John Munroe Group Limited

John Munroe Hospital - Rudyard

Inspection report

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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?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

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

The service was most recently inspected in January 2021. We carried out this inspection based on concerning information received about poor infection prevention and control practices and the impact on patient and staff safety. Following this inspection, we rated the service inadequate. The inspection placed the service into special measures.

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for John Munroe Hospital – Rudyard 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 the inspection site visit, we issued the provider with a requirement to provide documentation and closed-circuit television (CCTV) recordings specific to incidents involving challenging behaviour. We made this request because we identified concerns about the use of force and restraint with patients. The requirement was issued under Section 64 of the Health and Social Care Act 2008.

We also served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within four days that described how it would address our concerns. The provider's response did not provide enough assurance they had acted to address immediate concerns.

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

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

- We found force and restraint used by staff on patients during incidents was not always necessary or proportionate to the risks presented by the patient. Examples included; staff surrounding a patient's chair, pointing fingers at patients and pushing patients in their back.
- We saw incidents where unreasonable amounts of force were used by staff when restraining patients and this was not reflected within the incident form. The management team had no process in place to review or audit CCTV to ensure all incidents were recorded effectively.
- Equipment was not always fit for purpose. We found a hoist with pipe lagging to cover a sharp edge and staff had continued to use it even after the inspector asked for it to be removed.

Summary of findings

- Staff were not aware of all ligature anchor points or where ligature risk assessments were located. Ligature risk assessments did not clearly highlight the level of risk or mitigating measures in place for all ligature anchor points.
- We identified blind spots on two of the five wards which had not been identified by the provider and therefore the risks were not mitigated against.
- Staff were not aware of the requirement to complete observations after administering rapid tranquilisation and did not always complete these observations after administering this medication.
- Medication was not always stored at the recommended temperature and staff did not follow this up with a pharmacist to check the medications integrity.
- Waste continued to not be disposed of appropriately. There were clinical waste bags and general waste bags stored outside several wards and patient areas.
- Staff did not always follow infection control measures in line with the provider's policy. We saw examples of staff wearing masks below their nose and under their chin when we reviewed CCTV footage and visitors wearing a cloth face covering rather than a clinical face mask.
- Fridges consisted of food that had been opened and not labelled correctly increasing the risk of patients consuming spoiled food.
- Emergency equipment was not secured and checked in line with the provider's policy.
- Patient care plans did not include patient preferences in any area of care and did not include occupational therapy led activities plans.
- Patients did not have active discharge plans in place and the staff and patients we spoke to were not aware of any discharge plans.
- Staff were not appropriately supervised or supported in line with the provider's policy. We found some new staff had not had any managerial supervision.
- Governance processes in place were not effective and performance and risk were not managed well.

However:

- At the previous inspection the provider had one registered manager for both Edith Shaw Hospital and John Munroe Hospital. The provider now had a new management structure in place and a dedicated registered manager for the John Munroe Hospital.
- The provider had a Freedom to Speak Up Guardian in post who had received appropriate training and staff told us they knew how to contact her.
- Hand hygiene audits were now in place and being completed. Infection, control and prevention practices had generally improved within the service, other than a few exceptions seen on CCTV footage.
- Patients, relatives and carers knew how to complain or raise concerns. Family members we spoke to did not have any concerns in relation to raising complaints.
- Patients were now supported to access advocacy services. The advocacy services we spoke to did not have any concerns and felt communication had improved with the hospital since the previous inspection.
- 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.

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

Summary of findings

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 	John Munroe Hospital provides two core services: • Long stay rehabilitation mental health wards for working age adults. • Wards for older people for mental health problems. Long stay/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. Wards for older people with mental health problems provide assessment, care and treatment for people whose mental health problems are often related to ageing. This may include a combination of psychological, cognitive, functional, behavioural, physical and social problems. We have inspected, reported and rated both core services within this one report.

Summary of findings

Contents

Summary of this inspection

Background to John Munroe Hospital - Rudyard

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

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

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

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

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

- Horton is a male-only ward that supports up to 16 patients with chronic or complex mental health needs.
- Kipling is female-only ward for up to 16 patients with chronic or complex mental health needs.
- Rudyard is a male-only ward that supports up to 11 patients with organic conditions such as dementia.
- High Ash is a female-only ward for up to seven patients and provides locked rehabilitation.
- Larches is a male-only ward for up to six patients and provides locked rehabilitation.

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

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

- The provider must ensure that the care and treatment of patients meets their needs and reflects their preferences by enabling and supporting patients and/or their carers to make, or participate in making, decisions relating to the patients care or treatment. Regulation 9(1)(3).
- The provider must ensure patients have access to appropriate and adequate therapeutic intervention in line with National Institute of Care and Excellence guidelines. Regulation 9(1)(3).
- The provider must ensure that care and treatment is provided in a safe way to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Doing all that is reasonably practicable to mitigate any such risks. Regulation 12(2).
- The provider must ensure the proper and safe management of medicines. Regulation 12(2)(g).
- The provider must ensure systems and processes are established and operated effectively to prevent abuse or investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13(1)(2)(3).
- The provider must ensure all premises and equipment is clean and suitable for the purpose for which they are being used. Regulation 15(1)(2).
- The provider 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. Regulation 16(1).

Summary of this inspection

- The provider must ensure that they have a clear process by which staff can raise concerns, including verbal concerns and incidents, with agreed managerial responsibilities, and this should be implemented consistently. Regulation 16(2).
- The provider must ensure it has effective governance systems and processes which must be established and operated effectively. These should enable the provider to assess, monitor and improve the quality and safety of their services. Regulation 17(1)(2).
- The provider must ensure they promote a culture that encourages candour, openness and honesty at all levels. Regulation 20(1)(3).

What people who use the service say

We spoke to four relatives and carers and two people who use the service.

People who use the service told us they felt safe most of the time, were able to raise concerns if they had any and staff treated them with respect and were caring. However, relatives and patients also said there were a lot of agency staff on shift.

Relatives and carers told us that communication from the service was good and they could contact the wards for updates on their loved ones.

None of the relatives and patients we spoke with were aware of their, or their loved ones, individual discharge plans.

How we carried out this inspection

During the inspection visit, the inspection team:

- spoke with the registered manager and three ward managers;
- spoke with 14 other staff members including; nurses, occupational therapist, consultant psychiatrist, support workers, domestic lead and facilities manager;
- spoke with the local independent mental health advocate team;
- attended one morning meeting;
- looked at 14 care and treatment records of patients;
- looked at 22 prescription chart records of patients and;
- looked at a range of policies, procedures and other documents relating to the running of the provider.

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

Areas for improvement

Following this inspection, we served the provider an urgent notice of decision under Section 31 of the Health and Social Care Act 2002, detailing our decision to vary the provider's conditions of registration:

- The Registered Provider must not admit any new patients without the written agreement of the Care Quality Commission.

Summary of this inspection

- The Registered Provider must ensure all incidents of patient restraint and physical intervention at its hospitals are reviewed by a registered restraint trainer.
- The Registered Provider must ensure that incidents affecting patient care are assessed, monitored and evaluated by someone competent to do so and ensure that learning is disseminated across its hospitals to prevent further, unnecessary incidents reoccurring.
- The Registered Provider's recruitment procedures must be reviewed to ensure persons employed to work with patients do not pose any unnecessary risks to those patients. This includes carrying out a risk assessment for any members of staff with previous, relevant convictions.
- The Registered Provider must provide to the Care Quality Commission a weekly report which must include:
  - a summary of all incidents of restraint or physical intervention along with a record of actions taken by the provider in response within the previous 7 days,
  - details of outcomes of patients following an incident where care has been identified to be of poor quality within the previous 7 days, and
  - actions taken by the provider where care has been identified to be of poor quality within the previous 7 days.

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:

We told the service that it must take action to bring services into line with three legal requirements. This action related to one service.

- The provider must ensure emergency grab bags are secured effectively and have completed checklists in place. (Regulation 12(2)(g)).
- The provider must ensure staff are aware of the rapid tranquilisation policy and complete checks in line with this policy after administering rapid tranquilisation. (Regulation 12(2)(g)).
- The provider must ensure medication is stored at the recommended temperature and where this is breached, staff take appropriate actions to ensure the integrity of the medication is checked by the prescriber or the pharmacist. (Regulation 12(2)(g)).
- The provider must ensure all ligature anchor points and blind spots are identified, risk assessed and have clear mitigation in place. (Regulation (12(2)(b)).
- The provider must ensure general and clinical waste bags are disposed of and not stored outside ward areas. (Regulation 12(2)).
- The provider must ensure staff and visitors follow PPE guidelines outlined in the provider's infection control policy and national guidance. (Regulation 12(2)).
- The provider must ensure staff use approved restraint techniques and patients are not exposed to unnecessary risks of harm and abuse. (Regulation 12 (1)).
- The provider must ensure all safeguarding incidents are identified, recorded and reported. (Regulation 13 (3))
- The provider must ensure equipment is fit for purpose including patient hoists. (Regulation 15(1)(2)).
- The provider must ensure the environment is safe and free from sharp objects and fixtures are secured or removed. (Regulation 15(1)(2)).
- The provider must ensure the environments of dementia wards are dementia friendly. (Regulation 15(1)(2)).
- The provider must ensure effective processes are in place for staff to raise maintenance concerns and for the facilities manager to be aware of ongoing maintenance. (Regulation 15 (1) (2).

Summary of this inspection

- 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 ensure effective systems and processes are in place to ensure all patients have a discharge plan in place where it is medically appropriate. (Regulation 17).
- The provider must ensure it has effective governance systems and processes which must be established and operate effectively. These should enable the provider to assess, monitor and improve the quality and safety of their services. (Regulation 17(1)(2)).
- The provider must ensure all audits including cleaning audits give a clear outline of actions identified, who is responsible to complete them and when they should be completed. (Regulation 17(1)(2)).
- The provider must ensure they have a clear process in place to review or audit CCTV to ensure all incidents are recorded and reported correctly. (Regulation 17 (2)(b)).
- The provider must ensure they carry out an effective risk assessment before employing staff members with a criminal conviction, which takes into account their role alongside the disclosure made and clearly states the measure they will put in place to ensure patients are safe. (Regulation 18 (2)).
- The provider must ensure staff have completed basic life support and safeguarding children training. (Regulation 18 (2)(a)).
- The provider must ensure all staff receive managerial supervision in line with the provider's policy. (Regulation 18 (2)(a)).

Action the service SHOULD take to improve:

- The provider should ensure patient discharge plans are discussed at multi-disciplinary meetings. (Regulation 9(1)(3)).
- The service should ensure that observations are completed intermittently to give an accurate reflection of patient observations. (Regulation 12 (2)(b)).
- The provider should ensure food that had been opened is labelled correctly, clearly stating when it has been opened and when it should be consumed by. (Regulation 12(2)).
- The service should consider the patient group on Kipling and whether the environment is suitable for those with reduced mobility or using walking aids. (Regulation 15(1)(2)).
- The service should consider the number of sanitary facilities available within Larches compared to the number of patients on the ward. (Regulation 15(1)(2)).
- The provider should ensure there is an effective way to monitor if complaints are addressed and responded to in line with the providers policy timescales. (Regulation 17 (2) (b)).

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	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

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

Inadequate

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

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff completed environmental risk assessments of all ward areas, but we found these did not always remove or reduce all of the identified risks and some areas of risk had not been identified. There were potential ligature anchor points in the service that were not identified in the provider's ligature risk assessment. We identified ligature risks from bathroom shower cords on Horton and Kipling wards. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. Some staff we spoke with did not demonstrate an understanding of the ligature risks on the ward and did not know where to find the ligature risk assessment. Care plans did not inform whether patients had any risks associated with ligature anchor points. Ligature risk assessments for all wards did not give clear guidance on specific mitigating actions.

Staff could not always observe patients in all parts of the wards. Blind spots were found on three of the five wards. Two blind spots we observed in Horton and Kipling had not been identified or mitigated through the provider's environmental risk assessments. Horton had a blind spot from the corridor to the wet room. Kipling had a blind spot located in one of the corridors from patients' bedrooms to the main ward area.

Rudyard had a blind spot which the provider was aware of in the conservatory. The nurse stated this was mitigated by ensuring there was always a member of staff present there. During our tour of the ward there were two patients in this area and no staff member present. The inspector asked the nurse in charge to ensure one of the two staff members sat in the main lounge to come into the conservatory.

Not all environments were safe. Inspectors found a canvas on the floor with a nail exposed on the floor of Larches and Horton had an electric radiator that was fixed to the wall using two brackets with an exposed wire. This was not fully secured to the wall and had the potential to be removed from the wall.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Ward environments were not always suitable for the patient groups. Kipling consisted of narrow corridors where we observed a patient unable to manoeuvre. We saw the patient trying to come out of the lounge and into the corridor with a wheeled walker and unable to move in the corridor as they were unable to turn. Three staff had to assist the patient to go back into the lounge area. The patient appeared to be at a risk of falling.

Maintenance, cleanliness and infection control

Not all ward areas were clean, well maintained, well-furnished or fit for purpose.

Not all equipment being used by staff and patients was safe. We saw a patient hoist on Rudyard had sharp edges which made the hoist unsafe for use. The sharp edges had been temporarily covered with padded material, but the hoist was still in use. We asked staff on the first day of our inspection visit to remove the hoist from the patient area until it had been made safe. When we returned on the second day of our inspection, the hoist remained in situ. We were told the hoist continued to be used, exposing patients to the risk of harm. The inspector had to request for a second time for the hoist to be taken out of use.

Staff did not ensure cleaning records were up-to-date but ward areas appeared clean. There were omissions in cleaning records of Horton between 20 to 22 July 2021 and 29 to 31 July 2021. The records for these dates did not specify a time the ward was cleaned or who had cleaned it. The cleaning audits identified actions but did not state who was responsible for them, timescales for completion or whether they had been completed.

Waste continued to not be disposed of appropriately. We found clinical waste bags and general waste bags being stored on the floor outside Horton. There were general waste bags being stored on the floor outside and in the entrance of High Ash. Clinical and non-clinical waste must be disposed of in a way which prevents the risk of transmission of infection and/or prevents causing a hazard for patients and staff. Not disposing of waste in the appropriate way exposed patients to the risk of harm.

Food was not labelled in the fridges on two of the five wards, stating when it had been opened and the date when it should be consumed by. No fridge temperature recordings were taken for the fridges on Horton and Rudyard. This increased the risk of patients consuming spoiled foods.

Staff did not always follow the provider's infection control policy. We found designated foot operated hand hygiene sinks were now in place. We saw staff followed good hand hygiene practices, all staff were bare below the elbow and there was adequate personal protective equipment PPE available. There were now sufficient donning and doffing areas at the entrance of every ward. There was now also sufficient clinical waste bins for staff to dispose of face masks and other PPE. During our site visit, we saw staff were using PPE effectively and safely. However, we observed instances on closed-circuit television (CCTV) where some staff were not always wearing their face mask appropriately and were wearing masks below their nose or under their chin. This did not adhere to good IPC practices and was not in line with the provider's infection prevention and control policy and continued to be a concern from the previous inspection.

Hand hygiene and PPE audits had been completed for all staff planned to have these undertaken in July 2021.

Staff did not always follow the provider's policy on managing the risks of COVID-19. On the first day of our inspection, inspectors saw a visitor on site and within ward areas wearing a cloth face covering which was not in line with the provider's 'Covid Outbreak Management Plan'. The plan recommended everyone in the hospital wears Type IIR Fluid Resistant Surgical masks as a minimum.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Clinic room and equipment

Most clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medication. However, staff did not check, maintain, and clean all equipment.

Staff did not always check and secure emergency grab bags. The emergency grab bag on Larches was not secured effectively. The tag secured to the bag did not prevent it from being opened. Grab bags should be secured effectively to ensure all items are present and safe to use in the event of an emergency. Not doing so exposed patients to the risk of harm and not having access to the right equipment during a medical emergency. There were no records in place to evidence staff had regularly checked grab bags had adequate supplies of emergency equipment on Larches.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

However, the service had a high number of staff vacancies. At the time of inspection, the service had 22 out of 82 whole time equivalent care support worker vacancies and two out of 10 whole time equivalent registered nurse vacancies.

The majority of staff and patients we spoke with during our inspection were not concerned by the numbers of staff on duty. However, one family member and one patient felt there was a high number of bank and agency staff. Over one third of staff were bank or agency at the hospital between 5 July 2021 and 2 August 2021. Managers assured us they only used regular bank staff and agency staff who were familiar with the wards and patients to ensure patient needs were met. When we spoke to agency staff, they demonstrated a good understanding of the service and patients. The service had an ongoing recruitment campaign in place.

Mandatory training

Staff had completed and kept up-to-date with a majority of their mandatory training. The overall mandatory training rate was above 85% for the hospital including bank and agency staff.

However, only 62% of staff had completed basic life support training and only 70% had completed safeguarding children training. The provider told us the basic life support training compliance rate was low due to COVID-19 restrictions not allowing face to face training. As restrictions had now eased, they had relaunched this training. The mandatory training programme was comprehensive and met the needs of patients and staff.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they did not always use restraint only after attempts at de-escalation had failed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission and did not review these regularly, including after any incident. None of the 14 patient records we looked at considered the patients' ligature risk. Following the previous inspection, the provider told us they were going to put in place individualised COVID-19 risk assessments. Every patient record we reviewed had a COVID-19 risk assessment in place, but this was not personalised for individual risks and was the same document for all patients across all wards.

Management of patient risk

Staff we spoke with knew about risks associated with each patient, but these were not effectively recorded in individual risk assessments. Patient observations were not being completed in line with best practice. Staff were completing patient observation records in a predictable way and not intermittently. This meant patient observation records were not an accurate reflection of patient behaviour or activity. One staff member had completed patient observation records at the same time for four different patients on Horton. This was not an accurate reflection of patient observations. Individual ligature risk assessments were not in place in any of the care plans we reviewed despite the ward ligature risk assessments stating that ligature risks would be mitigated through individualised patient risk assessments.

One patient had been on Horton for three weeks and was cared for in bed but had no active risk assessments in place. Staff only knew he was on four hourly turns through the handover meeting and notes.

Staff did not always manage risks after an accident or incident had occurred. Staff failed to complete body maps in incident records we reviewed to record if injuries had been sustained or if additional observations had been carried out.

Use of restrictive interventions

Staff did not always make every attempt to avoid using restraint by using de-escalation techniques. During a review of CCTV footage, we saw patients being unnecessarily exposed to the risk of harm from staff. The use of force and restraint during incidents did not always appear necessary or proportionate to the risks presented by the patient.

We reviewed 10 incidents with CCTV footage where we saw evidence of patients unnecessarily exposed to the risk of harm from staff. The continued use of force and restraint during incidents did not always appear necessary and the use of force did not always appear proportionate to the risks presented by the patient. We saw examples of; groups of staff crowding round a patient's chair, staff pointing fingers at patients, staff pushing patients in the back and staff laughing after incidents have occurred.

The provider did not routinely audit the use of restraint techniques during patient incidents against corresponding CCTV footage. As part of the provider's response to these concerns, they told us they planned to review all incidents that occurred in communal areas in the previous four weeks against corresponding CCTV footage.

Staff did not always follow NICE guidance when using rapid tranquilisation. Staff on Horton ward were not aware of a policy of carrying out observations following the administration of rapid tranquilisation. On 7 August 2021, a patient had been administered rapid tranquilisation, but no observations were recorded post administration. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be increased by the effects of rapid tranquillisation.

Staff access to essential information

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

All staff could access patient notes, but they did not adequately inform of the patients' level of need and risk, to ensure staff supporting them had a good understanding of their care needs.

The service had recently implemented a new electronic care record system. Staff told us they were not confident in using the new system. All staff had received training on the system and the provider was in the process of implementing super users. Managers felt the system could deliver what is needed once it had the chance to be fully embedded. However, there was a risk of patients' needs and preferences not being met as detailed care plans were in place.

Medication management

The service did not use systems and processes to safely store medications.

Actions relating to medication management identified from the previous inspection had been addressed. We found single use syringes and medicines pots were no longer being washed and reused. We did not see medication being dispensed and saved until the patient was ready. We found open bottles of oral medicine were clearly labelled with the date of opening on them.

However, we identified new concerns relating to medication management at this inspection. Staff did not always follow systems and processes when storing medication. The maximum fridge temperatures on High Ash between 2 and 5 August 2021 were recorded as 14 degrees centigrade. Medication fridge temperatures are recommended to be between two and eight degrees centigrade. There was no guidance or log of the pharmacist being informed or consulted around the integrity of the medication. Staff stated the maintenance team had been informed but there was no log of what actions had been taken. There was an increased risk of patients being administered spoiled medication.

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 we found 88% of staff had completed safeguarding adults training and 70% of staff had completed safeguarding children training. The provider had identified a 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 force and restraint incidents, we saw staff present during, but not directly involved in the incident, had not raised safeguarding concerns about colleague's treatment of the patient.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers did not always investigate all incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff did not always apologise and give patients honest information and suitable support.

Staff did not report serious incidents and in line with the provider's policy. Staff did not always give an accurate description of incidents. One of the incidents we reviewed stated a patient "got up and walked out of the lounge and into their room". But the CCTV footage showed up to three staff crowding around the patient pointing at them and then pulling them up and pushing them in their back towards the lounge door. This incident had not been reported accurately or been reviewed by managers or reported to safeguarding.

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. Despite reviewing the CCTV footage CQC requested, the provider failed to identify concerns and we had to inform them of inappropriate practices in some instances.

Staff told us managers debriefed and supported staff after any serious incident. However, the incident records we reviewed did not evidence whether a debrief was offered to staff or patients.

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.

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 assess the physical and mental health of all patients on admission. They did not develop individual care plans which reflected patients' assessed needs, and they were not personalised, holistic and recovery oriented.

Staff told us they completed a comprehensive mental health assessment of each patient either on admission or soon after, but no evidence of comprehensive mental health assessments were found on the new care planning system. Patients did not have their physical health assessed soon after admission or regularly reviewed during their time on the ward. One patient had been on Horton for three weeks and was cared for in bed but had no active care plans in place.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Care plans were not personalised, holistic or recovery orientated. Care plans had generic plans in place for infection control, giving general guidance but not stating how the individual should be supported taking their individual care needs into account. Not all risks identified within the patients' care plan were reflected within the care plan interventions. For example, care plans stated a patient was at risk of falls and used a walking aid but did not give any details around how staff should support this individual to mitigate the risk of falls.

We found little evidence of individual patient goals within care plans. Care plans continued to lack detail and did not have patient specific occupational therapy led activities plans. The occupational therapy team currently had a weekly plan in place which covered both John Munroe Hospital – Rudyard and Edith Shaw Hospital. The plan showed the team only provided activities for one ward at a time. For example, on a Monday or Saturday afternoon there would be no activities at John Munroe Hospital – Rudyard as the team would be at Edith Shaw Hospital playing bingo. Staff told us individual activity plans were in place for patients on Rudyard but they were not available on the ward when the inspector asked to see them. These were later provided but still did not provide a plan of what activities would be delivered and only gave a list of suggested activities. On one record, we saw the activities record for a patient stating they had watched television throughout the day for two consecutive days.

All the care plans we reviewed did not include patient preferences in any area of care. The care plans in place were not personalised and referred to "the resident", or the patient's name but were not in first person or from the patient's perspective. There were no details on patient likes and dislikes specific to patient treatment and intervention. Only one of the 14 care plans we looked at had a de-escalation plan in place to support staff with non-restrictive interventions following challenging behaviour. One care plan stated the patient suffered from depression and emotionally unstable personality disorder, but in the interventions section this information was repeated with no detail of how to support the person.

We found records of regular multi-disciplinary meetings, but these continued to not involve all staff who were involved in the patients' care and treatment. For example, they did not include the involvement of an activity's worker or psychologist. Support workers continued to tell us they had attended meetings but to observe and not actively contribute. A lead therapist was now in post and planned to attend all multi-disciplinary meetings.

Multi-disciplinary meetings did not include a detailed discussion on discharge planning or patient goals for discharge.

Skilled staff to deliver care

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

The ward teams consisted of a full range of specialists but due to staff vacancies, patient access to these specialists on the ward was limited. Patients now had access to therapists on site, even though the lead psychologist worked remotely, assistant psychologists were on site to provide therapies. However, access to appropriate and adequate therapeutic intervention continued to be an issue for patients as the vacancy for one new psychologist and one occupational therapist have recently been filled and these staff members are still going through pre-employment checks.

Managers did not always support staff through regular, constructive appraisals of their work. We found eight staff had not received their three-monthly supervisions in line with the provider's policy. One staff nurse most recently received a documented supervision in December 2020 and two new staff had not received any documented supervision at all.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not work together as a team to benefit patients. They did not support each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge, but did not engage with them early on in the patient's admission to plan discharge.

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. However, the meetings did not include a full multi-disciplinary team including psychologists and occupational therapists due to staff vacancies. The lead occupational therapist who was now in post informed us she intended to attend all multi-disciplinary meetings in the future.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The wards had handover meetings in place where each patient and any incidents were discussed. There were daily morning meetings where all issues including; maintenance, incidents, staffing and complaints and compliments were discussed. These meetings were attended by the head of quality, registered managers, ward managers and nurse in charge for each ward. The information from this meeting was fed back to the staff on the wards through the handover meetings.

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 always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity.

During our site visit, we observed that staff were discreet, respectful and responsive when caring for patients. During the inspection we saw many positive interactions between staff and patients including patients singing with staff and picking flowers for them.

However, in our review of the CCTV footage of 10 incidents between May and July 2021, we saw multiple examples of unprofessional and abusive staff behaviour to patients. These were randomly sampled from Rudyard, Kipling and Horton. This included staff becoming visibly angry or threatening towards a patient and staff displaying negative body language such as surrounding a patient sat in chair and finger pointing. This is not in line with the provider's Restraint Reduction Management of Aggression Policy, which promotes treating everyone with dignity, respect and compassion.

Staff did not always maintain the privacy of patients during or after incidents. One incident showed staff laughing after an incident had occurred. Staff did not always show care and compassion towards patients during incidents. We saw an incident of a patient falling over and staff standing over them without assisting to check if they had sustained any injuries.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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.

Following our review of CCTV, the provider suspended several members of staff because of their conduct and behaviours towards patients.

Involvement in care

Staff did not involve patients in care planning and risk assessments or actively seek their feedback on the quality of care provided. However, staff did now ensure patients had easy access to independent advocates.

Involvement of patients

Staff did not involve patients and work collaboratively with them to develop their care planning and risk assessments. The care records we looked at did not demonstrate patient involvement in specific areas of care. The care plans did not include specific goals for each area of care need identified. This meant that the patient was not always adequately supported to have their voice heard and their wishes taken into consideration to inform their care and treatment. There were no individualised care plans on how staff should communicate or involve patients in their own care.

Patients could give feedback on the service and staff supported them to do this. We saw patients attended their monthly ward rounds through meeting minutes, but the areas of discussion at the ward rounds had not adequately been transferred into the patients' care plans.

Staff now made sure patients could access advocacy services. We saw posters on all wards informing patients on how they could access advocacy services. The advocacy services we spoke to did not have any concerns and felt communication had improved with the hospital since the previous inspection.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The family members we spoke to felt they were involved in their loved ones care as much as they could be, as contact was limited due to the COVID-19 pandemic.

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

Inadequate

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

Access and discharge

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not plan or manage discharge well. They did not liaise well with services that would provide aftercare and were not assertive in managing the discharge care pathway. As a result, patients were at risk of having excessive lengths of stay and a delayed discharge.

Discharge and transfers of care

Staff did not carefully plan patients' discharge or work with care managers and coordinators to make sure this went well. None of the care plans we reviewed had effective goal orientated and detailed discharge plans in place. Staff told us no discharge plans were in place and therefore there was a lack of goals and outcomes for patients to aspire to and achieve.

Ward teams had effective working relationships with external teams and organisations. We saw evidence of monthly Care Programme Approach (CPA) meetings involving commissioners and families. However, discharge was not discussed with personalised goals and patient preferences in mind at these meetings. On all three CPA plans reviewed on Rudyard, the discharge plan stated, "to remain at JMH until a suitable nursing home can be found" and there were no goals or preferences in care documented. This increases the risk of patients remaining in hospital longer than needed.

None of the four family members or two patients we spoke to were aware of their discharge plans. This was not in line with the provider's discharge policy, which promoted discharge as being an ongoing process that started on admission.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise. However, Larches only had one toilet and one bathroom for six patients. We were told patients could not use the toilet if another patient was having a shower or using the toilet. The provider had not considered the impact of this on patients or identified any suitable contingency arrangements.

Meeting the needs of all people who use the service

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

Rudyard is a dementia specialist ward but was not dementia friendly. Staff had completed a dementia friendly assessment in July 2021 on the ward and found the communal areas were sparse, lacked visual stimulation and all areas of the ward could not be observed due to ward layout. There was no action plan in place to address the issues identified within the assessment.

The provider had now changed the layout of the ward and implemented a one-way system to ensure patients were not passing each other on the ramp.

Listening to and learning from concerns and complaints

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients, relatives and carers knew how to complain or raise concerns. Family members we spoke to did not have any concerns around raising complaints.

The service clearly displayed information about how to raise a concern in patient areas on each ward. Staff understood the policy on complaints and knew how to handle them. All staff we spoke to knew how to deal with complaints and how to escalate issues they could not address at ward level.

Managers investigated complaints and identified themes. There was an audit system in place which identified themes and trends in complaints, whether they were from the same person or around a similar area. However, the audit from April 2021 to July 2021 found 13 complaints could have been dealt with at ward level but were escalated through the complaints process.

The audit system in place did not identify if complaints had been dealt with within timescales outlined within the provider's policy. One patient told us her complaint had not been resolved within the 28 days' timeline outlined within the providers policy. When asked for this information, the provider failed to share evidence of their complaints log stating when complaints had been received, dates they had been responded to and the date they had been resolved.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. The managers had introduced a monthly bulletin and issued its first bulletin in July 2021 highlighting lessons learnt.

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

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

Inadequate

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

Leadership

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

At the time of the previous inspection, there was one hospital manager responsible for both John Munroe Hospital – Rudyard and Edith Shaw Hospital. After the inspection, the provider shared plans to reorganise their management structure to ensure each hospital had their own registered manager.

The service had completed a full management restructure and had a new management system in place, including a dedicated registered manager for the John Munroe Hospital – Rudyard. Staff told us they knew who the managers were, and they were approachable and visible on the wards.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Culture

Staff told us they felt respected, supported, valued and could raise any concerns without fear. However, we saw evidence of a poor culture on incidents we reviewed on CCTV.

The provider had now provided training to the Freedom to Speak up Guardian, who was employed to work one day a week. Freedom to Speak Up Guardians support staff to speak up when they feel they are unable to do so by other routes. They ensure people who speak up are thanked, the issues they raise are responded to, and make sure the person speaking up receives feedback on the actions taken. The Freedom to Speak up Guardian planned to recruit Speak Up Champions in each ward to further improve access to speaking up in the service.

However, we identified significant concerns with the culture at the service within staff teams as we saw evidence of incidents of improper and ill-treatment of patients on CCTV that was not reported. We saw several incidents of inappropriate force and restraint witnessed by staff on the ward that had not been challenged or reported to management.

The staff survey completed in August 2021 found - 51% of staff who responded to the survey felt the organisations "safe to challenge culture" was inadequate or required improvement. The provider planned to have an action plan in place in response to the survey by September 2021.

Governance

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

There were no effective maintenance logs in place. The process was for each ward to post any maintenance jobs into a post box, which were then distributed to the maintenance team but there was no centralised record of what had been requested on each ward or what issues had been resolved. The facilities manager had a file of slips where members of the facilities team had stated they had completed specific tasks, but these were not always dated or signed to state who had completed them and there was no way of auditing if all slips had been returned. Staff on the wards told us they did not have a record of what jobs they had requested and what jobs had been completed.

This was highlighted as a concern when the hoist was asked to be removed from a patient's bedroom on Rudyard during our inspection. The maintenance team stated they had not been asked to remove this hoist and the nurse had stated she had already requested for the hoist to be removed. There was no record of this job request.

Following the site visit, we were made aware of a power cut on High Ash on 12 August 2021. We were informed by the hospital manager there was a planned power cut and the power company had hand delivered a letter informing the hospital of this plan. However, this letter was mislaid, and the information was not handed over to the management or facilities team. The hospital managed the power cut effectively and minimised the impact to patients. However, it further demonstrated the lack of oversight of maintenance work.

The governance meetings held discussed a variety of provider wide topics including; incidents, staffing, safeguarding and complaints, but did not have a process in place to review actions from previous meetings. Meeting discussions were not always an accurate reflection of the service. Minutes from the meeting held in May 2021 state there were no incidents to discuss. However, data submitted by the provider evidenced incidents had occurred at the hospital in or prior to May 2021.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

It was identified within the provider's governance meetings in June 2021 incident reports needed to be an accurate reflection of the incident. But inspectors found several incidents were the report was not a true reflection of the incident which had occurred. For example, an incident report from July 2021. The incident report stated a patient shouted and then went to his room. But the CCTV footage showed three staff members crowding around the patients chair pointing fingers at him and a staff member pushing the patient in the back towards the lounge door.

The provider completed investigations including root cause analysis for incidents and complaints. However, the quality of reporting continued to be mixed. Where incidents had been reviewed on CCTV the incidents were investigated effectively and actions had been taken. But the provider did not have a process in place to review or audit CCTV outside of investigations to ensure all incidents were recorded effectively. Therefore, we found not all incidents were reported and investigated appropriately. The provider's reports to CQC were not always complete and missed identifying concerns from the incidents and CCTV. For example, some reports didn't identify staff not wearing masks, or staff pointing fingers at patients or poor moving and handling.

Managers had not provided appropriate supervision and support to staff. We found eight staff had not received a three-monthly supervision in line with the providers policy, two of these were new managers who had not received appropriate managerial supervision or probationary supervisions.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care. Even though all staff had access to the electronic systems for care planning and risk assessing the information within them was not detailed or personalised. Managers had audit systems in place to check if care plans and risk assessments were in place, but these systems did not check the quality of the information they only checked if a care plan profile had been created.

The implementation of the new care record system had not been effective, meaning not all staff were confident in using the new system or accessing information. Five staff told us they were not confident in using the system and one felt more training was needed. The new system did not support or provide the necessary templates for all disciplines including occupational therapy, which delayed the implementation of these plans and clinical staff access to this information.

The provider did not have detailed risk assessments in place when employing staff with a criminal conviction. We looked at 13 risk assessment records for staff who had a criminal conviction. None of these records we reviewed detailed any measures 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 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems and processes were not in place to ensure all patients had a care plan in place that is detailed, personalised, goal orientated and from the patient's perspective. Effective systems and processes were not in place to ensure all patients had activities plans in place developed by the occupational therapy team. Effective systems and processes were not in place to ensure all patients had a discharge plan in place where it is medically appropriate. All audits including cleaning audits did not give a clear outline of actions identified, who is responsible to complete them and when they should be completed. The provider did not have effective and established governance systems and processes that were operating effectively. The processes in place did not enable the provider to assess, monitor and improve the quality and safety of their services. There was no clear or effective process in place for staff to raise maintenance concerns or for the facilities manager to be aware of any outstanding or completed jobs. There was not as clear process in place to review or audit CCTV to ensure all incidents were recorded effectively.

Regulated activity	Regulation

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not carry out effective risk assessments before employing staff members with a criminal conviction. Staff did not receive regular managerial supervision in line with the providers policy. All staff did not receive all mandatory training required for their role including basic life support and safeguarding children training.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not secure all emergency grab bags and complete safety checklists. Staff were not aware of the rapid tranquilisation policy and did not complete checks after administering rapid tranquilisation. Medication was not always stored at the recommended temperature and where this is breached, staff did not seek advice from the prescriber or pharmacist. Staff did not ensure all ligature anchor points and blind spots are identified, risk assessed and mitigated. Staff did not ensure general and clinical waste is disposed of and stored safely. Staff and visitors did not always follow PPE guidelines outlined in the providers infection control policy and National guidance. Staff did not always use approved restraint techniques and patients were exposed to unnecessary risks of harm and abuse.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Following the inspection, a notice of decision was issued to the provider and conditions were placed on their registration. This told the provider areas which must be improved. In particular:** 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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved. In particular:** Staff were using hoists that were not fit for purpose. The environment was not safe and free from sharp objects and fixtures were not secure.

This section is primarily information for the provider

Enforcement actions

Staff were not always made aware of facility issues that could impact on patient safety and care.

Environments of dementia wards were not dementia friendly.

Effective processes were not in place for staff to raise maintenance concerns and for the facilities manager to be aware of ongoing maintenance.