

Monet Lodge

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

Overall summary

We rated Monet Lodge as good because:

- the design and layout of the environment reflected best practice in dementia care, all areas were clean and clutter free, and ligature and falls risks were adequately mitigated
- the service had a stable staff team and an appropriate skill mix, which helped ensure continuity of care for patients' physical and mental health needs
- staff did not use prone (face-down) restraint or rapid tranquillisation techniques but did occasionally use the 'holding' technique (a low level of restraint), and only after de-escalation (calming down) techniques had failed
- medicines management practice, including storage, dispensation and administration was mostly in line with the relevant guidelines
- patients' care records were thorough, up-to-date and personalised, and contained a range of assessments and care plans associated with their physical and mental health needs
- patients received co-ordinated and all-round care and treatment from the multidisciplinary team, with each specialism contributing their specific skills and expertise
- staff received timely and meaningful supervision and appraisal, and managers encouraged their personal and professional development
- staff had a good understanding of the Mental Health Act (MHA), the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), the service adhered to the MHA and the revised MHA Code of Practice, and MHA documentation was in place and up-to-date
- there was a strong person-centred culture within the service and staff knew the patients and their relatives well
- we observed caring and respectful interactions between staff, patients and relatives
- relatives gave very positive feedback about Monet Lodge and were particularly impressed by the highly-motivated and caring staff, and the excellent care they provided
- the unit contained a full range of facilities and equipment to support treatment and care, and patients had access to a wide range of dementia-friendly activities tailored to their needs
- staff, including specialists, assessed patients' dietary needs and informed the unit's cook of any specific requirements
- the service had a clear governance structure, with effective systems and processes for overseeing all aspects of care including regular management meetings, a programme of audits and access to a service improvement team
- there was good morale among staff: they experienced job satisfaction, they felt valued and supported by colleagues and managers, and they shared the provider's vision and values for their service.

However:

- staff were not up-to-date with all their mandatory training
- medicines were not always ordered promptly, medicine errors were not always reported appropriately, and when nurses retrospectively corrected gaps found in medicine charts, this increased the risk of errors
- new 'capacity to consent to treatment' assessments were required for all patients because Monet Lodge had a new responsible clinician, but these had not yet started
- in one patient's care records, handwritten medical notes indicated that relatives had given consent for vaccinations on two occasions, with no reference to the MCA and the best interests framework (legislation that describes what to do when a person lacks the capacity to make a specific decision)
- although records contained information about patients' health-related dietary needs, we did not see any recorded information about their food preferences.

Summary of findings

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Good 

Monet Lodge

Services we looked at

Wards for older people with mental health problems

Summary of this inspection

Background to Monet Lodge

Monet Lodge is an independent hospital located in South Manchester, run by the provider, Making Space. Monet Lodge has a registered manager and 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, specialising in dementia care. The service provides care for informal

patients and patients detained under the Mental Health Act. The hospital contains two wards, one for male patients (Rivers) and one for female patients (Poppyfields). At the time of our inspection, the hospital was fully occupied.

The provider had an accountable officer for controlled drugs.

We inspected Monet Lodge four times between December 2012 and December 2013. We last inspected the service on 17 December 2013 and it was compliant with all the essential standards.

Our inspection team

Our inspection team was led by:

Si Hussain, Inspector, Care Quality Commission (CQC).

The team that inspected the service comprised five CQC inspectors and one pharmacy inspector.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the two wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six relatives of patients who were using the service
- spoke with the manager and deputy managers of the wards
- spoke with 10 other staff members including domestic staff and administrative staff
- spoke with the GP with a special interest in dementia (GPSI)
- looked at care records of seven patients
- looked at medication charts for six patients
- looked at four staff supervision records
- conducted a short observational framework for inspection (SOFI) exercise

Summary of this inspection

- carried out a specific check of the medication management on the wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

At the time of our inspection, we were unable to speak with patients because of the severity of their dementia. However, we conducted a short observational framework for inspection (SOFI) exercise, which involved close observation of staff and patient interactions for short periods. We observed excellent interaction between staff and patients. Staff knew the patients well and were very caring and respectful towards them.

We also spoke with six relatives of patients who were using the service. Relatives praised the staff and management, and gave positive feedback about all aspects of care. They commented on the high standard of cleanliness on the wards, the good condition of the building and facilities, and the caring and supportive attitude of staff towards the patients. Relatives expressed confidence about the safety of patients in the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- the hospital complied with the Department of Health gender separation requirements
- the environment reflected best practice in dementia care with consistent flooring throughout the communal areas and contrasting handrails along all corridors
- all areas of the unit were clutter free and there was a very high standard of cleanliness throughout
- the provider identified and adequately mitigated ligature and falls risks
- the service had a stable staff team and experienced low staff turnover and sickness rates
- the provider employed registered mental nurses (RMN) and registered general nurses (RGN) to help meet patients' physical and mental health needs
- the provider had a comprehensive mandatory training programme that included induction, and training on manual handling, safeguarding (protecting people from abuse), infection control, the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) (rules that ensure people are looked after in a way that does not inappropriately restrict their freedom), and food safety
- staff did not use prone (face-down) restraint or rapid tranquillisation techniques but did occasionally use the 'holding' technique (a low level of restraint), and only after de-escalation techniques had failed
- medicines charts were up-to-date and clearly presented to show the treatment people had received, and the relevant legal authorities for treatment were in place and monitored by nursing staff
- medicines were safely stored and emergency medicines were available
- staff received debriefs following incidents.

However:

- the average mandatory training rate was 70% which meant not all staff were not up-to-date with all their mandatory training

Good



Summary of this inspection

- medicines were not always ordered promptly, medicine errors were not always reported, nurses completed regular checks of the prescription charts but, where they found gaps in the record keeping, they corrected them retrospectively, which increased the risk of errors.

Are services effective?

We rated effective as good because:

- care records were comprehensive and contained a range of assessments and care plans associated with the patients' physical and mental health needs
- the provider's specialist dementia team supported the service to carry out best practice in dementia care provision
- the service had good access to a range of professionals from the local mental health trust and primary care services including a psychiatrist, a speech and language therapist, a GP with a special interest in dementia (GPSI), and social workers
- there were good working relationships between RMNs and RGNs, with each specialism contributing their skills, strengths and expertise to the provision of all-round care to patients
- staff received supervision on a two-monthly basis, and supervision records showed managers used a standard approach for supervision that included discussions about training and development needs, personal or work-related concerns, sickness absence, and any work performance issues
- the service adhered to the MHA and the revised MHA Code of Practice and MHA documentation such as detention records and approved mental health professional reports was in place and up-to-date
- in every case where staff needed approval to give a patient medication, the patient had a certificate of consent to treatment (T2) and a certificate of second opinion (T3)
- staff had a good understanding of the principles of the MCA, in particular, the starting point that people have the capacity to make decisions, and that capacity is specific to the decision being made.

However:

- new 'capacity to consent to treatment' assessments were required for all patients because Monet Lodge had a new responsible clinician, but these had not yet started
- in one patient's care records, handwritten medical notes stated that relatives had given consent for vaccinations on two occasions, but there was no evidence of the use of the MCA and the best interests process in this decision

Good



Summary of this inspection

- the training rate for MCA/DoLS was low at 11% but most staff were booked onto training sessions scheduled in the coming months.

Are services caring?

We rated caring as outstanding because:

- we conducted a SOFI exercise and observed excellent interaction between staff and patients and found that staff were responsive, supportive, and appropriately discreet
- relatives praised the staff and management describing them as caring, supportive and respectful
- staff had good working relationships with relatives, and relatives felt welcome in the unit at any time
- one relative described the staff and management as “wonderful” and another relative said “nothing is too much trouble for staff”
- three relatives we spoke with had noticed improvements in their relative since they moved to Monet Lodge
- staff knew patients well, and there was a strong person-centred culture within the service
- staff carried out assessments and care planning with patients and families, and care records showed evidence of relatives’ involvement.

Outstanding



Are services responsive?

We rated responsive as good because:

- the unit contained a full range of facilities and equipment to support treatment and care including a reception area, en suite bedrooms, a large communal lounge and dining area, a small female-only lounge, a fully equipped hair and beauty salon, and a well-maintained garden
- the unit employed a wellbeing co-ordinator three days a week who, supported by staff, offered patients a range of dementia-friendly activities tailored to their individual needs.
- staff worked with patients and relatives to understand the patients’ preferences and help personalise their rooms
- staff informed the unit’s cook of the patients’ dietary health requirements when they were admitted to the unit and following any changes
- the cook prepared meals taking into account each patient’s health conditions and any guidance from the speech and language therapist, for example, fork-mashable or pureed food
- relatives told us they knew how to complain and said they would be confident in doing so.

Good



However:

Summary of this inspection

- although records contained information about patients' health-related dietary needs, we did not see any recorded information about their food preferences.

Are services well-led?

We rated well led as good because:

- staff understood and shared the vision and values of the provider, especially those relating to specialist dementia service provision
- the service had a clear governance structure in place, with effective systems and processes for overseeing all aspects of care
- there was very good morale among the staff and managers of the unit, and the staff we spoke with expressed a strong commitment to the patients and the provider
- a sufficient number of staff of the right grades and experience covered shifts, and staff were able to dedicate a large amount of their time to face-to-face patient care
- the provider had a programme of audits in place that informed improvements in service delivery and practice
- the provider, Making Space, funded a dementia space team that provided expertise on best practice in dementia care, and helped the service identify areas for improvement
- the provider, Making Space, was involved in a number of dementia-focused initiatives, for example, a project exploring dementia in the black and minority ethnic (BME) community.

However:

- mandatory training levels were low in some areas but the service had plans to address these.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in reaching an overall judgement about the provider.

The service was adhering to the MHA and the revised MHA Code of Practice. MHA documentation such as detention records, approved mental health professional reports, and certificates of consent to treatment was in place and up-to-date.

The provider employed a permanent full-time mental health law manager who oversaw all matters relating to the MHA, for example, patients' rights, detention, renewals, and section 17 leave.

Following the appointment of a new responsible clinician to Monet Lodge, the mental health law manager, psychiatrist and registered manager had drawn up an action plan to complete new capacity to consent to treatment assessments.

The service complied with the Department of Health gender separation requirements. There were separate sleeping areas for male and female patients, and a separate lounge available for female patients.

All staff had a good understanding of the MHA and MHA Code of Practice but only 20% of eligible staff were up-to-date with MHA training, deemed essential for their roles.

There had been a MHA monitoring visit on 11 May 2015, which identified issues with out-of-date leave forms and inconsistencies in recording discussions about the patient's capacity to consent. By the time of our inspection, the provider had addressed these issues.

Patients had access to independent mental health advocates (IMHA), and the provider held a law clinic, at which relatives could gain advice and information.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider had recently experienced difficulties establishing the appropriate legal status for some of its patients owing to differences in interpretation of the MCA/DoLS and the MHA by the relevant local authority departments. At the time of our inspection, 14 patients were detained under the MHA, and three were subject to DoLS. A further three patients had urgent DoLS authorisations in place and were waiting for final decisions.






Staff had a good understanding of the principles of the Mental Capacity Act (MCA), in particular, the assumption that people have the capacity to make decisions, and that the consideration of capacity is specific to the decision being made. MCA/DoLS training was included in the mandatory training programme but at the time of our

inspection, the compliance rate was low at 11%. The provider had started to address this and most staff were booked onto training sessions scheduled in the coming months.

We found a good example of a thorough capacity assessment associated with a patient's 'do not resuscitate' (DNR) request. However, in one patient's care records, handwritten medical notes indicated that relatives had given consent for vaccinations on two occasions, with no reference to the application of the MCA and the best interests framework.

Patients had access to independent mental capacity advocates (IMCA), who attended care programme approach (CPA) meetings.

Wards for older people with mental health problems

Safe	Good 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

Are wards for older people with mental health problems safe?

Good 

Safe and clean environment

- The ward layout did not allow staff to observe all parts of the ward but staff presence throughout the unit and high levels of observations for all patients mitigated this risk adequately.
- The hospital complied with the Department of Health gender separation requirements by allocating separate wards for male and female patients. Patients shared the communal areas such as the lounge and dining area, and there was a separate lounge available to female patients.
- The environment reflected best practice in dementia care. For example, there was consistent flooring throughout the communal areas with contrasting handrails along all corridors. All areas of the unit were clutter free and there was a very high standard of cleanliness throughout.
- Communal bathrooms were clean and the cleaning rotas showed that domestic staff checked and cleaned each bathroom twice a day.
- The provider had completed a ligature (items that could be used for hanging) risk assessment in 2014 and adequately mitigated the risks identified. For example, anti-ligature rails supported the lounge curtains. However, the frailty of the patients meant there was a risk of falls if patients grabbed the curtains to steady themselves. The presence of armchairs close to the

curtains acted as a barrier and the continual presence of staff in the lounge area mitigated the risks adequately. Staff observed the patients closely because of their fragility.

- All bedrooms contained adjustable (profiling) beds. All windows had restrictors fitted.
- The building and grounds were modern, well furnished and well maintained. Staff recorded any repairs in a maintenance logbook that was kept in the office. The provider employed a dedicated maintenance worker for the unit, who ensured that all repairs were undertaken promptly.

Safe staffing

- The service had a stable staff team and experienced low staff turnover and sickness rates. The established staffing complement for the service was 33 whole time equivalent (WTE) staff. This included 12 WTE qualified nurses, and 21 WTE support workers. Between 1 May and 31 July 2015, the service reported two vacancies for qualified staff, which equated to a vacancy rate of 6%. During this period, the sickness absence rate was 5%.
- The unit employed both registered mental nurses (RMN) and registered general nurses (RGN). There was a minimum of one RMN on each shift.
- Day shifts comprised a minimum of two qualified nurses and four support workers, and night shifts comprised a minimum of two qualified nurses and two support workers. The staffing levels were increased as required to meet the needs of the patients. For example, during the past 18 months, there had been one additional support worker on every day and night shift.
- Staff and relatives perceived there were sufficient staff to provide care, and escorted leave and activities were rarely cancelled because there were too few staff.

Wards for older people with mental health problems

- The provider operated a shared bank staff system across two of its local dementia care units, which helped improve access to familiar and experienced staff at times of need. Some bank staff were long serving and worked regular shifts. Only staff who were familiar with them were allocated to patients who required 1:1 staff to patient care. Between 1 May and 31 July 2015, 18 shifts were filled by bank or agency staff and two shifts were unfilled because there were no qualified nurses available. However, in these instances, the service used additional support workers to support the RMN on duty.
- There was medical cover day and night with arrangements for medical staff to attend the unit quickly in an emergency. The local mental health trust provided access to psychiatry services, and there were enhanced GP services in place from a local practice.
- The provider had a comprehensive mandatory training programme that included induction and training on manual handling, safeguarding, infection control, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and food safety. However, staff were not up-to-date on all of their mandatory training. Although 93% of staff had received the provider's induction training, the average mandatory training rate was 70%. Training rates were less than 75% for basic adult resuscitation (70%), manual handling theory (74%), information governance (67%), health and safety (67%), MHA (20%) and MCA/DoLS (11%). Training was booked for some of these, including basic adult resuscitation and MCA/DoLS. For example, only three out of 27 eligible staff (11%) were up to date on MCA and DoLS training but training was booked for a further 22 staff.

Assessing and managing risk to patients and staff

- Prior to the inspection, the provider told us that it did not use restraint and therefore provided no data on the number of restraints. However, during our inspection, we found that although the provider did not use prone restraint or rapid tranquillisation, they occasionally used 'holding', a low-level restraint technique, when de-escalation techniques failed. We checked and found that staff had received the appropriate training to undertake this type of restraint, that is, positive handling level one and level two. We also checked and found that staff recorded these incidents as restraints, as required.

Following the inspection, the provider submitted data showing that seven incidents of restraints ('holding') involving two male patients had taken place between 1 March and 31 August 2015.

- The provider did not use seclusion (isolation) and segregation (separation) practices in the service.
- We reviewed care records for six patients, which contained risk assessments that were up to date. Staff undertook an initial risk assessment of every patient on admission. The manager or the deputy manager attended the initial assessments for all new patients, and ensured full historical information was available. The provider, Making Space, had devised its own comprehensive risk assessment tool informed by good practice guidance and tools. In addition, the unit undertook specific risk assessments, as required, for example, mobility, self-harm, and aggression. The information gathered informed the patients' care plans.
- There were good policies and procedures in place for the use of observation to minimise risks to patients. Staff reviewed patients' observation levels on a monthly basis or sooner if their circumstances changed. Routine observations took place every 15 minutes for patients at risk of falls. At the time of our inspection, three patients received 1:1 care.
- Staff received training on safeguarding and knew how to raise safeguarding issues. Staff we spoke with gave examples of scenarios that would require safeguarding alerts, and said they would be confident in raising them.
- We looked at six medicines charts. These were up-to-date and clearly presented to show the treatment patients had received. Where required, the relevant legal authorities for treatment were in place and monitored by nursing staff. All patients were registered with a local GP practice and supported by a GP with a special interest in dementia (GPSI). The GPSI monitored the patients' physical health. The GPSI prescribed medicines for the patients' mental health in consultation with the consultant psychiatrist. We saw that patients had the opportunity to meet with their psychiatrist at a ward round every two weeks.
- We reviewed the provider's medication management practices. While practice was generally good, we also found a number of errors. For example, staff had given patients medication from other patients' stocks when theirs had run out. We raised this issue with the provider who immediately held a staff meeting to remind staff of correct practice, and informed us that they intended to

Wards for older people with mental health problems

examine their processes to identify the reasons why medicines ran out. In another case, a nurse dispensed some medication and then when called away urgently, she asked a support worker to administer the medication. We discussed this issue with the provider. The provider assured us that this was a single, rare event and that staff were aware of the correct procedure.

- There was no evidence of regular clinical pharmacist support to the unit, and pharmacists were not part of patients' reviews. Although the service sought pharmacist advice in individual cases, we found one case in which it did not seek advice about the suitability of crushing medicines prior to administration. This meant that patients were at risk of receiving treatment that may not have been safe in a crushed form.
- The provider's policy described the procedure for the safe use of the covert (hidden) administration of medication. We saw one example where staff applied this to a patient's mental health medications but not to other medicines.
- Medicines were safely stored and emergency medicines were available, if needed. Staff, with support from the community pharmacist, completed audits of the storage of medicines and the handling of controlled drugs. The provider had identified an accountable officer for controlled drugs who maintained links with the local controlled drugs intelligence network (a group that oversees the safe management of controlled drugs).
- Nurses completed regular checks of the prescription charts but where gaps were found in the record keeping, they corrected them retrospectively, which increased the risk of errors. We found one undated chart. This made it difficult to tell when staff had administered the medicines.

Track record on safety

- The provider listed no reportable incidents under the serious incidents requiring investigation (SIRI) framework.
- The unit's prescription chart audits found errors that were breaches of its medicines policy. However, the unit had only reported one medicine error in the previous six months, and there was no record of the failure to follow the medicines policy. This meant that not all errors were being reported appropriately.

Reporting incidents and learning from when things go wrong

- The unit learnt from incidents and changed its practice, where necessary. For example, following an incident involving misplaced medication, the provider reviewed its medicines management practice, and increased the frequency of medicines checks.
- Staff confirmed they received debriefs following incidents. These took place at staff meetings, supervision sessions or during handover meetings.

Are wards for older people with mental health problems effective? (for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We reviewed care records for six patients. These were comprehensive and contained a range of assessments and care plans associated with the patients' needs. One patient's file contained 19 care plans including plans for physical health, nutrition, continence, mobility, communication, finances, and end of life. For ease of reference, care records contained a care summary and a brief history of the patient. Care plans were thorough, up to date and personalised. They were written in large font and pictorial format, and were person-centred, for example, "I prefer a shower," and "please ask if I would like tea or coffee."
- The service showed a strong commitment to assessing the risk of falls and taking preventative action. A physiotherapist from the local health care trust carried out falls assessments, with input from the GP, which informed the falls log, the falls prevention care plan, and the patient's required level of observation. All bedrooms were fitted with movement sensors that monitored overall movement.
- Care records showed that patients did not receive electrocardiography (ECG) tests, where required. The provider explained that patients received appointments but it was often distressing for them to attend hospitals. The manager had raised this concern at the hospital's clinical governance forum in July 2015. In response, the provider had ordered an ECG machine for the unit, and this was due to arrive the day after our inspection.

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- Records showed that all patients had hospital passports, which contained key information in case of admission to hospital.
- Records showed that all patients received physical health checks on a monthly basis. Staff supported patients to make positive changes to their health and wellbeing, for example, reducing their caffeine intake. The provider ran a smoking cessation service at one of its other locations, which was available to suitable patients.
- Care plans and daily records were stored in lockable cabinets in the lounge/dining room for easy access. All staff held keys to the cabinet.
- The service had access to a GP with a special interest in dementia (GPSI). The GPSI knew the patients well, and supported staff with the service's assessment, care planning and reviewing processes.

Best practice in treatment and care

- The service had developed a dementia strategy in line with the national dementia strategy (Living Well with Dementia 2009), the Prime Minister's challenge on dementia, and the national institute for health and care excellence (NICE) quality standard to support people to live well with dementia.
- The provider's specialist dementia team supported the service to implement best practice in dementia care provision. This included supporting practitioners working in the service, recruiting volunteers and offering specialist training.
- Medication was prescribed and reviewed in line with NICE guidance. Staff completed regular audits of patients' antipsychotic medicines. Staff monitored side effects and reported them at patients' reviews to ensure appropriate action was taken.
- We reviewed the provider's scheduled programme of audits. This included a wide range of audits that benchmarked practice against NICE guidance, for example, the assessment and prevention of falls, nutrition support in adults, delirium, the use of medication for non-cognitive symptoms, and the mental wellbeing of older people in care homes. In addition, the schedule of audits included checks on detention documentation, section 17 leave, and section 132 rights. Although some of the planned audits had been completed, we found that some had been

postponed owing to time constraints and other priorities. However, the provider had rescheduled these, and we were satisfied that systems were in place to continually assess and improve the standard of care.

Skilled staff to deliver care

- The commissioning arrangements for Monet Lodge meant that the service had good access to a range of professionals from the local mental health trust and primary care services. These included a psychiatrist, a speech and language therapist, a GPSI, and social workers. The psychiatrist and GPSI attended the unit twice a week. However, the unit reported difficulties in receiving occupational therapy support but had recently taken on occupational therapy students who were supported by the registered manager.
- The unit employed both registered mental nurses (RMN) and registered general nurses (RGN) to support the mental and physical health care needs of its patients. There were good working relationships between RMNs and RGNs, with each specialism contributing their skills, strengths and expertise to the provision of holistic care to patients. For example, RGNs monitored blood sugar levels, took blood tests and oversaw intravenous feeds.
- Staff were suitably experienced and qualified for their roles. In addition to mandatory training, staff received additional specialist training for their roles. This included breakaway and conflict management, dementia psycho-social intervention training and activating potential for communication training. All staff participated in the two-day person-centred care training course.
- Staff received supervision on a two-monthly basis. We reviewed four supervision records, which showed managers used a standard approach for supervision that included discussions about training and development needs, personal or work-related concerns, sickness absence, and any work performance issues. Staff and their supervisors signed and dated the supervision records.

Multidisciplinary and inter-agency team work

- Multidisciplinary team (MDT) meetings took place on a two-weekly basis and were well co-ordinated. They included as a minimum a psychiatrist, nursing staff, and the wellbeing coordinator. Support workers did not usually attend the meetings but could do so if there was sufficient cover on the unit. Care programme approach

Wards for older people with mental health problems

(CPA) meetings took place on a minimum six-monthly basis, and included social workers, a physiotherapist, occupational therapy students, speech and language therapy staff, the GPSI, advocates and relatives. The MDT invited other disciplines, such as pharmacy and dietetics, to attend, when required.

- The service had strong links with the local commissioners, the local mental health trust, and the local authority safeguarding team.
- Handovers took place between full day and night shifts and included brief reports on the patients' progress, issues and outstanding tasks. There were no formal handovers during shorter (half-day) shifts because very few staff were affected. However, staff leaving or starting shorter shifts received informal handovers from colleagues and team leaders.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- The service was adhering to the MHA and the revised MHA Code of Practice. MHA documentation such as detention records and approved mental health professional reports was in place and up to date. All patients who required them had certificates authorising the administration of medication had certificates of consent to treatment (T2) and certificates of second opinion (T3) in place.
- Patients received their rights on a regular basis. The provider had developed an easy read rights leaflet, which staff gave to patients.
- There were separate sleeping areas for male and female patients but they shared communal areas such as the lounge and dining area. However, there was a separate lounge available to female patients.
- The provider employed a permanent full-time mental health law manager who oversaw all matters relating to the MHA, for example, patients' rights, detention, renewals, and section 17 leave. The mental health law manager undertook quarterly audits specific to the MHA and MHA Code of Practice. We saw examples of completed quarterly audits on section 17 leave forms, consent to medical treatment, and section 132 rights. Additionally, staff undertook monthly audits on section 17 leave forms, and T2 and T3 forms.
- A new responsible clinician from the local mental health provider trust (Manchester Mental Health and Social Care Trust) had recently taken on responsibility for the patients in Monet Lodge. This meant that new capacity

to consent to treatment assessments were required for all patients. These had not yet commenced but the mental health law manager, psychiatrist and registered manager had drawn up an action plan to address these alongside other legal requirements.

- All staff had a good understanding of the MHA and MHA Code of Practice. Support workers and healthcare workers did not receive training on MHA but it was mandatory for qualified staff. However, only 20% of eligible staff were up-to-date with MHA training, deemed essential for their roles.
- There had been two MHA monitoring visits to the service on 2 October 2014 and 11 May 2015. By May 2015, the provider had addressed all the issues identified in the visit on October 2014. In May 2015, the findings of the visit included the following issues:
 - Patients' files contained out of date leave forms that were not scored through. This created the possibility of confusion about what leave had been authorised.
 - There was variability in the frequency of recorded discussions about the patient's capacity to consent. This meant it was unclear if the provider reviewed capacity to consent at appropriate intervals.
- The provider submitted an action plan in response to these issues on 2 June 2015, which showed how it intended to address the issues and identified timescales for doing so. At our inspection, we found that the provider had addressed the issues.
- Patients had access to independent mental health advocates (IMHA) who attended CPA meetings. The provider held a law clinic, which relatives could access for advice and information.

Good practice in applying the Mental Capacity Act (MCA)

- The provider had recently experienced difficulties establishing the appropriate legal status for some of its patients, which it reported was due to differences in the interpretation of the MCA/DoLS and the MHA by the relevant local authority departments. The provider had made 11 DoLS applications between February and August 2015, and a number of patients had been assessed under the MHA. This had resulted in the increase in the number of patients detained under the MHA. For example, in May 2015, seven patients were detained under the MHA, and four patients were subject to DoLS. At the time of our inspection, 14 patients were

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detained under the MHA, and three patients were subject to DoLS. A further three patients had urgent DoLS authorisations in place and were waiting for final decisions.

- Staff had a good understanding of the principles of the MCA, in particular, about the presumption of capacity and its decision-specific application. Staff knew they could consult the mental health law manager for further advice and information.
- We found a good example of a thorough capacity assessment associated with a patient's 'do not resuscitate' (DNR) request. However, in the GP notes of one patient's care records, we found two references to consent being given by relatives for vaccinations. We raised this with the provider and the GP but were unable to establish whether it was a recording error or the wrongful application of the MCA. However, we could find no evidence of the application of the MCA and the best interests process in this case.
- MCA/DoLS training was included in the mandatory training programme but at the time of our inspection, the compliance rate was low at 11%. The provider had started to address this and most staff were booked onto training sessions scheduled in the coming months.
- Patients had access to independent mental capacity advocates (IMCA), who were invited to CPA meetings.

Are wards for older people with mental health problems caring?

Outstanding



Kindness, dignity, respect and support

- We conducted a SOFI exercise and observed excellent interaction between staff and patients. Staff were responsive, supportive, and discreet, when necessary.
- Relatives gave excellent feedback about the staff and management. One relative commented on the staff's "very supportive interaction with patients." Another relative described the staff as "wonderful." Another relative said, "nothing is too much trouble for staff." Three relatives we spoke with perceived improvements in their relatives since they had moved to Monet Lodge.

- Staff showed an excellent understanding of each patient's needs and family circumstances. Staff showed a person-centred approach in their attitudes and behaviours towards patients. This included domestic staff.
- There were systems in place such as flexible shift patterns, which helped ensure a supply of familiar staff on shifts, and supported continuity of patients' care.
- Staff had good working partnerships with families and carers, and were sensitive to their needs. For example, staff prepared patients for visits from relatives by talking to patients or showing them photographs. Staff welcomed visits from relatives at any time. They offered them drinks and snacks and invited them to join activities.
- Staff were very aware of the specific needs of their patients and were committed to ensuring the environment was safe, familiar, warm and welcoming.

The involvement of people in the care they receive

- Care plans showed that staff included patients and relatives in assessment and care planning.
- The planned admission process was thorough and informative, and involved the patient and relatives.
- Noticeboards held information about advocacy services, available to patients and relatives.
- The service held a monthly tea party for patients and their relatives.
- Communication between staff and families was very good. Staff invited relatives to attend CPA meetings and kept them up-to-date on the patient's progress.
- The provider, Making Space, held law clinics, which relatives could access for advice and support on a range of issues including patients' rights, legal processes such as appeals, and information on the MHA, MCA and DoLS.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good



Access and discharge

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- At the time of our inspection, the service was operating at full capacity as it had recently admitted three new patients.
- Manchester Clinical Commissioning Group (CCG) commissioned the service for Manchester residents registered with Manchester GP practices. All patients were therefore from the local area.
- In the past six months, there had been one delayed discharge caused by a change in the patient's family circumstances.
- Discharge planning was part of the CPA process.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit was located in a single storey building in a residential area of South Manchester. The unit contained a full range of facilities and equipment to support treatment and care. These included a reception area, two corridors comprising en suite bedrooms, a large communal lounge and dining area, a small female-only lounge, and a fully equipped hair and beauty salon. There was a pleasant, well-maintained garden area visible and accessible from the lounge. The accommodation was spacious with a good standard of décor and furnishings. The unit was warm and welcoming, and had a good atmosphere. The design of the large communal lounge and dining room made people feel at home. It contained a number of smaller seating areas, which gave patients the opportunity to choose where they felt comfortable. For example, the seating area near the windows and patio doors looked out onto the garden; there was a small quiet area with books and games; there was a TV area; and there was a seating area set out around a fireplace, which gave the appearance of a living room.
- Manchester City Council had awarded Monet Lodge a food hygiene rating of five (very good) in September 2013.
- Staff worked with patients and relatives to understand the patients' preferences and help to personalise their rooms. Patients also had a memory box outside their bedroom, which contained personal photos and memorabilia.
- The unit employed its own cook, and the food was of good quality. Patients and their relatives could make hot drinks at any time.
- Relatives commented that patients' possessions were kept safe. Patients had lockable drawers in their

bedrooms, and bedroom doors locked automatically when a patient left the room. However, patients did not have keys to their rooms. This was because of the nature of the patient population and because all bedroom door locks could be opened by the same key. This meant that there was no opportunity for patients with sufficient capacity to hold their own keys.

- The unit employed a wellbeing coordinator for three days a week. The coordinator, supported by staff, offered patients a range of activities tailored to their individual needs, for example, board games, old films, newspapers, and hairdressing. Dementia-friendly therapeutic activities offered included the reminiscence group, old photographs and memory books. The unit held events for patients and relatives such as music and theatre, animal visits, and remembrance events. The provider had its own mobile multi-sensory unit, containing sound, light, touch and music functions, and during our inspection, we saw staff place the unit near to patients who benefited from it.
- The indoor and outdoor design and layout of the unit meant that patients could walk around freely and remain safe.

Meeting the needs of all people who use the service

- Staff informed the on-site cook of patients' dietary health requirements when they were admitted to the unit and following any changes. The cook prepared food taking into account guidance from the speech and language therapist, for example, fork mashable or pureed food. However, we did not see any recorded information on patients' files about patients' food preferences.
- Staff produced care plans in accessible formats. We saw care plans written in large font and pictorial format.
- The service held a remembrance event led by a local vicar to commemorate the end of World War II. The service invited relatives of former patients to this event.
- Patient and relatives were actively involved in the whole care pathway from referral to discharge.
- Patients and relatives received a welcome pack prior to admission, which contained information about the service and contact details.

Listening to and learning from concerns and complaints

- Relatives told us they knew how to complain and said they would be confident in doing so.

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- The provider received two formal complaints between August 2014 and July 2015. One complaint was not upheld and the other was converted to a safeguarding incident.

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

Good 

Vision and values

- Staff were aware of the vision and values of the provider and the local service. In particular, staff commented on the strong patient focus, the team-working ethos, and the strive for excellence in dementia care.
- All staff benefited from the additional training on dementia care and the availability of expert advice. In particular, they were aware of the need to have a good understanding of dementia and its impact on the lives of patients and relatives.
- Staff knew the structure of the provider organisation, Making Space. Staff also knew who the senior managers were within Making Space, and said they often visited the lodge.

Good governance

- The service had a clear governance structure, with effective systems and processes for overseeing all aspects of care. These included the clinical governance forum, and the hospital managers' committee, which took place on a quarterly basis. The minutes of the clinical governance forum from March 2015 showed that the forum discussed issues, identified actions and monitored progress pertaining to the quality and safety of care.
- Staff received mandatory training, supervision and appraisals. However, mandatory training levels were low in key areas such as MHA, MCA and DoLS.
- A sufficient number of suitably qualified and experienced staff covered shifts, and staff were able to dedicate a large amount of their time to face-to-face patient care.

Leadership, morale and staff engagement

- The staff we spoke with expressed strong commitment to the patients and the provider. Most staff were

long-serving employees. Staff found the environment challenging due to the complex nature of patients' needs but felt supported by colleagues and management. Staff spoke highly of the manager and deputy manager of the service. The managers of Monet Lodge commented on the good working relationships they had with the provider, Making Space.

- We observed good team working and mutual support between staff of all grades. Unqualified staff, including domestic staff, reported feeling equal to all other staff and part of a bigger team. One staff member said, "I'll be here until I retire."
- Staff said the provider supported them to undertake training and develop their careers. For example, one domestic worker said she had achieved the national vocational qualification (NVQ) in health and social care level two, and was considering applying for an NVQ level three course.
- Staff had the opportunity to give feedback on any aspect of the service during their supervision sessions or at staff meetings. One staff member gave examples of changes the provider made following her suggestions.
- The principles of the duty of candour underpinned the complaints process, which encouraged a culture of openness and transparency when errors were made and harm caused.

Commitment to quality improvement and innovation

- The provider had a programme of audits in place that informed improvements in service delivery and practice. Managers reported the outcomes of audits and associated action plans to the hospital managers' committee. The committee oversaw progress with the action plans.
- The provider, Making Space, had recently introduced the Care Certificate framework across all its services. The Care Certificate identifies a set of standards for care workers to adhere to, and includes education and training. Care Certificate training was mandatory for new employees in a support worker role. Monet Lodge had two staff who had completed the Care Certificate assessor training.
- The provider, Making Space, funded a dementia space team that provided expertise on best practice in dementia care and helped the service identify areas for improvement. The service had developed a strategy in line with the national dementia strategy (Living Well

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with Dementia 2009), the Prime Minister's challenge on dementia, and the NICE quality standard to support people to live well with dementia. The strategy presented three key objectives for the organisation:

- Communication, training and learning will continue to develop, support and improve the experience of people with dementia who use services and their carers.
- Services will work towards being dementia friendly, and ensure people who have dementia receive a service that addresses and meets their needs.
- Services will provide an environment that is dementia friendly for the people who use the services and promote an effective working environment for the staff.
- At the time of our inspection, the provider, Making Space was involved in a number of dementia-focused initiatives. A project exploring dementia in the black and minority ethnic (BME) community aimed to identify specific issues and concerns for BME patients to help improve access to the right care at the right time. The provider was developing spirituality care plans to support compassion-focused therapy for patients at Monet Lodge, and it was rolling out training for local staff on distress, nutrition and pain in dementia care.

Outstanding practice and areas for improvement

Outstanding practice

- The unit offered a high quality, dementia-friendly environment. This included the design and layout of the unit, the décor and furnishings, the high standard of cleanliness and hygiene, and the facilities, for example, there was a fully equipped hair and beauty salon on-site, and the unit had a mobile multi-sensory unit, which incorporated light, touch and sound functions.
- The provider, Making Space, employed a dedicated mental health law manager who oversaw all matters relating to the MHA, for example, patients' rights, detention, renewals, and section 17 leave, and undertook regular audits.
- The provider, Making Space, funded a dementia space team that provided expertise on best practice in dementia care and helped the service identify areas for improvement.
- The provider, Making Space, was involved in a project exploring dementia in the black and minority ethnic (BME) community. This aimed to identify specific issues and concerns for BME patients to help improve access to care services.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure staff fully adhere to medicines management practices. Medicines should be ordered promptly, and any errors should be reported and dealt with appropriately.
- The provider should ensure all staff are up to date with mandatory training.
- The provider should ensure that capacity assessments are undertaken in line with the Mental Capacity Act, and that decisions are recorded correctly.
- The provider should record patients' dietary preferences.