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Manon House

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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.

Overall summary

During the inspection we found:

- Risk assessments of people using the service had not been regularly reviewed and there were no plans in place showing how identified risks would be managed or mitigated.
- When restrictions were placed on people there were not always care plans in place to explain this.
- The service did not have safe arrangements in place for the storage and disposal of medicines.
- The manager failed to recognise safeguarding concerns even when these were being investigated by the local authority safeguarding team.
- There was no incident logs and incidents were not routinely recorded or reviewed so that the staff and manager could learn from these.
- People's needs were not assessed comprehensively and recorded.
- People's care plans contained limited information and were not holistic or recovery orientated.
- Some information about people was placed in another person's care records.
- There was no record that staff had received any training since 2013-2014.
- Staff had a poor understanding of the Mental Capacity Act and guiding principles. There was no record that they had received training.
- There was little evidence of people's involvement in planning their care.
- People using the service were not encouraged or supported to develop independent living skills.
- There were no planned or structured activities being arranged for people who required support and encouragement.
- There was no system for recording formal or informal complaints. There was no information for people using the service about how they could complain.
- There was no system in place to assess and monitor standards of care in order to identify improvements in quality and safety.

However,

- We observed kind and caring interactions between staff and the people using the service.
- The food was of good quality and snacks and drinks were available at all times and dietary needs were met for those of different ethnicities and religions.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Risk assessments of people using the service had not been regularly and there were no plans in place showing how identified risks would be managed or mitigated.
- When restrictions were placed on people there were not always care plans in place to explain this.
- The service did not have safe arrangements in place for the storage and disposal of medicines.
- The manager failed to recognise safeguarding concerns even when these were being investigated by the local authority safeguarding team.
- There was no incident logs and incidents were not routinely recorded or reviewed so that the staff and manager could learn from these.

Are services effective?

- People's needs were not assessed comprehensively and recorded.
- People's care plans contained limited information and were not holistic or recovery orientated.
- Some information about people was placed in another person's care records.
- There was no record that staff had received any training since 2013-2014.
- Staff had a poor understanding of the Mental Capacity Act and guiding principles. There was no record that they had received training.

Are services caring?

- There was little evidence of people's involvement in planning their care.

However,

- We saw positive, kind and caring interactions between staff and people who use the service.

Are services responsive?

- The provider did not have a system in place to ensure complaints were recorded and handled effectively.

Summary of findings

- People could access activities independently, but there were no planned or structured activities being arranged for those who required support and encouragement.

However,

- The food was of good quality and snacks and drinks were available at all times and dietary needs were met for those of different ethnicities and religions.
- People had access to a telephone and the use was monitored.

Are services well-led?

- There was no system in place to assess and monitor standards of care in order to identify improvements in quality and safety.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Long stay/ rehabilitation mental health wards for working-age adults		We did not rate the service as this was a focussed inspection and did not cover all aspects of the service provided.

Manon House

Detailed findings

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

Detailed findings

Contents

Background to Manon House

Manon House offers residential accommodation and support services to men aged 18 years and over with mental health problems. The service has six beds.

The service is registered to provide:

- Accommodation for persons who require treatment for substance misuse
- Accommodation for persons who require nursing or personal care
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

However, we found that Manon House did not provide accommodation for persons who require treatment for substance misuse or assessment or medical treatment for persons detained under the Mental Health Act 1983.

There is a registered manager in place at the service.

Our inspection team

Team Leader: Elizabeth Kennea, Inspector, Care Quality Commission

The team who inspected Manon House consisted of four people: two CQC inspectors, an expert by experience and a specialist advisor with a background in nursing and substance misuse.

How we carried out this inspection

We inspected this service because we had received information of concern.

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

During the inspection visit, the inspection team:

- visited Manon House, looked at the quality of the environment and observed how staff were caring for people
- spoke with two people who were using the service
- spoke with two staff members; a support worker and a senior support worker
- spoke with the registered manager
- looked at the records of four people using the service
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service

Are services safe?

Our findings

Safe staffing

- From 7.00am to 10.00pm daily there was one support worker on duty. The registered manager provided support as required. At night there was one sleep-in support worker and one staff member who was awake. The registered manager was on call. A deputy manager attended the service one day a week. These staffing levels had not been estimated using a recognised tool.
- The two staff who worked during the day agreed the shifts they would cover between them. They worked six days week, which was a total of 46 hours and this included a weekend shift of 11 hours. The registered manager was on call and would cover if required. People using the service told us there was always a member of staff available.
- The service did not use bank or agency staff and there was not a system in place for staffing levels to be increased in response to any change in needs of the people being supported or to cover any sickness or leave.
- People who used the service could go out unescorted and access regular activities. However, there was no structured plan of activities for people either within the home or in the community.

Assessing and managing risk to patients and staff

- We reviewed the records of the four people using the service. We found a risk assessment was completed for each person. The risk assessments made statements about risks affecting individuals including serious risks such as suicide and arson. However, there were no corresponding risk management plans. One of the risk assessments had not been reviewed for a period of over seven months, between February 2015 and the time of inspection. The registered manager told us due to the low number of people using the service staff knew them and assessed risk as part of the usual day and this was why there were no up-to-date records. However, the service was not doing all that was reasonably practicable to mitigate the risks affecting people that had been identified. As a result, care and treatment was not being provided in a safe way.
- When restrictions had been placed on individuals there were not always care plans in place to explain this and ensure that staff and the person using the service understood the restriction. For example, one person using the service had his telephone use monitored by staff. Staff said this was because they thought he was using the phone too often. This was not included in the person's care plan. There was a risk that people were having restrictions placed upon them without these being recognised or agreed with the person concerned.
- There was a blanket restriction placed on when people using the service needed to return to the service in the evening. The front door to the service was locked at 10.00pm. There was a statement given to people on admission for them to sign to show they agreed with this policy. Staff told us there was flexibility given to those who wanted to go out later and this would be agreed between the person and staff on duty. However, there was not a written policy and this was not documented.
- The manager told us staff were trained in safeguarding. However, the most recent safeguarding training record was dated 2013-2014. There was no record that staff had completed any training in 2015. Staff told us it was difficult to complete training along side their day to day duties.The manager told us he was looking to introduce a programme of safeguarding e-learning for staff.
- The service did not have safe arrangements in place for the storage and disposal of medicines. The service had not carried out an audit of medicines since February 2015. We found that one resident was keeping prescribed medication in an unlocked communal cupboard and one of these medications was not logged in the medication book. The locked medication cupboard contained out-of-date medication including that for a person who no longer resided at the service. The medication cupboard also contained loose papers and old files and was generally untidy. There was a risk that staff might use out of date medicines if they were not disposed of safely and in a timely manner.

Track record on safety

- In the twelve months prior to inspection there were three safeguarding incidents recorded by the local authority safeguarding team. These were not recognised as legitimate safeguarding concerns by the registered manager and there was no associated recording

completed by the service. One related to a child under the age of one staying overnight, with the mother, in a person's bedroom. The failure of the manager to recognise the incident as a safeguarding concern meant there was a risk that people were not being adequately protected from abuse.

Reporting incidents and learning from when things go wrong

- There was no incident log. There were no structured meetings in place for staff to discuss incidents or share learning. Staff told us that the low number of people, often stated to be two, although there were four at the time of inspection, negated the need for formal incident reporting because staff were meeting people's needs and incidents did not occur. This was contrary to the information received regarding the safeguarding concerns in March 2015. This approach could put people and staff at risk of harm should there be an serious incident. Without assessing and monitoring the safety of the service, including recording, reviewing and learning from incidents, there was a risk that the service would not improve safety and quality and protect service users from harm.

Are services effective?

Our findings

Assessment of needs and planning of care

- We reviewed the care records of four people who used the service. The records did not contain a comprehensive assessment of people's needs. The registered manager said he knew the people using the service well and understood and could meet their daily needs. However, the failure to fully assess and record people's needs put people at risk of receiving inappropriate or unsafe care and treatment. The information recorded about people was not sufficient to inform any new staff of people's care needs.
- We reviewed the care plans of four people. Care plans contained limited information and were not holistic or recovery orientated. The care plans contained statements such as 'Outcome: to remain mentally well'. The only subsequent action to help the person maintain their mental health was for staff to support them to take medication. There was no record of of the person's interests, preferences, strengths or goals.
- The service kept paper records. These were kept in different places in the service and moved around by staff. In two people's individual care records we found documents which related to another person using the service. This was potentially confusing for staff. People using the service could access their care records when they wanted to. Their confidentiality was at risk from the filing errors and lack of proper management of the care records.

Skilled staff to deliver care

- The manager and staff told us they received appropriate training to support them in their roles including safeguarding, mental capacity, first aid and medication training. However, the most recent staff training records available were for the period 2013-2014. Staff told us it could be difficult to take time away from work to complete training. There was a risk staff were not updating their knowledge of best practice and changing the way they provided support to people accordingly.

Multi-disciplinary and inter-agency team work

- There was a lack of multi-disciplinary work with other local services. Staff described the service as 'isolated' from local care coordinators and health services. The manager had some involvement with care programme approach meetings, but these were not regularly documented on people's care records.

Good practice in applying the MCA

- Staff did not show a good understanding of the Mental Capacity Act and guiding principles. This could result in people not being supported to make their own decisions and being deprived of their liberty. There was no record to show staff had received any training in this area.
- People's care records did not record any issues relating to their mental capacity. The registered manager told us that if formal capacity assessments were required this would be the responsibility of the care co-ordinator.

Are services caring?

Our findings

Kindness, dignity, respect and support

- Staff demonstrated compassion for the people they supported. We observed positive interactions between staff and people using the service.

The involvement of people in the care they receive

- The documented evidence of people's involvement was limited to their signing to confirm they had seen the care plan. Not all care plans were signed. People were not able to tell us the details of their care plans. They said they did have care plans, but did not know what they contained.
- The service had monthly community meetings. These were attended by staff and people using the service and decisions were made about the arrangements for support. The minutes from these meetings were available, but stopped in May 2015. Staff could not explain the reason for this. People were able to raise issues important to them and felt listened to, but did not know if action was taken following these discussions.

Are services responsive?

Our findings

The facilities promote recovery, comfort, dignity and confidentiality

- There were rooms and spaces where people could take part in activities including a kitchen, lounge and garden, but these were not being used by people to engage with activities. The kitchen was open and accessible and people could make snacks and drinks, but all meals were prepared for them. They were not supported to develop independent living skills.
- People who used the service had their own rooms which were personalised. All bedrooms had ensuite facilities.
- There were no structured activities being provided by the service. People told us they would like to go out more and in particular take part in sporting activities.

Listening to and learning from concerns and complaints

- There was no system for recording formal or informal complaints. The manager and staff told us that no complaints had been received and the low number of people using the service enabled the staff to provide adequate support to prevent complaints.
- No information was provided for people on how to make a complaint, such as a leaflet or poster.
- People told us they could raise issues and did feel listened to, but did not know if action was taken or change occurred as a result of something they raised with staff.
- There was no system for learning from complaints or issued raised by people.

Are services well-led?

Our findings

Good governance

- The manager told us staff were compliant with mandatory training, including safeguarding, mental capacity, first aid and medication training, but there was no written evidence to confirm this was the case. There were no systems in place to monitor staff training. The most recent record was for the 2013-2014 period.
- There were no systems for reporting incidents and escalating risk information, disseminating information and learning, or monitoring standards within the service. Incidents were not recorded which meant there was a risk the service could not learn from them in order to prevent reoccurrence. Similarly the manager did not recognise safeguarding incidents.
- Staff understood safeguarding but there was not a process for recording and reporting concerns. There were three safeguarding investigations started by the local authority in March 2015. The manager said they did not recognise these incidents as legitimate safeguarding matters.
- The service policies and procedures were accessible, but not kept in a designated area. They were generic and not adapted to the needs of the service. In a policy titled 'social inclusion' there were six pages covering the support people using the service could expect to receive to be active in the community. However, the service did not provide structured activities or have systems to put the policy into practice.
- No audits had been completed, other than medication audits prior to February 2015, and there was a lack of understanding from the management team as to what audits should be completed and how this information could be analysed and used to improve the service. The focus of the manager and staff was on completing daily tasks such as supporting people to attend appointments. There was a lack of consideration given to outcomes for people and for the service.

Leadership, morale and staff engagement

- Leadership was fragmented with the registered manager taking responsibility for many tasks such as completing assessments, but also providing regular support to people such as supporting them to attend appointments. We heard different accounts from staff as to who held responsibility for other tasks including supervision and completing audits. There was no clear system for delegation from the registered manager to other senior members of the team.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that risk assessments of people using the service are completed on admission and reviewed regularly. There must be plans in place to minimise the risks to people.
- The provider must ensure that there are safe arrangements in place for the storage and disposal of medicines.
- The provider must ensure that the manager and staff understand and recognise safeguarding concerns and refer these to the relevant local authority safeguarding team.
- The provider must ensure that all incidents that occur in the service are recorded and reviewed so that the staff and manager can learn from these and improve standards of safety.
- The provider must ensure that people's needs are assessed comprehensively and recorded.
- The provider must ensure that people's care plans contain detailed information and are holistic and recovery orientated.
- The provider must ensure that staff receive appropriate training and this is repeated at regular intervals so that they remain up to date and adequately trained to fulfil their role.
- The provider must ensure that people are involved in planning their care and that this is recorded.
- The provider must ensure that people using the service are supported to develop independent living skills.
- The provider must ensure that there are structured activities arranged for people who require support and encouragement.
- The provider must ensure that there is a system for recording formal or informal complaints. There must be written information for people about how they can make a complaint.
- The provider must ensure that there is a system in place to assess and monitor standards of care in order to identify and implement improvements in quality and safety.

Action the hospital SHOULD take to improve

- The provider should ensure that when restrictions are placed on people they have care plans that explain this. Restrictions should be reviewed regularly.
- The provider should ensure that information in people's care records is about them and not about someone else.
- The provider should ensure that staff understand the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and how this applies to their work with people.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of people using the service did not always reflect their needs and preferences. The service did not work collaboratively with people to assess their needs and preferences. People were not enabled or supported to understand their care or treatment choices or achieve their rehabilitation goals. This was a breach of regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment provided to people was not always appropriate and safe. The risks to health and safety of people using the service were not always assessed. The service was not doing all that was reasonably practicable to mitigate the risks to people. Medicines were not properly and safely managed. This was a breach of regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

People using the service were not protected from abuse and improper treatment.

Systems to protect people were ineffective. The staff and manager had failed to recognise incidents as safeguarding concerns or refer them for appropriate investigation.

This was a breach of regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not have an accessible system for identifying, receiving, handling and responding to complaints by people using the service and others. This was a breach of regulation 16(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems established to assess, monitor and improve the quality and safety of the service provided. There were no incident logs and incidents were not recorded. Therefore staff could not learn from these and make improvements in the service. This was a breach of regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate training to enable them to carry out their duties safely and effectively. This was a breach of regulation 18(2)(a)