Making Space

Monet Lodge

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

Monet Lodge provides care for up to 20 older people with complex mental health problems, specialising in dementia care.

Following this inspection, we took urgent action and served a Notice of Decision which placed conditions on the hospitals registration. The Notice of Decision prevented them from admitting any further patients. In addition, it required that all patients received support to be discharged or were found appropriate onwards placements that could meet their needs by 31 March 2022.

Our rating of this location went down. We rated it as inadequate because:

- The service was not safe. It did not have enough nurses to provide care for the patients. Staff did not manage risk well. There were a high level of restrictive practices including enhanced observations (when a specific number of staff stay with patients at all times) with no clear rationale, the use of containment (stopping patients moving freely around the hospital) and the use of mechanical restraint in the form of lap belts and groin straps which stopped patients moving out of their bed or chair. The need for these to be used had not been assessed by a specialist in this area and there was no clear rationale for their use. Staff were sometimes restraining patients and were not trained to do this. This meant that there was a high risk of injury to patients due to incorrect techniques potentially being used.
- Medicines were not always safely managed, and staff had little or no understanding of what constituted a safeguarding concern. Not all staff had the training required to keep patients safe.
- Staff did not develop holistic, recovery-oriented care plans informed by a comprehensive assessment. Information in care plans was often outdated or incorrect. They did not provide a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. There was no access to psychology and patients did not receive input from a clinical psychologist. Clinical audits were not up to date or complete and they were not used to evaluate the quality of care the patients received.
- The ward teams had access to some specialists required to meet the needs of patients at the hospital. However, there was little or no input from specialists such as dietitians, physiotherapists and speech and language therapists. Staff had not received regular supervision and none of the staff had received an annual appraisal. Decisions made at multidisciplinary team meetings were often not acted upon by the wider staff team, this was in part due to a lack of permanent staff at the hospital.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. We found that staff made the assumption that patients lacked capacity without undertaking any assessments of their capacity. Families were often asked to sign for decisions without consulting the patient first and outside of a legal framework. It was difficult to identify which patients were detained under the Mental Health Act (MHA) or were subject to a Deprivation of Liberty Safeguard as recording in patients' notes was poor and staff had little knowledge and understanding of their responsibilities. The lead for the Mental Health Act had left the organisation and although the provider had organised some cover for this, there were no staff who were formally trained in the MHA to ensure that obligations under the Act were carried out.
- Staff did not always treat patients with compassion and kindness and did not respect their privacy and dignity. We saw many examples of this during our two-day inspection. We saw that staff often talked over patients, ignored patients, and talked about their personal hygiene needs in the main lounge. Patients were told to sit down whenever they tried to get up.

Summary of findings

- Staff did not understand the individual needs of patients. Some staff we spoke with did not know the names of the patients they were looking after. We found that care plans did not contain information about the patients' lifestyle, hobbies, and family. Care plans were often generic containing information that did not refer to the patient in a meaningful way. Staff did not involve patients in any decisions about their care, although families were asked to review care plans and sign them.
- We found that many patients at the hospital were ready for discharge but there had been no attempt to support patients to move on from the hospital. Following our enforcement action, all patients were reassessed and only four of the eighteen patients were found to require continued hospital care. The lack of skilled staff at the service to assess patient needs meant that patients stayed in the hospital for much longer than they needed to.
- The service was not well-led, the registered manager had left and although a new manager had been brought in the provider lacked oversight of the service provided at the hospital. The governance processes did not ensure that ward procedures ran smoothly.

However:

- The environment was clean and well furnished, with dementia friendly signage.
- There was evidence of good working practice between the GP and consultant psychiatrist.
- Some carers were positive about the care provided to their loved ones.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Monet Lodge

Monet Lodge is an independent hospital located in South Manchester. It is run by the provider Making Space. Monet Lodge did not have a registered manager at the time of our inspection but did have a new hospital manager in post.

The service provides the following regulated activities:

• Assessment or medical treatment for people detained under the Mental Health Act 1983

• Diagnostic and screening procedures.

• Treatment of disease, disorder, or injury.

Monet Lodge provides care for up to 20 older people with complex mental health problems; it specialises in dementia care. The service provides care for patients who are either detained under the Mental Health Act or Deprivation of Liberty Safeguards. The hospital contains two areas within one ward, one for male patients (Rivers) and one for female patients (Poppyfields). At the time of our inspection, the hospital had 18 patients. The bedrooms were single occupancy with en-suite facilities.

We have inspected Monet Lodge eight times between December 2012 and February 2021. We inspected the hospital in February 21 rated the key questions safe and well-led inadequate and placed the hospital in special measures. We undertook a further inspection in August 21, although we saw some improvements the hospital remained in special measures. We carried out this latest inspection to follow up on the progress made following the previous inspections. The inspection was carried out earlier than planned, due to concerns we had around the safety of patients within the service and the care they were receiving. At this point we took urgent action and served a Notice of Decision.

What people who use the service say

We were not able to gather feedback from patients using the service during this inspection due to the severity of their illnesses. However, we observed interactions in the main lounge area throughout our inspection and found interactions to be mixed. We saw some kind and caring interactions, but we also saw many examples of care that was not of the standard patients have a right to and should expect to receive.

How we carried out this inspection

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.

Before the inspection visit, we reviewed the action plan the provider had sent us following our last inspection. We also reviewed new intelligence we had received about the service during that time.

During the inspection visit the inspection team:

• undertook a site visit and looked at the cleanliness and maintenance of the environment

Summary of this inspection

• spoke with the head of quality and co-production, the manager at the hospital, the regional head of operations and the consultant psychiatrist for the service

• spoke with other staff members, including nurses, support workers, cleaning staff and the chef

• looked at nine care records, which included care plans and risk assessments

• looked at 18 medicines administration charts and completed a full review of medicines management, this included observing a medicine round

• spoke to 3 carers

• looked at cleaning records

• looked at maintenance records

• reviewed the duty rota and staffing arrangements

• reviewed staffing information

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Wards for older people with mental health problems

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

Are Wards for older people with mental health problems safe?

Inadequate

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

Safe and clean care environments

The hospital was not safe. We found several concerns that related to patient safety.

Safety of the ward layout

Staff did not complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified. We found that the environment was generally clean and, for the most part, well maintained. We did find one bedroom where a television had been pulled off a wall and another where a plug socket was hanging off; this was out of reach of any patients. The provider told us that they undertook planned daily, weekly, and monthly audits of the environment. We asked for all audits undertaken by the service in the last six weeks. We received one audit which was carried out in February 2022. We were not assured that regular audits of the environment had been completed and timely action was taken to maintain the environment and equipment.

Staff could not observe patients in all parts of the hospital. The ward had lots of blind spots such as corridors around corners and dead ends. The risks posed by these were managed by undertaking patient observations: all patients were on a minimum of 15-minute checks throughout the day and one hourly checks at night. The hospital had several patients who were on one-to-one observations throughout the day.

The ward was mixed sex. Female and male patients were segregated by two separate corridors. There was no way to stop patients from walking into the other corridor, but staff observations mitigated this as much as possible. Each corridor had a bathroom for patients to use and all bedrooms contained a toilet and sink.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff did not have access to personal alarms, but patients had easy access to nurse call systems. During our observations on the ward we found that alarms often rang out for some time before staff responded to them. There was no robust system in place to ensure alarms were responded to in a timely manner, for example, a nominated response

person on each shift. It was difficult to understand what alarms were sounding for, patients had sensors in their bedrooms that sounded the alarm if they crossed them. This had not been individually risk assessed so that patients who were not a risk or did not pose a risk were able to walk about their room freely without an alarm sounding. This meant that for patients who were at risk, the alarm did not alert staff to a potential issue as there were often several alarms sounding at once.

Maintenance, cleanliness, and infection control

Ward areas were clean, generally well maintained, well-furnished and fit for purpose.

However, staff did not make sure cleaning records were up to date, we saw evidence of large gaps in the cleaning records. The mattress audit, which was due to be completed monthly, according to the providers policy, had last been completed in September 2021. There was a note in the audit about a damaged mattress but no evidence of what was done about this.

We observed staff follow infection control policy around handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. At the time of our inspection, the service was using high levels of both registered and support staff from agencies. There was only one registered mental health nurse working within the service; two others who were both on long term sick. There were no permanent registered general nurses currently in work on the dates of our inspection, all registered general nurses were from an agency. There was one registered general nurse on long term sick. However, the agency nurses who were working at the hospital were booked for three months so were working regular shifts at the hospital. There were 18 support staff who were employed at the time of our inspection but two were on long terms sick. It was extremely difficult to decipher the staffing rota to know how many staff were currently in work, off sick and had left. We asked the provider for an up-to-date list of permanent staff in the service but there were staff names on the rota that were not on the list, likewise there were names on the list that did not appear on the rota.

Agency staff names on the rota were often blank but with a date and time of shift worked, therefore, it was not always clear who had worked shifts or if they went uncovered. The provider gave us no evidence to show how this was monitored despite us asking for this information. We were provided with a list of over 2,500 agency staff that had worked at the service in the last six months, there did not appear to be any oversight of this list.

Inadequate

Wards for older people with mental health problems

On the first day of our inspection, we witnessed a member of agency staff arrive for a shift. Nobody at the service knew who the staff member was or what agency they had come from. The name on the staffing rota did not appear to match the person who had arrived, it took staff some time to work out who this person was, and they were eventually let onto the ward to work.

The service told us they had four vacancies for registered nurses and five vacancies for support staff at the time of our inspection.

The service had extremely high rates of bank and agency registered nurses. The service was using agency staff to cover all its registered nursing shifts on day and night shifts at the time of our inspection, apart from one shift covered each week by a permanent registered mental health nurse.

The service had extremely high rates of bank and agency nursing assistants. The service was using agency support workers to cover six out of eleven staff on a day shift and six out of eight staff on night shift.

Managers were unable to limit their use of bank and agency staff as the service was so short of permanent staff to cover shifts. The service did try to use familiar staff where possible but due to the high number of staff being used from agencies, it was inevitable that some staff had not worked at the service before.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed all agency induction checklists the service had completed. We saw that out of 13 induction checklists we reviewed on site, there were seven that were not signed to say who had completed the induction. For two staff who were on the staffing rota, there was no induction checklist present. However, for some agencies there was a profile present for the member of staff which included a photo of the staff member and their training record.

The service had high turnover rates. Since our last inspection in August 2021, 20 staff had left the service.

Managers supported staff who needed time off for ill health.

Levels of sickness were high, at the time of our inspection; sickness was at 35% (eight out of 23 clinical staff were off sick).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The manager could adjust staffing levels according to the needs of the patients.

Staff had not kept records of when patients had regular one to one sessions with their named nurse. There were not enough nurses in the service to be able to provide this level of care. We observed little meaningful interaction between staff and patients; this was also reflected in the care records which contained minimal information about the type of interactions that would have supported patient's needs. Patients who were detained under the MHA did have details of escorted leave requirements written up by the consultant psychiatrist. However, we saw little evidence of patients receiving their leave.

The provider had stopped all training in physical intervention over a year ago. Despite this, staff had continued to use restraint on patients. There were four examples of this in incident forms between December 2021 and February 2022. There were also references to staff placing their hands on patients in the patient records. For example, “Staff intervened

and removed the patient from the area." All patient care plans detailed that patients required two staff members or more to assist with personal hygiene. When we asked staff why this was, we were told it was to talk to the patient to stop them becoming distressed. However, two members of staff told us that should the patient continue to be distressed they would then hold their arms gently. There was a risk of harm to patients when staff were using techniques they were not trained to use. Older adults often have more fragile bones and skin, and this can lead to injury if the correct techniques are not used. Staff were not aware of the fact that placing their hands on patients was a form of restraint.

We received information prior to the inspection about the use of lap belts and groin straps to keep patients seated in their chairs. We asked the provider to send us information about the patient's consent, capacity assessments and any decisions that had been made on the patient's behalf in relation to the use of mechanical restraint. The provider was not able to give us this information. We raised this as a safeguarding concern with the local authority and asked them to investigate this. We also asked the service to provide us with a specialist assessment which deemed the use of the mechanical restraint necessary; they were unable to provide us with this information. The provider ceased the use of mechanical restraint immediately once we raised this issue with them and sought specialist assessments of the patients that were restricted by the using of mechanical restraint. We visited the service two weeks after this issue was raised and found that there were still no capacity assessments in place for those patients. The local NHS trust was supporting the service to complete these.

Staff did not share key information to keep patients safe when handing over their care to others. We reviewed handover sheets that were available to use at the service. We found that information in the handover documents were not always consistent with what was in the patients notes or care plans. We found patients whose care plan stated they required a puree diet, but the handover sheet told us they required soft diet or bitesize. One patient was described as 'detained,' but they had not been subject to detention under the Mental Health Act for some time. Other information was not clear such as patients described as having "slightly" thickened fluids with no direction for staff on how much thickening agent to use. Given the high use of agency staff working within the service, it was vital that this information was kept up to date to minimise the risk of harm through chocking.

Medical staff

The service had a consultant psychiatrist who offered three sessions per week at the hospital, this was an agreement with the local NHS trust. There were two half days on site and one-half day for completing necessary paperwork. There was no junior doctor cover provided as part of this agreement. Any health-related concerns would go via the GP that worked into the service. They were responsible for the prescribing of all medication, changes to medication and physical health investigations such as blood tests and annual health checks.

If the consultant psychiatrist was on leave, they would arrange cover by another consultant psychiatrist within the local NHS trust. The service could also access the out of hours consultant psychiatrist on call.

In an emergency the staff on site had access to emergency equipment and basic emergency drugs. However, the hospital would need to dial 999 to request an ambulance if there was a medical emergency.

Mandatory training

Staff had not completed and kept up to date with their mandatory training. The training records were extremely difficult to review. There were staff on the list who had left the service, some courses that appeared to be in date were in red which indicated they were out of date. For example, 12 people were showing as being in date for medication foundations training, but had completed training as far back as 2013, the course was required every two years.

The training tracker did not tell us how often a course should be completed so it was difficult to judge if staff were in date for certain courses. We asked the provider for this information. We found that some courses such as dementia awareness and mental health were only due to be completed "as and when required." This training would be essential in a specialist dementia service for staff to have up to date specialised knowledge in the field they were working in. For dementia awareness training, 18 out of the 28 staff had not completed the training in the last four years.

We found that a number of training courses had a low compliance rate, and the impact of long-term sickness meant that the actual number of staff on shift with the correct training could be lower than the percentages below.:

Data protection 68% of the 28 eligible staff were up to date

Fire training 68% of the 28 eligible staff were up to date

Moving and handling objects 71% of the 28 eligible staff were up to date

MCA and DoLS 68% of the 28 eligible staff were up to date

Medication foundations 21% of the 28 eligible staff were up to date

Infection prevention and control 61% of the 28 eligible staff were up to date

Although the mandatory training programme was comprehensive and met the needs of patients and staff, managers did not monitor mandatory training and alert staff when they needed to update their training. We reviewed the training records for all staff and found that these were inaccurate. There were many staff on the list who were not permanent members of staff and some that no longer worked at the service. This meant that the compliance figures were incorrect. We saw examples of courses that should be completed three yearly showing as in date, when the staff had completed the course up to 9 years ago. There was a lack of oversight of the training figures at a senior level in the service as errors in the system were not recognised, raised, or rectified.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission. However, most risk assessments just listed several problems the patient had. They were not able to explain how the risk could be managed and did not give staff the tools they needed to identify when a risk was increasing and be able to implement techniques to reduce it again. Risk assessments were not always updated after incidents, and risk assessments did not feed into care plans to enable staff to understand how to manage the risk safely. For example, several patients had a risk of their skin breaking down due to not being mobile. We did not see details of how staff should monitor the patient's skin, how often they should be checked or what to do if skin was breaking down. This was similar for patients who were a risk of violence to others, choking and falls.

We saw one example of a patient who required a pureed diet. However, neither the risk assessment nor care plan detailed what to do in the event the patient started to choke, other than to, "pat the patient on the back." It gave no indication of basic first aid the staff should use or what position to feed the patient in.

Management of patient risk

Inadequate

Wards for older people with mental health problems

Staff did not always know about risks to each patient and did not act to prevent or reduce risks. When we spoke to staff about specific patients risks, they were not able to tell us how these should be managed. For example, when asking staff about how they used thickening agents in patient's drinks who had swallowing difficulties, the answers often differed dependent on who you asked. Guidance on this was not clear for staff and used vague language such as "slightly thickened," this left the amount open to interpretation and staff had taken this description to mean different amounts. The description should have been clear, given a specific amount and not be open to interpretation in this way. Staff followed procedures to minimise risks where they could not easily observe patients. The ward did have blind spots where patients could not be always seen. However, the patients were all on higher levels of observations (minimum 15-minute checks throughout the day) and there were high numbers of staff on each shift.

Use of restrictive interventions

There was a culture of using restrictive practice at the hospital. During our two-day inspection, we saw many examples of patients being told to sit down each time they stood up. This demonstrated that some staff would rather patients stayed sat down in the lounge, rather than assisting them to move around if they wanted to. Patients were placed in chairs and then their feet were placed on footstools, this stopped them from being able to get up independently. Many patients were placed on one-to-one observations, we did not find sufficient detail in records of when this started and why. When we requested a list of dates and times patients were placed on one to one and the reasons why, we did not receive this level of detail. When we instructed the provider to discharge all the patients from the hospital, very few remained on this level of observations. Staff did not understand the Mental Capacity Act definition of restraint. Prior to our inspection, we had received information that some patients were being restrained using lap belts and groin straps. This had not been recognised by the provider as a form of restraint and no safeguards had been put in place to assess that this was the correct decision for the patients' wellbeing. The provider had then immediately placed all those patients on one-to-one observations, we did not see any evidence of why this was necessary and what the level of observations was preventing. We saw one patient who was on one to one, remain in the same chair in the lounge throughout the entire day. The member of staff on one to one did not interact with the patient, the patient did not attempt to get up. We were not provided with any information of why this was an appropriate level of restriction.

The provider did not train staff in a restrictive intervention's reduction programme, which met best practice standards. The staff were not trained in restraint, but it had still been used on four occasions in December and January 2022. We saw examples in patient records of language that indicated staff had placed their hands on patients, but this had not been recognised as restraint or incident reported as such. We were unable to review CCTV footage of these incidents as the providers CCTV only recorded for 28 days and then it was wiped. We did attempt to review one incident that was inside of the 28-day period, where it was recorded that "staff intervened and took the patient away". However, the incident occurred just off the camera, so we were unable to see how this was managed. We referred all incidents that had documented the use of restraint to the local safeguarding team to review.

We reviewed patient records and found that it was not routine to document what de-escalation techniques if any, were used to try to reassure patients who were distressed. We saw some care plans that documented only the use of medication as an option for when patients were distressed. We did not find any patients with a positive behavioural support plan in place, although the providers policy did state that all patients would have one. Care plans and risk assessment did not explain to staff what signs of distress the patient may show, how to reduce this distress and warning signs or triggers for increasing distress.

Safeguarding

Inadequate

Wards for older people with mental health problems

Staff did not understand how to protect patients from abuse. Staff had training on how to recognise and report abuse, but evidence suggested they did not know how to apply it to their everyday work.

Staff received training on how to recognise and report abuse, appropriate for their role. The training figures for safeguarding showed that 96% of staff had completed safeguarding training within the last three years. However, it did not tell us what level of training this was, the policy for safeguarding adults stated that all staff would undertake online Level 1 (Awareness) Safeguarding training.

Staff could not give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff did not know how to recognise adults and children at risk of or suffering harm. Prior to our inspection we received information that patients were subject to the use of mechanical restraint, this was in the form of lap belts and groin straps. We requested information from the service about how the decision to use this type of restraint had been made, we were not provided with any evidence to support the use of these methods of restraint. The staff working at the service had not recognised that the use of these methods was a form of restraint and had also not recognised that this was a safeguarding issue. We requested that the service report these incidents to the local safeguarding team. We also made referrals to ensure that this had been done.

During our onsite inspection we found a further seven incidents that should have been reported to safeguarding in the six months prior to our inspection, this had not been completed. These included incidents of patient-on-patient assaults and episodes of restraint. We requested that these incidents were reported to safeguarding immediately, we also reported these ourselves. One incident involving a serious assault on a patient was not reported to safeguarding until over two weeks after the incident occurred.

Staff did not always know how to make a safeguarding referral and who to inform if they had concerns. Some staff when asked about this just said they would tell the manager. The process set out in the providers policy was not always followed. We found evidence of incidents that clearly met the threshold for making a safeguarding referral, but this was not done, even after incident forms were reviewed by senior leaders.

Staff access to essential information

Patient notes were not comprehensive although all staff could access them easily. The service used paper records, although there was a plan to move to electronic records. Records were often difficult to navigate, there was conflicting information in patient records, and this led to a high risk of mistakes.

Records were stored in cupboards in the main lounge. At the time of our inspection these cupboards were not kept locked. However, there were always staff in the main lounge area, the cupboards were behind the nursing station but were not inaccessible to patients.

Medicines management

The service did not always use systems and processes to safely administer or record medicines.

Staff did not always follow systems and processes when safely administering or recording medicines. Although we found the provider had improved on some areas from the previous inspection; some areas had not improved, and some had become worse. The hospital had introduced a new electronic prescription record. We found gaps in the electronic

record and could not be sure whether medicine had been given as prescribed by the doctor. The provider did not have a robust system in place when doses had been changed by a health care professional. It was not always clear whether the correct dose had been given from the records. Staff were still not recording when fluid thickening powder was added to a drink for patients with swallowing difficulties, so we could not be assured this was done correctly. Body maps were not available to guide staff on where a medicine patch should be applied.

We found the medicines room was clean and organised and we did not find any medicines out of date, which was an improvement since the previous inspection. We looked at emergency medicines and they were also in date.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

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

There had been a recent serious incident in the service, although staff had reported the incident on the electronic system, they had recorded this as a near miss, the incident was clearly a serious incident that required further escalation. The manager had reviewed the incident and upgraded this at a later date, at this point a review of the serious incident was begun.

Managers investigated incidents, but we found that the correct action was not always taken following this. As an example, we found seven incidents that should have been reported to safeguarding that had been reviewed by managers and closed. Some had been identified as a safeguarding concern, yet a referral was still not made until we asked them to do so during our inspection.

However, we did see evidence of staff speaking to relatives post incidents and staff apologised and gave patients relatives honest information and suitable support. Lessons learnt were shared with the team, usually via email or face to face. However, due to the high turnover of staff, high use of agency staff and infrequency of supervision and team meetings, we were not assured that lessons learnt led to sustained change in practice.

Staff knew what incidents to report and how to report them. We did see evidence of staff completing incident forms following incidents. However, only permanent staff had access to the incident reporting system (unless they were working at the hospital for over three months on a regular basis). This meant that staff sometimes had to wait for a manager or a permanent member of staff to complete these.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong that had come to their attention. However, staff were not always aware when things had gone wrong until this was highlighted to them by outside agencies. For example, the use of mechanical restraint. Therefore, we could not be assured that duty of candour was followed effectively.

There was little evidence that changes had been made as a result of learning from incidents. We saw evidence of differing advice about what consistency patient's diets should be, despite a recent choking incident within the service.

Inadequate

Wards for older people with mental health problems

We saw differing descriptions of whether patients required, puree, bitesize or fork mashable diet. There was a lack of review by the speech and language team and basic care plans that described the concern but did not tell staff how to manage a choking patient safely. When we spoke to staff, they were unable to tell us what measurement of thickening agent was needed in patient drinks and descriptions in records were vague for example "slightly thickened."

Staff did not meet to discuss the feedback and look at improvements to patient care. We requested team meeting minutes for the 6 months prior to our inspection, we were provided with one set of minutes from December 2021. We were told by the manager that 12 supervision sessions had been completed, we did not receive any confirmation of dates of supervision and which 12 staff this related to.

Are Wards for older people with mental health problems effective?

Inadequate

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

Assessment of needs and planning of care

Staff completed a mental health assessment of nearly all patients either on admission or soon after. From the nine care records we reviewed, we found one who had not had a mental health assessment completed in their record.

Patients did not have their physical health assessed soon after admission. Out of the nine records we reviewed, we did not see any where the patient had a full physical examination on admission to the service. However, we did see evidence of physical health being reviewed during admission. This included basis checks such as weight, blood pressure and pulse. We also saw evidence of when patients were losing weight, appropriate checks being carried out by the GP to find out if there was a treatable explanation for this happening. We did see good evidence of the GP who worked into the hospital ensuring that patients had their physical health monitored for things such as blood tests. The GP visited the service several times a week and was able to ensure that these checks were carried out quickly when required. However, we did see some patients who despite having their physical health monitored, were not adequately cared for. We saw patients who required air flow mattresses to reduce the risk of skin breakdown, who had them set to the wrong weight. This meant that patients were at higher risk of their skin breaking down. When we asked staff why the mattresses were not set to the correct weight, and in one instance not even switched on, staff were unable to tell us. There was no documented evidence of how often this should be checked and by whom. The manager of the service did not have oversight of this issue.

Prior to our inspection we received information that some patients did not have a care plan. We were told by the service that they were developing new, more person-centred care plans for each patient. This was taking some time to complete but we were told these would be more tailored to meet the patients' specific needs. However, when we visited the hospital, we found that care plans were basic and contained little detail other than a list of problems. We did not see details in care plans of how a problem could be safely managed, what could exacerbate a problem and what could make it better. The care plans were not holistic and were not person centred, there was little evidence of patient involvement and although some relatives had been invited into the hospital to read and sign the care plans, we did not see evidence that they were involved in the development of them. We saw some examples of care plans that were not specific to the patient they were written for, an example of this was that nearly all patients had a care plan that was developed to discuss the patients' sexuality. Every single care plan stated that the patient was male or female and that they liked to wear casual clothes, this did not evidence that care plans were written with the patient in question in mind.

Staff regularly reviewed care plans, however, this was often a review of incorrect or outdated information and the review did not recognise this.

Best practice in treatment and care

Staff did not provide a range of treatment and care for patients based on national guidance and best practice. They provided no dementia friendly activities to stimulate patients such as singing for the brain or reminiscence activities. They did not have access or make referrals to a clinical psychologist. They ensured that patients had good access to physical healthcare provided by the local GP, but physical health conditions were not always managed safely and effectively. There was no evidence of staff supporting patients to live healthier lives. Staff did not use recognised rating scales to assess and record severity and outcomes. Clinical audits had not been taking place and were not used to improve care.

Staff provided little in terms of care and treatment suitable for the patients in the service. Patients who became agitated, were often given sedating medication as a first line of treatment. Patients did not have positive behavioural support plans which directed staff on how to best provide care for the patients. We did not see evidence of activities that would benefit the patient's mood and sense of wellbeing for the stage of dementia they were at. In previous years, the hospital had provided therapeutic sessions such as pet therapy, sensory equipment and art and music therapy sessions. We did not see evidence at our last three inspections of this type of therapeutic intervention taking place, despite national institute of health and care excellence guidance suggesting that this would be beneficial for patients with severe dementia.

Staff did not effectively identify patients' physical health needs and record them in their care plans. We saw examples of patients with conflicting diagnosis of physical health conditions in their care records. An example of this was a patient who was identified as being diabetic on their Waterlow assessment, there was no reference to this anywhere else in the patient records. This meant their Waterlow score was higher than it should have been, and staff had not recognised this during reviews.

Staff did not always meet patients' dietary needs. There was a recent choking incident at the hospital where a patient who should have been given a pureed diet was given a normal diet. Despite this serious incident, we found that patients records contained conflicting and vague information on what the dietary needs of some patients were. We saw different diet types recorded in different records. Staff were unclear on the amount of thickening agent they should be using in patient drinks.

Staff did not help patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff did not use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology in some areas to support patients. The hospital had recently introduced a new electronic medication system.

Staff took part in clinical audits, but these were often ad hoc and at times incomplete. There were no quality improvement initiatives ongoing at the hospital.

Managers did not use results from audits to make improvements.

Inadequate

Wards for older people with mental health problems

Skilled staff to deliver care

The ward team did not include or have access to the full range of specialists required to meet the needs of patients on the ward. Managers did not make sure they had staff with the range of skills needed to provide high quality care. Supervision was not in line with the three-monthly timescales set out in the providers policy. Appraisals were not being done at the time of our inspection as the provider had only introduced a trial appraisal system to start from 1 April 2022. The provider had an induction programme for new staff, but as the hospital was staffed with a lot of agency staff who did not receive the providers induction, this meant that not all staff were fully inducted to the service.

The service did not have access to a full range of specialists to meet the needs of the patients on the ward. There was no psychology provision within the service and we did not see evidence of any patients accessing psychology in the hospital. There was also no occupational therapy provided within the hospital, although there was one for the whole provider, they were not specialised in working with dementia patients. Other specialities such as podiatry, speech and language therapy and dietitian were all accessed outside of the organisation. Staff told us this was not always easy, and some professions could not be accessed at all.

At the time of our inspection the hospital only had one registered mental health nurse who was currently in work, that person only worked two shifts per week. There were no permanent registered general nurses in work at the time of our inspection, all these shifts were covered by agency staff. It is however, recognised that there is a national crisis in relation to staffing for healthcare services.

Managers did not ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. The provider had dementia awareness eLearning training that was provided “as and when required.” Some staff had not completed this training for many years. There was no further specialised training in dementia care. Mental health eLearning was also “as and when required,” again some staff had not completed this for many years.

Managers told us they gave each new member of staff a full induction to the service before they started work. However, as many of the staff were from an agency, we also looked at their induction process. We were told each member of agency staff was allocated someone to go through the induction checklist with them. However, we found examples of the forms not being filled in correctly, some firms not signed by the person completing the form and for some staff on the rota, we could not find an induction checklist that had been completed.

The provider told us they had introduced an appraisal system as a trial in June 2021, for services with high levels of recruitment such as Monet Lodge and had been told they could commence this from 1st April 2022 throughout 2023. There had been no appraisals completed at the time of our inspection.

Managers did not support medical staff through regular, constructive clinical supervision of their work because they were not directly employed by the hospital. Instead, they worked for the local NHS trust or the local GP.

We did not see evidence of regular team meetings. This was something we had noted on previous inspections, where team meetings were either not taking place or were done via a team brief over email, rather than face to face. We requested the minutes from the last six months, we were only provided with minutes from a meeting in December 2021.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Inadequate

Wards for older people with mental health problems

There was no specialist training being undertaken by anyone at the service in terms of mental health or dementia care. However, six staff had completed a leading into the future course, this was to develop leadership skills. There were also additional eLearning courses that staff had completed on an ad hoc basis.

Managers had recognised poor performance in some areas and were attempting to make steps to address this with staff. However, due to the large numbers of staff on long term sick, this had to be delayed. The human resources department were supportive of any performance issues that needed to be addressed and were available to support managers through this process.

Multi-disciplinary and inter agency teamwork

Although we did see evidence that staff from different disciplines worked together as a team to benefit patients, we often saw this was not communicated well within the wider team. This was mainly due to the significant lack of skilled staff working at the service to carry out these tasks. They had effective working relationships relevant services outside the organisation, in namely the local mental health trust.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The weekly ward round included the consultant psychiatrist, the GP, and nurses from the hospital. We did see some good evidence of multidisciplinary working between the GP and the consultant psychiatrist in terms of discussing patient symptoms, ruling out physical health causes and looking at the links between physical illness and behaviours that may challenge others. However, we did find that often decisions made in the multidisciplinary meetings were not communicated to the wider team. The lack of information shared and documented in handover and the poor quality of the patient records meant that information often got lost in the system.

Ward teams had effective working relationships with other teams in the organisation. There was an occupational therapist that worked for the provider, they were able to come into the service when requested to carry out assessments of patients.

Ward teams had effective working relationships with external teams and organisations. The local NHS trust, and the community mental health team for older adults within this trust were working hard to try and support the hospital to improve. They have offered to support staff in terms of care planning, Mental Capacity Act training and support and guidance for qualified staff working at the service. However, this had become more difficult as time went on due to the number of permanent staff leaving the service. The high turnover of staff had impacted on the community mental health team's ability to ensure there were staff working within the service who they could pass their knowledge onto. This in turn meant that this information could not be filtered down to other staff in the hospital. By the time we inspected the service, it was clear that the team would need to actually take on those roles themselves and complete care plans and capacity assessments for the hospital to ensure the safety of patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice, and they did not always discharge these well. Managers did not make sure that staff could explain patients' rights to them.

There was no specific training for staff provided around the Mental Health Act. At the time of our inspection, there was only one registered mental health nurse working within the service. Staff were unable to tell us during the inspection which patients were detained, it took some time for us to be provided with a list of detained patients. Some patient's records described patients as being detained when they were not detained. There were no staff in the hospital who had any specialist knowledge of the Mental Health Act, there were 12 detained patients at the time of our inspection.

The mental health law manager had recently left the service. There was no replacement for this person at the time of our inspection. However, the provider had cover provided by a member of staff who had previously taken on this role for maternity cover. The consultant psychiatrist was noted as the main point of contact for any advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support. However, this person had recently left their post and the post was vacant at the time of our inspection.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Information about independent mental health advocacy was available within the service. We did not see any evidence of patients who were involved with the advocacy service at the time of our inspection. We did request some feedback from the advocacy team involved but received no response. Patients were presumed to lack capacity and no capacity assessments were carried out at the service; therefore, it would have been difficult for the service to know who required this involvement.

Patient rights were not routinely visited, we struggled to ascertain from the hospital staff which patients were detained.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans did not include information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. However, the last audits were completed in January 2022, this was around the time the mental health law manager had left the service. We did not see evidence of ongoing audits since that time.

Good practice in applying the Mental Capacity Act

Staff did not support patients to make decisions on their care for themselves. They did not understand the providers policy on the Mental Capacity Act 2005 and did not assess and record capacity clearly for patients who might have impaired mental capacity.

Staff received training in the Mental Capacity Act, but this was not kept up to date. At the time of our inspection only 68% of the 28 eligible staff had completed this training, eight of these staff were on long term sick leave. Staff at all levels in the hospital had little understanding of the Mental Capacity Act and its guiding principles.

Inadequate

Wards for older people with mental health problems

There were nine Deprivation of Liberty Safeguards applications made in the last 12 months. When we requested the DoLS tracker for the service from the manager during the inspection, they confirmed they did not keep an actual tracker but relied on their memory. We requested the DoLS tracker post inspection and were provided with this, however, the manager was not aware that this existed. We were able to see on the tracker that one patient's DoLS had expired in January 2022, but the urgent application was not made until March 2022. On the two days we inspected the service, we found it difficult to ascertain who was subject to a DoLS. For one patient the record showed that their DoLS had expired some 12 months earlier. We eventually found that there was an updated form, but this took some time to locate. The current DoLS was due to expire in eight days and no plans had been made to relook at this. It was clear from all the evidence above that there was not oversight at a senior level that was picking up on these issues in a timely manner.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards. However, this was not always followed, we did not see patients within the hospital being given the choice to make decisions for themselves where this may have been possible. We saw language used in care plans such as, "I cannot think for myself" and, "I can not make decisions about my care." We saw these comments with no evidence of staff attempting to engage with patients in a way that they may be able to understand, for example, picture cards or easy read documents. There was also no evidence of any recorded capacity assessments or best interest decisions if the patient was deemed to lack capacity for a specific decision.

Due to the fact that patient's capacity was not assessed for any decisions, we were not assured that decisions were made in the best interest of patients and considered the patient's wishes, feelings, culture, and history. We did not see any evidence of this being taken into consideration. We saw one patient record that clearly outlined that the patient preferred male carers, we observed female carers attending to that patient throughout our inspection.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary. However, staff did not keep track of these applications. We found evidence in records of incorrect dates and out of date paperwork. We saw one patient, whose DoLs was due to expire in the coming days, staff had not made plans to reapply for this. We received a tracker for DoLS after our inspection at our request. This indicated several DoLS applications that had been made in recent weeks, it did not tell us under what authority the patient was held prior to this. We also saw one patient whose DoLS appeared to have expired in 2020 and another who did not appear to have been reviewed since 2016. We contacted the service for clarification on these issues but did not receive a response.

The service did not monitor how well it followed the Mental Capacity Act or act when they needed to make changes to improve.

Are Wards for older people with mental health problems 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. Staff did not understand the individual needs of patients and did not support patients to understand and manage their care, treatment, or condition.

Inadequate

Wards for older people with mental health problems

Staff were not always discreet, respectful, and responsive when caring for patients. We spent extended periods observing how care was provided in the main lounge during our inspection. This was where most patients spent most of their day. We observed that at times staff talked over the top of patients about their care needs. For example, shouting across the room which patients needed their incontinence aids changing. We also observed one patient being told to, "sit" in a very loud voice.

We did not observe many meaningful interactions between staff and patients during our inspection. We often saw staff who were on one-to-one observations of patients not speaking to them at all for several hours. We also observed some CCTV footage to review incidents, during this review we saw again, extended periods of time where staff stood over patients sat in chairs whilst talking to a colleague. We did, however, see some caring interactions between staff and patients at times. We observed some staff explaining to patients what they were being served for their lunch as well as chatting whilst walking to and from their bedrooms. We did not see staff giving emotional support to patients, we observed some patients becoming distressed at times and shouting out, it was unclear why this was happening, but staff did not attempt to engage with the patients and find out why. Some patients had information in their records that they preferred a quieter space, but throughout the two days we were on site, we saw those patients in the main lounge which was extremely noisy. The radio was playing on the television all day with no consideration for what the patients may like to listen to.

Staff did not support patients to understand and manage their own care treatment or condition. Although it is acknowledged that the patient group had severe cognitive impairment, we did not see any evidence of staff attempting to provide information to patients in a way that they may be able to understand or participate in. We saw most decisions being made for patients daily, with no regard for the patient's personal views, wishes or interests.

Although some staff were kind and respectful to patients, they did not always understand and respect the individual needs of each patient. When we spoke to staff about patients, they often only knew basic information about each patient. This was in part because most staff were not working long term at the hospital. Some members of staff needed to check with others to find out patient's names. Permanent staff who had worked for longer at the service did know the patients well, but this was not always possible to communicate to the agency staff as there were so many on each shift. Patients, therefore, had their basic needs met but staff did not engage with patients in a meaningful way about the things they enjoyed.

Staff told us felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff did not involve patients in care planning and risk assessment and only sought feedback from relatives on the quality of care provided. We did not see evidence of anyone accessing the independent advocates.

Involvement of patients

Staff did not involve patients or give them access to their care planning and risk assessments. We reviewed patient care plans in 9 out of the 18 patient records. We saw that care plans were often generic and did not include patient's views. Although most of the patients at the hospital did have severe cognitive impairment, we did not see any attempts to engage the patients in their care plan in a way they could understand. We did see some evidence of relatives being

asked to come into the hospital to review and sign patient care plans. However, relatives did not always have the legal responsibility to do this, and patients had not been assessed as lacking capacity to do this for themselves. Although it is good practice to involve relatives in care plans, to give valuable information about the patients' likes and dislikes, it is important to ensure that this is what is in the best interest of the patient and most importantly to firstly establish if they can do this for themselves. We did not see evidence of the use of pictorial or easy read care plans that the patient may have been able to engage with and understand.

Staff did not involve patients in decisions about the service.

We reviewed feedback forms from relatives during the inspection, we did not see or receive any evidence of patient feedback forms.

There was an advocacy service that usually worked into the hospital. We contacted the advocacy service for feedback or any evidence of involvement with patients, unfortunately we did not hear back from them. The provider told us that patients could not access the locally commissioned independent advocacy service due to staffing pressures at the advocacy service. This meant that they did not have access to an important safeguard to promote their legal and human rights. While the hospital did not commission the independent advocacy service, they did not escalate the access issues to the funders to ensure patients had this important safeguard.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, due to the number of issues we found during the inspection that had not been reported to the CQC and safeguarding, we were not assured that the provider always recognised significant issues in care. Therefore, families would also have not been made aware of these.

Staff made attempts to involve families or carers in patients' care. At the time of our inspection some relatives had been invited into the hospital to review patient care plans.

Staff helped families to give feedback on the service. We reviewed carer feedback from surveys and feedback forms. There were mixed views of the service, there was also a low completion rate (7 completed for 18 patients). The questions in the survey were often worded in a way that the patient would need to answer them, an example of this is "does my service help me choose what I do." Several relatives had answered that they were unable to answer on their relative's behalf, so no answer was given. Staff turnaround, poor communication, lack of video calls, lack of activities, lack of access to the community and garden space and lack of regular updates on their loved one's care were all raised as negative feedback. However, there were some positive answers, around the staff being caring and the improvements in the environment.

Staff gave carers information on how to find the carer's assessment.

Are Wards for older people with mental health problems responsive?

Inadequate

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

Access and discharge

We found that patients' discharge plans were not discussed as part of the weekly multidisciplinary team meetings. The care programme approach meetings, where care coordinators were invited to discuss their patients care had not been happening for over six months. This meant that those patients had remained in hospital when they were well enough to leave due to lack of individualised discharge planning.

A bed was available when a patient needed one, there were two empty beds at the service.

Bed management

Managers made sure bed occupancy did not go above 85%.

Managers did not regularly review length of stay for patients to ensure they did not stay longer than they needed to. We discussed discharge planning with managers and the consultant psychiatrist. We were told that discharge planning meetings were not occurring within the service and records confirmed this.

The service had one patient who was from out of the area.

Due to the lack of specialised staff in the service, there was no ongoing assessment of patients' needs to decide when it was appropriate to discharge patients.

Care programme approach meetings had not been taking place for over six months and this was mainly due to the lack of specialised staff to lead on these. Therefore, at the time of our inspection there were at least eight patients that the consultant psychiatrist described as being ready for discharge from a hospital. However, this had not been arranged. There was no system within the service to flag a patient as a delayed discharge, length of stay was not monitored. Some patients had remained in the service for many years, with the longest admission being 14 years. Once we had completed our inspection and had asked the provider to discharge all patients by 31st March 2022, the patients were all reassessed by a social worker to determine what level of care they would need. At this time, 14 of the 18 patients were assessed as not needing hospital care. Therefore, there was a pattern of patients remaining at the hospital for some time despite their records not detailing any reason why they would need to remain in a hospital rather than a care home.

Staff did not move or discharge patients at night or very early in the morning.

If a patient needed more intensive care then a bed would need to be made available in the local NHS Trust.

Discharge and transfers of care

There was no system in place at the hospital to monitor any delays in patient's discharge.

Patients remained in hospital when they were well enough to leave.

Staff did not carefully plan patients' discharge and did not meet with care managers and coordinators to make sure this went well. There had been no care programme approach meetings at the hospital for over six months. The consultant psychiatrist identified at least eight patients who were well enough to leave at the time of our inspection. However, this was not monitored or communicated to care coordinators.

Staff supported patients when they were referred or transferred between services.

Inadequate

Wards for older people with mental health problems

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 with an en-suite bathroom and could keep their personal belongings safe. However, there was one main lounge where patients spent most of the day, this was noisy and did not allow for a quiet space for patients. We did not receive any complaints about the food, and this appeared to be of a good quality.

Each patient had their own bedroom, which they had the opportunity to personalise. We saw some patients who had photographs and other treasured belongings in their bedrooms and in the memory boxes on their bedroom doors.

The hospital was limited in terms of space for patients. There was one main lounge which was large and had seating for patients. However, this was very noisy and often patients would become more distressed in this area as the day progressed. The service had tried to create a smaller lounge space for a quieter area. However, as this had no door there was no way to block out the noise from the main lounge area. Unusually, this space was then used for patients who tended to make more noise than others. The salon which in previous years had been used for hairdressing and other relaxing activities, was full of junk and could not be used as a therapeutic space. Other than that, there was just the patients' bedrooms for them to spend time in. The service had made use of the corridors where at each end there was a window that looked out onto the garden. These had been decorated in different themes to make them a pleasant area to sit. However, during our inspection we did not see these being utilised to spend one to one time with patients who needed a quieter or less chaotic space. This was disappointing given the time that had been spent to improve these areas since our last inspection.

The service had a visitors lounge just off the main reception.

Patients had access to a walkaround telephone should they wish to make phone calls in private.

The service had an outside space that patients could access easily. However, most of the carer feedback forms highlighted that their relative did not get much, if any, access to outdoors and fresh air.

There was a small kitchen area in the main lounge where staff could make hot drinks for patients, most patients did require some assistance from staff to do this.

The service offered a variety of food, we did not have any complaints about the quality of food from patients or in carer interviews or surveys. The kitchen had been assessed by environmental health and given five stars.

Patients' engagement with the wider community

Staff made some attempts to help patients to stay in contact with families and carers. However, we reviewed carer feedback forms, spoke to relatives, and found that communication was a key area that relatives were not happy with. Comments included that there was not enough communication from the manager, video calls needed to occur more often and that weekly updates had not been completed.

There was no evidence that we observed, saw in records or that we were told about that showed staff encouraged patients to develop and maintain relationships both in the service and the wider community. We did not see any evidence of any involvement in local groups or services that would have been suitable for the patient group.

Inadequate

Wards for older people with mental health problems

Meeting the needs of all people who use the service

The service did not meet the needs of all patients. Staff did not always help patients with communication and advocacy. The service did not offer cultural and spiritual support.

The service could support and make adjustments for disabled people. There was lots of dementia friendly signage around the hospital and interactive boards on corridors. We did not see evidence of communication aids being used or mentioned in care plans.

The service did have access to information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. However, we were not always assured that this was communicated well within the staff team. We saw evidence of differing information regarding patients' diet and fluid needs in care records, the kitchen, and the dining room. We did ask for this to be corrected prior to us leaving the hospital.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them. However, we did not see evidence of this being shared with the staff team and the wider service.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The complaint poster highlighted the point of contact in the service. A service audit completed in November 2021 by a volunteer, highlighted that although complaint information was visible in the service this was not written in a dementia friendly way.

It was difficult to assess staff understanding of the complaints policy due to the number of non- permanent staff working at the hospital. However, all staff we spoke to told us that they would refer any complaints to the manager of the service

Managers investigated complaints, there had been one formal complaint recorded in the six months since our last inspection.

Senior staff knew how to acknowledge formal complaints and relatives received feedback from managers after the investigation into their complaint. We did not see evidence of informal concerns that were raised in carer feedback forms being documented to look for themes and trends. However, there was some evidence in feedback forms of carers acknowledging that they had met with the manager to discuss their concerns.

The service used compliments to learn, celebrate success and improve the quality of care. One member of staff recently received an award for their work during the pandemic.

Are Wards for older people with mental health problems well-led?

Inadequate

Wards for older people with mental health problems

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Since our last inspection, the registered manager had left the organisation. There were also other senior staff off on long term sick. There was a distinct lack of leaders with relevant experience in the main hospital staff team, there was no clinical lead and only one registered mental health nurse. The new manager had a good track record in turning around failing services but did not have a background in managing hospitals for patients with dementia. However, the senior leadership team had been basing themselves at the hospital to support the team. The provider had also given notice on their contract to the commissioners of the service, this was due to expire on 31 March 2022.

There had only been three staff meetings during the last year. We requested the team meeting minutes for the last six months: the most recent minutes were from December 2021. The minutes prior to this were from April 2021. The December meeting minutes were brief, contained incomplete sentences and gave no information for staff who were not in attendance at the meeting. There was no evidence that these minutes had been shared with staff and there was no date for a future meeting.

Commissioners had concerns about the service and their ability to meet reporting requirements.

Culture

Staff did not feel respected, supported and valued. They were not always comfortable raising concerns due to fear of retribution.

The staff group felt stressed and there were high levels of sickness due to work related stress. The staff that were still at work told us they felt stressed and frustrated. The morale in the team was low and twenty staff had left since our last inspection in August 2021. However, one staff member had won an award for services during the pandemic.

Governance

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

The governance structure was not effective and there was a lack of oversight from the manager and the provider. There were not effective systems and processes established to ensure that the quality and safety of the unit was assessed, monitored, and improved.

Following our inspection, we asked for information about staff training. We found this information to be incorrect as it still contained many staff that had left the service. This meant that compliance percentages were inaccurate. We also

noted that the provider had ceased training for staff in managing violence and aggression, yet staff continued to use restraint. Senior managers had reviewed incident forms containing restraint of patients and had not recognised that the staff were not trained to use this. They were also not referred to safeguarding appropriately. There was no oversight of agency staff training in this area.

We did not see any evidence that staff supervision was taking place on a regular basis. We requested this information as part of inspection, despite reminders we never received this. The manager told us that they had completed twelve supervision sessions since they started at the service. However, when we requested evidence of this, we did not receive it. We did receive an overview of two discussions with agency nurses around medication. The provider told us that supervision notes were confidential so they could not be shared, but when we asked for a list of staff names and the dates their supervision session had taken place for the past six months, this was never received. There was no overview at a senior level of this information and the provider did not keep track of who was receiving supervision and how often to identify areas that were failing. The provider policy stated that staff should have access to supervision at least three monthly.

Staff appraisals were not taking place at the time of our inspection. The provider reintroduced an appraisal as a trial in June 2021. However, these were not due to start in services with high levels of vacancies until April 2022. Therefore, we were unable to assess how the provider ensured that staff were given the opportunity to develop and identify key training that would be useful for their role.

Key audits were not being completed. For example, we requested the most recent medicines audit. We were told this was completed in January 2021 by the manager. However, when we requested this audit, it was not provided.

Management of risk, issues, and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

We saw that the review of incident forms was not always used to ensure patient safety and reduce the risk of incidents reoccurring. For example, we saw incidents where patients had assaulted one another, and this was not immediately flagged as a safeguarding concern. We also saw that it was not routine to record on incident forms what steps were taken to reduce the incidents of violence and aggression prior to the use of restraint or medication. Although all incidents were reviewed by a senior member of staff, we did not see a great level of scrutiny when information was unclear or did not tell us what led to an incident or what happened post incident. We did not see any evidence of debriefs taking place to support patients and staff following an incident. We did not see trends or themes in incidents being discussed in team meetings.

Information management

The patient records were not accurate. We saw numerous examples of conflicting information which meant the risk of error was high. Examples of this were around diabetes management, choking risk, patients likes and dislikes.

We found that staff had not always made notifications to the Care Quality Commission as required. We found numerous examples of historic incidents that should have been reported to safeguarding and subsequently CQC which were not. We raised seven safeguarding concerns with the local authority whilst we were on site inspecting, we did not receive notifications for any of these from the provider. We also found some incidents that had been reported to safeguarding but not to the CQC.

Inadequate

Wards for older people with mental health problems

Team managers did not have access to information to support them with their management role. This included information on the performance of the service, staffing, and patient care. We asked the manager for the DoLS tracker and although this was later provided to us from another member of staff, the manager did not know that this tracker existed. We also found it difficult to get vital information about patients, for example we requested a list of patients and their level of observations for the six weeks prior to our inspection. This was so we could accurately check the number of staff required on each shift against the staffing rota. We did receive a list eventually, but this did not tell us the information we needed to scrutinise this effectively.

Patient records were kept in a cupboard in the main lounge. During our inspection, these cupboards were left unlocked, although staff were always present in the lounge area.

Engagement

Carers had opportunities to give feedback on the service their loved one received in a manner that reflected their individual needs. However, we did not see any evidence of the provider trying to engage patients in feedback about the service. Although patients were severely cognitively impaired, we did not see any innovative thinking around how patient feedback could be captured in some way. We saw evidence in carer feedback forms that they also felt their loved one should be given this opportunity. Some relatives had left questions unanswered, simply stating that they did not feel they could answer on their relatives' behalf. Feedback from carers was mixed, we did see some positive comments about the service, but for the most part carers commented that they were unhappy with the care their loved one received.