effectiveness of medications can be affected by changes in storage temperatures.

Staff made regular checks of emergency equipment to ensure it remained in working order. This included an automated external defibrillator and oxygen.

Safe staffing

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service had enough nursing and medical staff, who knew the patients and received basic training.

The service had a planned staffing establishment of six substantive whole time equivalent registered nurse positions. When we inspected, no registered nurse positions were vacant. In addition to registered nurses, the service had a planned staffing establishment of 14 support worker positions. When we inspected, three whole time equivalent support worker positions were vacant. Staff worked two shifts to cover the 24-hour period.

Mandatory training

The provider ensured mandatory training was available to all staff. The provider's completion target for mandatory training was 90%. When we inspected, the provider reported staff completion rates of 95% to 100% for mandatory training. Staff completion of basic life support fell short at 59%. The provider told us COVID-19 restrictions had prevented face to face training and the provider had relaunched the training when restrictions eased.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. They did not always use recognised restraint techniques with patients and staff actions to manage risk was not always proportionate to the risk presented. Staff did not always follow best practice to de-escalate and manage challenging behaviour

Assessment of patient risk

We looked at three patient records on the provider's new electronic records system. Staff completed risk assessments of every patient on admission and updated it regularly. The risk assessment tool covered risks to self, risks to other, vulnerability and neglect.

The level of detail in completed risk assessments varied. We found two records provided detailed descriptions of the patient's risk and one did not. For example, the assessment did not provide detail of how a patient demonstrated verbal and physical aggression. Detail in risk management interventions also varied. Staff completed some detailed interventions that demonstrated good knowledge of the patient and their individual needs, but this was not consistent across all.

Use of restrictive interventions

The provider included training in de-escalation and a recognised restraint technique as part of mandatory training with staff. At the time of our inspection, the provider recorded staff completion of 96%.

Staff told us restraint was rarely used with patients. Between May and July 2021 staff recorded seven episodes of restraint in the service. Staff recorded no use of facedown restraint and no recorded use of rapid tranquilisation with patients.

We reviewed CCTV footage of nine patient incidents that had occurred at the service since May 2021. We found the use of force from staff with patients was not always proportionate to the risk presented. In four incidents, staff did not always use recognised restraint techniques with patients. We saw examples of staff pulling, pushing, dragging and lifting patients to remove them from communal areas of the service.

Our review of CCTV footage did not support that staff used de-escalation practices with patients to prevent incidents escalating. We saw staff rarely attempted to use de-escalation with patients during incidents. Instead we saw staff immediately used low level holds to remove patients from communal areas to their bedrooms. Staff missed opportunities to de-escalate and support patients following incidents, we saw staff did not always remain with the patient once removed to their room.

The provider did not routinely audit the use of restraint techniques during patient incidents against corresponding CCTV footage. During the inspection, we reviewed one incident from August 2021 against the CCTV footage. The review identified staff failed to use a recognised restraint technique to remove a patient from a communal area of the hospital. As part of the provider's response to this concern, they told us they planned to review all incidents that occurred in communal areas in the previous four weeks against corresponding CCTV footage.

Safeguarding

Staff did not understand how to protect patients from abuse and the service did not always work 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 not been sufficient to meet this requirement and concerns remained.

The provider made safeguarding training available to staff. Training included the safeguarding of adults and children. At the time of our inspection the provider reported all staff had completed the training. The provider had an identified safeguarding lead in the service.

We were not assured staff always identified and escalated concerns of abuse or improper treatment of patients in the service. In our review of restraint incidents, we saw staff present, but not directly involved in the incident, had not raised safeguarding concerns about colleagues' treatment of the patients. We found the provider had not made safeguarding referrals to the local authority following their own review of CCTV footage specific to incidents of restraint, redirection and challenging behaviour. Following our review of the same footage, staff acted on our direction to make the necessary referrals.

Our discussion with the local authority safeguarding team identified concerns about the quality of safeguarding referrals made by staff. We found the provider's referrals were not an accurate reflection of the incidents reviewed on CCTV and omitted key detail, including that the CCTV footage evidenced ill-treatment of patients.

Staff access to essential information

Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records.

At our previous inspection we found staff did not always have easy access to clinical information. Staff had accessed patient records from a number of sources including an electronic database, an online folder structure and a paper folder. Since then the provider had introduced a new electronic records system.

The new system provided all staff with access to up to date patient information. Support workers used mobile electronic devices to access patient information and record patient observations, including diet and fluids, throughout the day.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The new system had gone live on 28 July 2021. However, the new system had been launched without all the necessary applications to support multidisciplinary working. For example, staff told us the provider's new electronic records system had been launched without applications to support the interventions of occupational therapy and psychology staff. We found care plans did not demonstrate plans specific to these disciplines. We also found the quality of risk management and care plan interventions recorded on the new records system to be poor. The understanding of staff, and ability to use the new system needed time to improve and embed.

Medication Management

The service used systems and processes to safely prescribe, administer, record and store medications. However, staff did not operate systems to review the effects of medications on each patient's physical health and ensure they remained safe for use.

Staff generally managed medications safely, including controlled drugs.

The providers new electronic records system had also introduced electronic prescriptions to the service. We found prescriptions recorded patient allergies and a complete record of medication staff administered to patients.

However, we found the service did not have a process for the safe management of high dose antipsychotic medicines. There was no document specifically to monitor and record all of the necessary physical health checks for patients prescribed antipsychotic medication greater than that recommended by the British National Formulary. Staff had not acted on the outcome of a June 2021 pharmacy audit requesting a high dose antipsychotic monitoring form be put in place for patients. This meant it would not be easy for staff to see when patients were due physical health checks, the results of checks and if prescribed doses of antipsychotics remained safe for the patient to use.

Reporting incidents and learning when things go wrong

The service did not manage patient safety incidents well. Staff did not recognise incidents or report them appropriately.

Between May and July 2021 staff recorded 29 incidents at Edith Shaw Hospital. We saw the most common incident category staff recorded was challenging behaviour, accounting for 19 of the 29 incidents. The provider reported no serious incidents had occurred in the service during this time.

We found staff did not always accurately report and record patient incidents. It was not routine practice for staff involved in incidents to record the incident. Instead they reported the incident to the nurse in charge who then recorded it, often without being present at the incident. The provider's clinical governance discussions in June 2021 recognised this, identifying a need for additional action to ensure incident recording was factual and comprehensive. The provider planned further factual recording and reporting training for staff, but this had not been implemented by the time of our inspection.

Incident reports did not always accurately describe staff and patient actions during an incident. For example, in the report of an incident that occurred in May 2021 staff recorded no use of physical interventions with a patient. However, CCTV footage showed staff used physical interventions inappropriately to unnecessarily lift and move a patient from a hospital communal area.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We were not assured the provider investigated all incidents thoroughly. Senior staff did not routinely have access to CCTV footage to support incident investigations. They requested access to footage from a member of the provider's human resources team only when a reported incident specifically identified a safeguarding concern. Senior staff had missed the opportunity to identify concerns about the practice of staff with patients during incidents that didn't immediately identify a safeguarding concern.

The providers own review of CCTV footage specific to incidents of restraint, redirection and challenging behaviour, failed to identify all occurrences of inappropriate practice by staff. In some instances, the provider required guidance from CQC's review of the same footage to identify and act upon examples of inappropriate practice by staff.

The provider had taken some action to improve the understanding and application of the Duty of Candour. The Duty of Candour is a legal responsibility on providers to be open and transparent with people receiving care and treatment. We saw Duty of Candour was a standing agenda item at the provider's clinical governance meetings. However, as not all incidents were accurately reported and recorded, this impacted on the provider's ability to apply the Duty of Candour.

Staff told us they received feedback from the investigation of incidents. Since July 2021, the provider circulated a monthly lesson learned bulletin to all staff.

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

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not always complete care plans to be personalised and recovery-oriented.

Following our previous inspection, we told the provider they must ensure the care and treatment of patients meets their needs and reflects their preferences. We saw the provider had introduced a new electronic records system which included tools for recording patients' preferences and care planning.

We reviewed three electronic patient records. We found staff completed patient 'front sheets' with personalised information written from the patients' perspective. This included information about; what mattered to the patient, what they enjoyed doing and key personal contacts. Staff told us they'd asked patients if they wished to be involved in their assessments and care planning, but all had declined.

The application to develop care plans on the new electronic records system appeared poor. Care plans were not always personalised and recovery-oriented. We saw staff often failed to record the patient by name in care plan interventions, instead identifying them as "the resident". Some care plans only recorded statements about a patient's likes or dislikes and they had no detail of what care should be delivered. We saw examples of staff recording conflicting interventions in plans. For example, one plan recorded the patient would like to be reminded of activities and that the patient wouldn't like to be reminded of activities. However, we saw staff attempted to develop care plans to meet all of a patient's needs and saw some examples of detailed care plan interventions that displayed good knowledge of the patient and understanding of their needs.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Skilled staff to deliver care

The service included specialist staff required to meet the needs of patients but there was little evidence of therapeutic activity taking place.

Following our previous inspection, we told the provider patients must have access to appropriate and adequate therapeutic intervention. During this inspection we saw some improvement, but this was not sufficient to meet the requirement in full. The provider split their psychology and occupational therapy resource between its two hospital locations. They had successfully recruited a consultant psychologist and had recommenced psychological therapies with patients. One patient record we looked at demonstrated regular activity with an assistant psychologist and another recorded a patient's refusal to engage in psychological therapies. The manager told us the service received enough therapy resource to meet the needs of patients.

Staff told us the provider's new electronic records system had been launched without applications to support the interventions of occupational therapy and psychology staff. We found care plans did not demonstrate plans specific to these disciplines.

Support staff delivered patients activities as part of their role. They reported occupational therapy and psychology staff delivered little therapeutic activity in the service. Support staff had access to activity resources including an interactive touch screen activity table to use with patients. Community meetings with patients included discussions about activities in the service including patient's activity preferences and motivation to participate. The provider had introduced a therapeutic kitchen to the hospital. The registered manager believed this would increase rehabilitation interventions and promote independence for patients.

We found staff did not always act in a therapeutic way to support patients. From the CCTV footage we reviewed, we found the immediate response from staff at the onset of an incident or challenging behaviour was to remove patients from communal areas and back to their bedrooms. This occurred in all incidents of CCTV we reviewed. We discussed this with the provider who agreed that this was not therapeutic for patients.

The provider supported staff through regular annual appraisals of their work. At the time of our inspection, the provider reported 90% completion of annual appraisals.

The provider supported staff with regular supervision. At the time of our inspection the provider reported 93% of staff recorded an up to date supervision meeting.

The manager monitored staff performance. The provider had guidance in place to escalate and manage concerns of poor staff performance. After receiving our concerns about the practice of staff with patients during incidents, the provider took immediate action to suspend staff from working in the service. However, the provider had not always initiated action against all staff identified in the incidents. We had additional discussions with the provider to ensure they took appropriate action with all necessary staff.

Multidisciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit patients.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff and patients met regularly at ward reviews to discuss and plan care. However, records did not demonstrate the presence of a multidisciplinary team of staff at these reviews. We noted an absence of psychology and occupational therapy staff. The newly recruited occupational therapy lead told us they planned to attend and participate in future ward reviews. However, we did see support workers regularly identified as attendees of ward reviews and this had improved since our previous inspection.

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

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not treat patients with compassion and kindness. Not all staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

In our review of the CCTV footage incidents between May and August 2021, we saw examples of unprofessional and ill treatment of patients by staff. This included staff pulling, pushing, dragging and lifting patients.

Staff did not always appear to understand or assist patients to manage their condition. We saw the response of staff to behaviour that challenged was often limited to removing patients from communal areas. We saw few examples of staff engaging with patients positively during incidents to de-escalate or better understand the behaviour being presented.

Staff did not always raise concerns about disrespectful, discriminatory or abusive behaviours towards patients. In the incidents we reviewed, staff present during but not directly involved in the incident had not raised concerns about the way colleagues treated the patient.

Involvement in care

Staff ensured patients had easy access to independent advocates.

Staff now made sure patients could access advocacy services. We saw information about independent advocacy displayed in communal areas of the service. Staff from the advocacy service told us it was easy to arrange to see patients in the service and they had supported patients during complaint investigations. This had improved since our previous inspection.

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

Insufficient evidence to rate

We did not apply a rating to responsive during this inspection. This was because we did not gather enough evidence across all responsive key lines of enquiry to make a determination on the rating.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Access and discharge

Staff did not develop plans specific to managing discharge.

Staff did not develop care plans specific to managing patients discharge. The provider's new electronic records system did not include a care plan template for staff to plan and manage discharge. However, records from patient reviews and Care Programme Approach meetings identified staff planned and discussed discharge when they met.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms. Patients and staff worked together to personalise bedrooms.

Patients had access to outside space. This included a visiting pod introduced to support safer visits for patients during the COVID-19 pandemic.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Following our previous inspection, we told the provider they must ensure any complaint received is investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

Staff escalated concerns that could not be locally resolved to the quality and assurance team to be managed as a formal complaint. Between April and July 2021, the provider recorded no formal complaints had been received for Edith Shaw Hospital. In the same period, the provider recorded 11 compliments received about the service.

Patients we spoke with told us they knew how to raise a concern or complaint. We saw the provider had developed an accessible information leaflet for patients detailing how to do so.

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.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

The CQC registered manager had been in post since April 2021. This was a new role specific to Edith Shaw Hospital, the registered manager role having previously covered both of the provider's hospital locations.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff told us the manager was visible, approachable and listened to patients and staff. This had improved since our previous inspection.

Leadership development opportunities were available. Records from the clinical governance meeting in June 2021, detailed additional leadership training for ward managers and registered managers in November 2021.

Culture

The provider had not acted to risk assess the service's culture and concerns had not been raised about staff ill-treatment of patients during incidents. However, the provider had promoted the role of the Freedom to Speak Up Guardian and staff we spoke with felt respected, supported and valued.

Staff we spoke with felt respected, supported and valued.

At our previous inspection, we reported staff did not always feel able to raise concerns without fear of retribution. When raising concerns, staff told us they did not feel they were treated with respect nor did they feel supported. We told the provider they must have a clear process by which staff can raise concerns, including verbal concerns and incidents.

During this inspection we saw the provider had promoted the role of the Freedom to Speak Up Guardian with staff. Staff we spoke with were familiar with the role of the Speak Up Guardian and felt confident to raise concerns. Between April and June 2021, the provider recorded 10 cases reported to the Speak-Up Guardian and noted a reduction in formal complaints from staff. The person appointed to act as the Freedom to Speak Up Guardian had received appropriate training but had limited time to dedicate to the role. The provider planned to recruit Speak Up Champions amongst its staff group to further improve access to speaking up in the service.

At our previous inspection we told the provider they should assess the potential risks of a closed culture. A closed culture is a poor culture in health or care services that increase the risk of harm. We found the provider had not acted to assess the risk of a closed culture. The registered manager told us they monitored the practice of staff daily and had no concerns of a closed culture in the service. During the inspection, we saw evidence to support the presence of a closed culture including the ill-treatment of patients during incidents and the failure to speak up or report ill-treatment of patients which staff had observed.

In August 2021, the provider completed a colleague's survey with staff from across the John Munroe Group. The survey did not record how many staff responded or at which location they worked. The majority of respondents to the survey rated the providers 'safe to challenge culture' and 'collaborative communication between managers, staff and teams' as requires improvement or inadequate.

Governance

Our findings from the other key questions did not demonstrate governance processes operated effectively or that performance and risk were managed well.

Edith Shaw Hospital and John Munroe Hospital shared the same governance structure. Senior staff from both locations met monthly at clinical governance meetings. The agenda for clinical governance meetings provided a framework to ensure essential information was shared and discussed. For example, the agenda included safeguarding, incidents and

staffing. However, records of clinical governance meetings did not demonstrate staff always discussed items identified on the agenda. For example, records for the May 2021 governance meetings reported no incidents were reported or discussed. However, information from the provider showed incidents had occurred in the service during or prior to May 2021.

The provider's action plan to meet the requirement notices issued following our previous inspection had not been sufficient to improve safety and quality in the service. Concerns remained from our previous inspection including; safeguarding, person centred care and effective governance systems. We also saw the provider had not addressed all the actions we told them they should take to improve the service, and some had now become actions the provider must take. For example, previously we told the provider they should assess the potential risks of a closed culture and this had now been escalated to an action the provider must take.

The provider's existing systems and processes did not always work effectively to ensure safety and quality in the service. We were not assured the provider's systems operated effectively to prevent ill treatment or abuse of patients. The provider's system to manage incidents did not provide assurance staff always reported incidents accurately or incidents were always thoroughly investigated. During investigations staff did not always recognise all the risks presented during an incident. When risks were identified, staff did not alwaystake appropriate action to manage the risk or to escalate concerns to the relevant external organisation.

The providers implementation of a new electronic patient record was not effective. We saw the record system had been introduced without the necessary applications to support the work of all clinical staff. For example, the record system did not have the necessary applications to support the work of occupational therapists. The practice of staff to plan care and develop detailed and personalised care plans with patients appeared poor. It was not clear how effective staff training and support to use the new electronic record had been.

Not all audits staff completed provided sufficient assurance. The provider's monthly care records audit captured the practice of staff to complete care records but did not always capture the quality of recording. The provider did not always act on the outcomes of audits. For example, the provider had not acted on the outcome of pharmacy audits requesting a high dose antipsychotic monitoring form be put in place for patients.

The provider did not complete detailed risk assessments of staff employed with a disclosed criminal conviction. We looked at two risk assessments of staff with a disclosed conviction. Neither detailed actions the provider had taken to ensure any risks posed by the previous convictions were mitigated against. This was not in line with the provider's local 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Records did not demonstrate the presence of a multidisciplinary team of staff during ward review meeting to discuss and plan patient care.

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 service's ligature risk assessment provided no description of identified risk, the level of potential harm presented by the risk and no actions to manage or reduce the risk identified Our review of incident showed not always use recognised restraint techniques with patients. We saw examples of staff pulling, pushing, dragging and lifting patients. Senior staff did not routinely access CCTV footage to support incident investigations. We saw missed opportunities to identify concerns about the practice of staff during incidents.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff present, but not directly involved in incidents where colleagues ill-treated patients, had not raised safeguarding concerns about the treatment they observed.

This section is primarily information for the provider

Requirement notices

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 The provider's existing governance systems and processes did not always work effectively to ensure safety and quality in the service. The electronic patient record had been introduced without the necessary applications to support the work of all clinical staff. The practice of staff to plan care and develop detailed and personalised care plans with patients appeared poor. There was no complete record of physical health checks for patients prescribed antipsychotic medication greater than recommended by the British National Formulary. The provider did not complete detailed risk assessments of staff employed with a disclosed criminal conviction. We did not see detailed actions the provider had taken to ensure any risks posed by the previous convictions were mitigated against. The provider had not acted upon previous recommendations to assess the potential risks of a closed culture. During this inspection we saw evidence to support the presence of a closed culture. It was not routine practice for staff involved in incidents to record the incident. Our review of incidents in the service did not demonstrate staff accurately described staff and patient actions during an incident. There was no system in place to ensure patients always had access to a range of recognised and approved therapeutic activities. There was no system in place to ensure that care plans were always personalised and recovery-oriented.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Staff completion of basic life support training was recorded as 59%. This fell below the providers target completion rate.

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 17 HSCA (RA) Regulations 2014 Good governance Following the inspection, an urgent Notice of Decision to impose conditions on the provider's registration was issued under Section 31 of the Health and Social Care Act. Incidents of patient restraint and physical intervention at its hospitals were not reviewed. Incidents affecting patient care were not assessed, monitored and evaluated by someone competent to do so. Learning was not disseminated across its hospitals to prevent further, unnecessary incidents reoccurring. Recruitment procedures were not being followed to ensure persons employed to work with patients do not pose any unnecessary risks to those patients. This included carrying out a risk assessment for any members of staff with previous, relevant convictions.