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 well-led?	Inadequate

Summary of findings

Overall summary

Due to the concerns we found during this inspection, we asked the provider to take urgent and immediate action.

The provider addressed the most serious concerns immediately. We have also issued warning notices for three breaches of regulation to ensure that swift action is taken and plans put in place to maintain improvements.

Our rating of this service is inadequate. We rated it as inadequate because:

- The service was not safe, unclean, not well equipped, not well furnished, not well maintained and unfit for purpose.
- Staff had not received basic training to keep patients safe from avoidable harm.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines.
- The service did not have a good track record on safety. Environmental risks had not been escalated or addressed.
- 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.
- Governance structures were ineffective and there was a lack of oversight from the registered manager and provider.
- We were concerned that there were elements of a closed culture that had developed in the service since last inspected.

The service will be placed in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
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 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 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 17 patients. The bedrooms were single occupancy with en-suite facilities.

The provider had a registered manager and an accountable officer for controlled drugs.

We inspected Monet Lodge seven times between December 2012 and October 2019. We last inspected the service in October 2019 and the service was rated as Good overall.

This inspection was triggered by intelligence we had received about the hospital. This was an unannounced inspection.

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 how staff were interacting with patients and we undertook structured observations using the short observation framework for inspection. A short observation for inspection is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves.

We undertook a 40 minute observation over a mealtime period and noted a low number of interactions overall, some positive, some negative. We would expect to see a higher level of interactions over a mealtime in this type of service.

How we carried out this inspection

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent to us by the service. A notification is information about important events which the service is required to send to us. We also reviewed information we had requested from the registered manager in relation to staffing and infection control.

During the inspection visit the inspection team:

Summary of this inspection

- undertook a site visit and looked at the cleanliness and maintenance of the environment
- spoke with the registered manager and clinical lead
- spoke with other staff members, including nurses, support workers and the chef
- attended and observed one handover meeting
- undertook structured observations using the short observation framework for inspection
- looked at four treatment records, which included care plans and risk assessments
- looked at three medicines administration charts
- looked at cleaning records
- looked at maintenance records
- reviewed the duty rota and staffing arrangements
- reviewed three staff files

Areas for improvement

Action the service MUST take to improve:

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

- The service must ensure that the premises and equipment are safe and well maintained (Regulation 12(1)(2)).
- The service must ensure that infection prevention practices are improved, including assessing the risk of, and preventing, detecting and controlling the spread of infections (Regulation 12(2)(h)).
- The provider must ensure the premises are clean and complaint with the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Regulation 12(2)(h).
- The service must ensure the proper and safe management of medicines, including where treatment is authorised by the Mental Health Act 1983 and taking account of the Mental Capacity Act 2005 particularly in relation to covert medicines (Regulation 12(2)(a)(b)(g)).
- The service must ensure that assessment of risks, including environmental risks and risk registers, are used to do all that is reasonably practical to mitigate risks and that these are reviewed and amended regularly to address changing practice (Regulation 12(2)(b)).
- The service must ensure effective mitigation of risks, including ligature and environmental risks and that these are regularly reviewed and actions taken when required (Regulation 12(2)(b)).
- The service must ensure safe moving and handling practices are used including ensuring staff follow patients plans and are suitably trained and supervised (Regulation 12(2)(b)(c)(d)(e)).
- The service must ensure that assessments of patient's care include all relevant health and safety concerns and are reviewed regularly (Regulation 12(2)(b)).
- The service must ensure that staff are supported to complete patient risk assessment tools correctly and that the results of these are acted upon (Regulation 12(2)(b)).
- The service must ensure that drinks thickeners are stored safely in accordance with the patient safety alert (Regulation 12(2)(b)).
- The service must ensure that all staff receive training in basic life support and managing violence and aggression to ensure they can respond to clinical or medical emergencies (Regulation 12(2)(b); Regulation 18(1)).
- The service must ensure a systematic approach to determine the number of staff and range of skills in order to meet the needs of patients and keep them safe (Regulation 18(1)).
- The service must ensure an induction process for all staff, including agency staff (Regulation 18(2)(a)).
- The service must ensure that staff receive appropriate ongoing supervision (Regulation 18(2)a)).

Summary of this inspection

- The service must ensure that staff are supported to complete mandatory training and that action is taken quickly when training requirements are not met (Regulation 18(2)(a)).
- The service must ensure there are effective systems to assess and monitor this service with scrutiny and overall responsibility for this service at a board level or equivalent (Regulation 17(1)).
- The service must ensure the registered manager assesses, monitors and acts on information relating to the quality and safety of this service (Regulation 17(2)(a)(b)).
- The service must ensure there are systems and processes to identify where quality and/or safety are being compromised and respond appropriately and without delay (Regulation 17(2)(a).
- The service must ensure there are systems and processes which identify and assess risks to the health, safety and welfare of patients who use the service and that these are escalated and acted upon (Regulation 17(2)(b)).
- The service must ensure risks to patients who use the service are continually monitored and appropriate action is taken where a risk has increased (Regulation 17(2)(b)).
- The service must ensure that records relating to patients care and treatment are complete, accurate and up to date (Regulation 17(2)(c)).

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	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Wards for older people with mental health problems

Safe	Inadequate
Well-led	Inadequate

Are Wards for older people with mental health problems safe?

Inadequate

Safe and clean care environments

The service was not safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not complete and regularly update thorough risk assessments of all wards areas, and did not remove or reduce risks they identified.

There were maintenance issues including broken fixtures and fittings leading to ligature risks and the risk of electrocution. There were three bedrooms where broken electrical sockets had been covered with paper to prevent tampering.

In a bedroom corridor, a safety grille was missing from a radiator cabinet. In one en-suite bathroom, a shower unit had been partially removed exposing pipework. In one bedroom the door handle was broken. In four bedrooms there were holes in the wall which had not been filled when furniture or fixings had been removed. In three bedrooms, curtains were not properly secured and in one of these a makeshift curtain had been tied from each end of a curtain rail.

In the dining area, there was a broken drawer in the TV unit, with the front missing but the drawer carcass and fittings intact. The dining area kitchen had a cupboard with a door missing and a broken drawer.

The service complied with guidance on mixed sex accommodation. There was a male and a female corridor for bedrooms. There was a female only lounge but staff told us this was used for visits and multidisciplinary meetings. This was not well maintained and had a table where much of the laminate covering had been peeled away leaving one sharp pointed edge. This would not have been a safe environment for patients to access.

There were potential ligature anchor points in the service in the form of trailing wires and leads, poorly fitted window coverings and furniture fixtures and fittings. Staff did not recognise these potential ligature anchor points and did not mitigate risks to keep patients safe.

The ligature risk assessment was overdue for completion, having been last completed in March 2020 and for completion every six months. It did not include individualised risks in rooms including trailing leads or bed rails.

Staff had access to alarms in patient's bedrooms, however in one bedroom the alarm was out of reach at the bottom of the bed and in one room the alarm was difficult to access as a high backed chair was placed in front of it. Movement sensors were in use in all bedrooms but we saw these were blocked with folders and pictures in some patient's bedrooms to prevent them from sounding an alarm. During observations in communal areas we saw that staff did not respond rapidly to these sounding.

The garden area was full of old chairs and tables from the lounge and some of these had exposed foam or soft furnishings with them which were exposed to the elements. The garden was not a safe area for patients to use.

Maintenance, cleanliness and infection control

The service was not clean, well maintained, well furnished or fit for purpose.

In the communal lounge/dining area, there was dust evident on high and low surfaces, including the skirting board, radiators and light fittings. The walls and radiators were dirty, with marks and spills. One radiator had medicine pots and spacers drying on paper towels on top of it. Some of the lounge chairs had stains and dirt on the surfaces and seams. There was one chair with ripped fabric and a stained porous fabric footstool in use.

In the dining area, we saw that the tables were dirty and were not cleaned before the evening meal was served. There were stains to the ceiling and the floor. The worktop in the kitchen area was warped and expanded with water damage. In the kitchen area there was a cupboard door missing. In the fridge there was out of date food. Juice had been left on the side in uncovered jugs and this was served with food at teatime.

In the female lounge, the chairs were in poor condition and a non-easy clean fabric and the table had had nearly all the veneer peeled away leaving one pointed section attached.

In two patients' bedrooms there were chairs which were stained and damaged.

Moving and handling equipment, including the hoists in use at the service, had been checked and serviced. Some equipment was stored in a storeroom where there were also a number of walking frames and aids which were no longer used. These had not been disposed of and other equipment was then being stored inappropriately, for example, a wheelchair was stored in the hairdressing salon.

Staff completed cleaning records but these were only partially completed. The housekeeping team had members of staff off work but there had not been appropriate plans put in place to ensure the service was cleaned.

Cleaning schedules indicated that the cleaning of most areas of the service be completed on a daily basis. Cleaning records showed this was being completed on only some days of the week when there were housekeeping staff on duty.

The level of dirt, marks and dust showed the service was not being cleaned thoroughly regularly.

Staff were not following infection control policy, particularly in relation to coronavirus (COVID-19) guidance. One staff member was overheard being told to put a mask on. The clinical lead and registered manager were both wearing cloth masks rather than disposable masks. We saw staff on the unit wearing masks under their chins during the inspection.

The provider had not been able to arrange regular testing for staff or patients for COVID-19. Whilst staff and patients had been offered vaccinations, the lack of routine testing presented a high risk to both patients and staff. This had been highlighted to commissioners and the local authority but was still not in place when we inspected. The registered manager was having to order one test at a time for patients who had symptoms.

Staff did have access to sufficient supplies of personal protective equipment and hand sanitiser was available at fixed points around the service. Perspex screening had been installed in the reception area.

Laundry was not being managed safely. Dirty laundry skips were stored in the female bathroom which was used for dirty laundry for all patients in the service, including a red bag for infected linen. The bathroom was in regular use for patients who required assistance bathing or showering. In the laundry room there were six bags on the floor in front of the washer and dryer. Three of these were red bags for infected linen. It was unclear how long they had been there. Patient's clean clothing was being stored in a trolley with individual baskets on a corridor between the kitchen and the laundry room. The provider told us clean laundry was only placed on the trolley for transportation to the patients' bedrooms.

In the main kitchen, the chef was not following the four-week menu, which meant that staff could not be sure what meals had been served. The chef was unaware of any patients with specific allergies or intolerances or any patients requiring a special diet. There was no written information relating to soft or pureed diets and the chef would ask nursing staff how many soft meals were needed.

There were two fridges and two freezers, so four on the temperature monitoring sheet, but these were not labelled so staff wouldn't be able to tell which appliance was which. The dial thermometer in the fridges were not relied upon, and other measures were used to check temperatures. There were no stickers on opened food jars and condiments in the fridge to indicate when opened. In the freezer, foods were not labelled as to the date stored.

The cooker had not been cleaned, and the floor between appliances and in gaps was dirty.

An infection control audit had been undertaken in the service in January 2021 with a compliance score of 74% but no urgent action had been undertaken to improve. Some issues had been raised at previous annual audits and action had not been taken.

Clinic room and equipment

The clinic room contained accessible resuscitation equipment that staff checked regularly.

In the clinic room, the worktops were cluttered. The floor was peeling away from the wall which presented an infection risk. There were paint chips on the floor from where paint has been knocked loose from the door frame or walls and there were grooves and marks to the walls. There was a large hole in the wall below the alarm point.

The handwashing sink was not compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections guidance as it was too small and not appropriately secured to the wall. There was chipboard and mould apparent under the sink. It was blocked from use by two large waste bins.

Safe staffing

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

Inadequate

Wards for older people with mental health problems

Nursing staff

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

The manager told us that staffing numbers were set on a ratio of patients to staff. There had not been a needs-based assessment of staffing requirement and many patients required staff assistance for personal care and assistance at mealtimes. During observations of the evening meal, staff sat and assisted a patient to eat, then would assist another patient from the lounge to the dining area and assist them to eat. The first patient had not finished their meal and continued to eat with their hands. Another patient was asked if they wanted tea and refused. There was no further discussion with the person encouraging them to eat. The patient's food and fluid charts indicated they had refused most meals that week. We reported this to the registered manager and followed up after inspection.

At the time of this inspection, laundry and housekeeping staff were absent due to sickness and their work had not been adequately covered.

The service had difficulties with chef cover during January and February 2021 due to furlough and vacancies.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had been using bank and agency staff to cover when regular staff were off sick, isolating or to cover for enhanced observations. There was a core group of agency staff covering shifts regularly within the service. However, the agency was not on the provider framework and whilst urgent agency staffing could be supplied by an agency not on the framework, routine agency use was expected to be arranged through the provider framework.

There was a high use of agency staff and we had concerns about their knowledge and skills with this patient group. We had concerns about agency staff having sufficient understanding of the English language to fulfil their role. Staff need to be able to communicate effectively with patients in terms of de-escalation and managing behaviour that challenges and to reassure patients who are distressed or upset. We were not assured that some staff were able to do this. We saw a memo from the clinical lead in the duty rota which was apparently a copy of a text message sent to agency staff noting "continuous complaints" about staff speaking in their native language, rather than English, whilst working. This had also been the subject of a complaint in 2020.

There were concerns that agency staff were not suitably trained, particularly in relation to moving and handling patients and prevention and management of violence and aggression training.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift.

New staff including bank staff completed a comprehensive induction pack when they started work. Agency staff did not receive a formal induction into the service and there was no documentation to show what their understanding of the service and their duties was.

The service had low vacancy rates and had been actively recruiting for nurses and support workers. There were vacancies for one registered nurse and two support workers at the time of inspection.

The service had increasing rates of bank and agency nursing assistants. We reviewed the duty rotas for January and saw increasing use of agency staff as the month progressed. The service had patients requiring enhanced observations which accounted for much of the use.

The service had low rates of bank and agency nurses. The service maintained staffing establishments of two qualified nurses on all day shifts and most night shifts during January 2021.

Managers supported staff who needed time off for ill health. Staff had been supported when they were ill and individual return to work arrangements made where needed.

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

Day shifts had two registered nurses per shift. The service employed mental health nurses and general nurses, which was positive in ensuring mental health and physical health needs were met. There were occasions in the duty sheets where two general nurses were on duty. Both staff were experienced nurses who had completed elearning modules relating to Mental Health Act and Mental Capacity Act /Deprivation of Liberty safeguards. However we were not assured that these staff had sufficient knowledge and expertise in mental health care.

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

Additional staff had been required when patients required a higher level of observation.

Managers followed recruitment processes when appointing staff members, including bank staff. We reviewed three personnel files and all were well maintained and showed recruitment checks completed, including disclosure barring service checks, references obtained and identification checks before commencing employment.

Staff shared key information to keep patients safe when handing over their care to others.

We observed the evening shift handover. This took place in the main lounge and the confidentiality aspects of this did not appear to have been considered. Staff used a handover sheet to ensure they discussed relevant information and changes.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to attend the service quickly in an emergency.

Medical cover was provided by a consultant psychiatrist from the local mental health trust.

There was also an enhanced GP service in place from a local practice. Regular medical reviews were evident in care records.

Staff could contact the out of hours GP practice for urgent medical issues out of office hours and at weekends. In an emergency, staff would contact the emergency services for assistance.

Mandatory training

Staff had completed and kept up-to-date with some of their mandatory training.

The provider could not initially supply figures for the number of staff up to date with basic life support training. We were told that two of the eleven nurses employed and half the support workers were up to date with basic life support training. This equated to 40% of staff trained. This training was not listed on the mandatory training matrix kept by the registered manager.

Not all staff had completed prevention and management of violence and aggression training. Figures supplied by the registered manager showed 81% of staff had completed this training. The spreadsheet provided by the service indicated 75% of staff were up to date. One member of staff included as up to date had completed this over four years ago. Two members of staff had been working in the service since 2018 and 2019 respectively without being trained. Whilst there had been an impact on all face to face training due to the pandemic, this training had last been run in September 2019.

Most staff, 94% of eligible staff had completed infection prevention e-learning in the last 3 years. In addition, 40% of staff completed additional face to face infection prevention training in 2019 from an external provider. Most staff, 89%, had completed mandatory COVID-19 e-learning in the last year.

A number of staff were out of date in completing fire awareness training. Staff have been reminded to complete this and information received from the manager since inspection showed this had now been completed by 89% of staff.

Health and safety training was completed every three years. Six staff were out of date and one was new in post, meaning 81% of staff were up to date.

Most staff had completed level 1 moving and handling (97%) and level 2 moving and handling (92%).

Most staff were up to date with Mental Health Act training (90%), Mental Capacity Act training (97%), Deprivation of Liberty Safeguards training (97%), Falls training (95%), Dysphagia training (89%), Dementia training (95%) and Equality and Diversity training (95%)

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers did not monitor mandatory training and did not alert staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using recognised tools, but these were not always reviewed regularly.

Staff completed best practice risk assessment tools to assess risk of pressure damage, nutritional needs, pain and falls assessments.

Some scales had not been calculated correctly and some scales were not completed with all the information needed to calculate correctly. For example, a choking assessment was noted as scoring 4 but added up to 10 whilst another scored as 14 but should be 8. One patients Waterlow scale did not include past and current medical history which added to the score and risk of developing pressure damage.

All patient records had a falls risk assessment completed. Two patients had falls risk assessments fully completed but not dated. One patient had a falls assessment which was blank but had a handwritten risk summary completed at the bottom.

One patient had a bed rails risk assessment which was regularly reviewed in 2018 but there were no more up to date reviews in the file.

We reviewed four clinical records. The quality of records was variable, with some up to date and reviewed regularly and others not up to date or reviewed regularly. Staff completed moving and handling assessments and mobilising care plans, and whilst two of these were detailed and specific to individual needs, two lacked detail about how best to support people.

Speech and language therapists had visited and completed plans for some patients. These had not always been incorporated into care plans, for example, one patient had been assessed as needing a soft diet and pureed foods but this was not in the nutrition section of their care plan.

Some records contained conflicting information. For example, in one patients clinical record, there was guidance for staff in understanding what a level five diet was, with guidance for a level six diet within the same section. In one patient's risk assessment, they were noted to be subject to 2:1 observations with 1:1 crossed out and amended. The observation sheet stated 1:1 observations.

Some care plans contained standard content which had not been added to or individualised.

Management of patient risk

Staff did not always consider risks to each patient and did not always act to prevent or reduce risks.

In the dining area, we found drinks thickener in an unlocked cupboard. Storage of thickeners has been the subject of a patient safety alert where harm had been caused by the accidental swallowing of the powder, when it had not been properly stored out of reach. Staff immediately removed this to secure storage.

We saw poor moving and handling techniques used twice during observations of the communal areas where patients where assisted to stand by staff lifting under their arms. We also saw good moving and handling practice with a member of staff slowly walking with a patient with their arm placed gently at the back for reassurance.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff observed patients who required enhanced observation. Whilst care plans outlined the level of observation, it was not clear from care plans what the purpose of enhanced observations was and what specifically staff needed to be aware of. Whilst there were separate male and female bedroom corridors, these were not monitored by staff. We saw staff locked the bedroom door of patients that were cared for in bed. Patients were not mobile and would need staff assistance to mobilise. Staff told us this was to ensure they were not disturbed by other patients.

Use of restrictive interventions

Levels of restrictive interventions were low.

There had been five reports within the last 12 months when patients required use of restraint.

There was no use of seclusion or rapid tranquillisation in this service.

One patient was being nursed in a confined area of one of the bedroom corridors away from other patients. This was to try to isolate the patient due to concerns relating to infection control and COVID-19, but it was not clear how this situation had been agreed or decided. There was no guidance for staff to follow in this situation. Staff did not recognise this as segregation. We saw that this was not consistently applied across the service when other patients had not been isolated in similar circumstances.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training with 86% of staff up to date with safeguarding adults training and 91% up to date with safeguarding children training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. This was discussed with staff in supervision sessions.

The registered manager had notified CQC when safeguarding alerts were raised.

Staff access to essential information

Patient notes were comprehensive and all staff could access them easily.

The service had paper notes but the provider was in the midst of changing to an electronic records system. The paper notes were stored in large ring binder files. In some files, there were additional documents and correspondence filed at the front. It was not always easy to find the information needed and it was not clear where new or temporary staff would look first for information they needed. Some patients had a hospital passport near the front of their file which contained relevant information, but not all files had one of these.

Records were stored securely.

Medicines management

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.

Staff did not always review patients' medicines regularly.

We reviewed three medication charts. We found out of date consent to treatment documents with all three charts. This included forms authorising treatment under the Mental Health Act (T3 and section 62 forms) which were no longer in use.

Two patients were assessed by medical staff as requiring covert administration of medicines. Covert administration is when medicines are administered in a disguised format. Medicines could be hidden in food or drink without the knowledge or consent of the person receiving them.

Medical staff had completed an authorisation form for each patient. This decision had been made without liaison with nursing staff, pharmacy staff or the patient or their carer. The forms only included medicines prescribed for mental health problems. There was no information on this form of how to prepare this medicine (for example, crushed or as a liquid) and how to administer (in food or a drink).

One patient was being prescribed a medicine above the British National Formulary limit and this had not been recognised by staff.

One patient was prescribed a benzodiazepine as an as needed medicine. The stock balance for this medicine was incorrect on two occasions and staff had just corrected the balance without reporting it as an incident. Because of the discrepancies in stock recording, it was difficult to know what dose has been given each time and there are dangers associated with benzodiazepine overdosing and abrupt withdrawal.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Medicines were stored appropriately within the clinic room, including controlled drugs and recordable medicines. Prescription charts and consent to treatment documents were stored appropriately in accessible folders within the clinic room.

Track record on safety

The provider has previously had a good track record on safety.

At this inspection, we were concerned that environmental hazards had not been acted upon and that maintenance reports were not being made for serious defects and routine issues.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

In the six months between August 2020 to January 2021 there had been 58 incidents reported including near misses. The most commonly reported incidents were aggressive behaviour and cuts/grazes/bruises.

Managers debriefed and supported staff after any serious incident.

We saw from personnel records that staff were offered support by managers following incidents.

Inadequate

Wards for older people with mental health problems

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

Inadequate

Leadership

The registered manager and clinical lead for the service have been in post for some time. They have previously shown they had a good understanding of the service they managed. However; there was a lack of leadership in this service. The registered manager had been working from home for periods due to the coronavirus pandemic and lockdowns. They told us they were at work in the service three days per week and working from home two days per week. The clinical lead was working four days per week at the service.

There had been no staff meetings during the last year. Instead, the registered manager sent a monthly team brief. This included information in a set format under specific headings, directing staff to previous emails sent and folders in the service. In the last six months of team briefs, there were no items submitted by staff although there was occasional items addressing staff concerns. Whilst the brief was sent by email to staff and printed for reading in the staff room, it was unclear whether staff read this, and this was not checked, despite it containing time relevant information for staff to act on, for example, renewing mandatory training. Issues with staff not being up to date with mandatory training, including Fire Awareness, was included in team briefs in January 2021 and December 2020 but a high level of staff were out of date when mandatory training levels were reviewed following this inspection. This does not show good oversight or management of staff.

Other information in the team briefs suggests that some of the concerns raised at this inspection have been present for some time and had not been appropriately addressed by managers. For example, we observed poor moving and handling practice. In the team briefs for January 2021 and December 2020 there was a section relating to staff not following care plans and not using hoists when this was indicated by a care plan. If managers were aware of this, this should have been addressed immediately with staff concerned rather than included as an item in the team brief, particularly where this carried immediate risks to patients and staff.

Data provided following this inspection was sometimes incomplete and/or incorrect. The registered manager had not maintained oversight of key issues in the service, including routine and urgent maintenance, completion of audits, overseeing staff training, induction and training for agency staff.

At the conclusion of the inspection, our feedback was met with explanations about coronavirus and a lack of contractors willing to work on site. There was little recognition of the concerns raised or the need to urgently address these. We asked how often the manager checked the environment and looked around the service area and the manager told us they did not do this.

Culture

We were concerned that there were elements of a closed culture that had developed in the service since we last inspected. A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones. This will also have been impacted by the coronavirus (COVID-19) pandemic.

Inadequate

Wards for older people with mental health problems

The service is at higher risk of developing a closed culture given that patients may not be able to communicate when they have concerns about the service and/or staff. During the last year, carers and relatives have been unable to visit their loved ones. Professional visits have been limited and commissioners had reduced the frequency of their visits. There had been one commissioner contract performance meeting in the last 12 months and this had been held via video conferencing.

This lack of oversight also extended to the wider provider management. This service is a single site location which operates in isolation. Senior managers had not visited the service regularly.

Whilst not a focus for this inspection, it was clear that there was little meaningful activity occurring in the service. In patient records, section 17 leave was granted for hospital appointments or medical visits rather than for exercise or therapeutic activity. The garden area had previously been refurbished prior to our last inspection, but at this inspection was unusable as it was full of broken or old furniture from communal areas. Observations by inspectors in the communal areas showed low interaction with patients by staff, and staff often congregated by a nursing station.

The environment was not homely or welcoming. There did not seem to have been any consideration that broken furniture and unclean surroundings were not a pleasant environment for people to live in. In the main communal area, one wall was dominated by a large office type wall planner. Despite our inspection taking place at the end of February 2021, this was for 2020, the previous year, and no-one had thought to take it down.

The registered manager had been asked about closed cultures prior to this inspection and they told us that there an open culture and an “open door” policy in terms of the manager and clinical lead, including phone or email contact if not available on site. They told us staff were regularly offered supervision, that the manager and clinical lead were visible within the service and that there were regular surveys for carers and staff to obtain feedback and identify issues and regular incident reporting review.

Staff were not receiving regular supervision. We reviewed three personnel files and we saw supervision records in all personnel files, but for one staff member there were three records from the previous year, one staff member had had supervision once last year. Staff meetings had been cancelled because of the pandemic, and communication with staff was via handovers or through email. The provider had completed a carer feedback survey across the organisation in late 2019.

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 registered manager and the provider.

There weren’t effective systems and processes established to ensure that the quality and safety of the unit was assessed, monitored and improved.

We asked for information following inspection about staff training. This was incorrect and incomplete. Staff were overdue training in key aspects of their role and this had not been identified. We could not ascertain whether staff were up to date with life support training as the manager could not supply this information. We asked for a ligature risk assessment and this was overdue for review by five months.

We were told that the preferred staffing agency had been appropriately assessed and checked, however following inspection we were told the agency was not on the provider framework. We had seen previous profiles supplied by the agency and were not assured that staff had had the appropriate level of training for working in the service, nor could we be sure about timely disclosure and barring service checks for all staff.

Maintenance issues were not reported promptly. The provider maintenance file showed that the issue of a missing radiator grille had been reported eight weeks before this inspection with four other minor issues reported in the following weeks. None of the other concerns noted during this inspection had been identified or reported. Some of the lounge furniture had been replaced some months ago and the broken furniture placed outside, rendering the garden unusable. No action had been taken to arrange removal.

Staff were covering over sensors for the alarm system. The problems with the alarm system sounding continuously had been raised as an issue at the last inspection in 2019 and the provider had indicated they had arranged for a new alarm system to be fitted.

There were no regular environmental audits of the service. We found items stored inappropriately, for example, equipment which belonged to patients who had moved on from the service, with no plans for disposal. Wheelchairs were being stored in the hair salon and dirty laundry stored in a communal bathroom.

Issues with cleaning and laundry had not been identified or acted upon.

The provider had not been able to arrange regular testing for staff for COVID-19. Whilst staff and patients had been offered COVID-19 vaccination, the lack of routine testing presented a high risk to both patients and staff. This had been highlighted to commissioners and the local authority but was still not resolved when we inspected.

Management of risk, issues and performance

The provider risk register was dated May 2020 and whilst it included training compliance and operational compliance, these were both assessed as low risk with mitigations in place. The mitigations for mandatory training suggested that "compliance was close to target" and that there was "action planning with those services under target". Mitigation for operational compliance included "regular briefings and updates will be provided to all employees and Trustees throughout 2018/19" which suggests this item remains on the register from an earlier version. No specific services were on this risk register.

The local risk register, for Monet Lodge and another service operated by the provider had been completed in October following a request by commissioners. The risk of an outbreak of COVID-19 was rated as low and this had not been updated following positive cases within the service during January and February 2021. Mitigation included compliance with deep cleaning, appropriate use of personal protective equipment (PPE), use of red laundry bags, weekly teams meetings and regular testing of all service users and staff, which were issues identified at this inspection.

Neither risk register provided a target or timescales for risk reduction if applicable or review dates.

At a more senior level, the Quality and Audit committee oversaw governance from services and provided assurances to the board. Data was reviewed within the meeting relating to performance and themes/trends. There had been a gap of 12 months between meetings taking place in September 2019 to October 2020, although the board had continued to meet during this time.

The minutes from the meeting in October 2020 include a discussion about audits, noting that each service had a programme of operational audits but these were not reviewed by this committee. (The notes indicate some hospitals audits were reviewed in the separate Hospital Managers committee but the most recent minutes for this meeting included a specific Mental Health Act audit and the hospital managers committee is largely concerned with administration of the Mental Health Act. There were no audits listed on the previous two meeting minutes.) The corporate risk register was discussed but this was not actively reviewed within the meeting. There was also some discussion about how local risks were escalated and whether a risk management strategy and process was needed.

The minutes for the meeting in February 2021 showed that an assurance cycle had been agreed, and that actions relating to internal risk management toolkits would be completed for the next committee meeting in a further six months. These minutes also indicated the organisation being on target for mandatory training.

The meetings do not provide sufficient assurance and the frequency of six months is too far apart for a committee focussing on quality and assurance, particularly as the board meets more frequently and this committee provides assurances to the board.

Whilst this inspection did not include specific inspection of the administration of the Mental Health Act, we were sent information relating to the governance arrangements for this. We reviewed minutes for the Hospital Managers Committee Meeting, which was related to the administration of the Mental Health Act across the hospitals run by the provider. These showed good practice in maintaining contact with the delegated hospital managers and keeping them aware of new case law, information specific to their responsibilities under the Act and ensuring appropriate training was available.

Information management

Staff had access to information needed to do their work. The hospital paper records were in the process of being moved to an electronic records system.

Staff made notifications to external bodies as needed such as commissioners, the local authority safeguarding team, care quality commission and health and safety executive.

Engagement

The provider organised an annual staff survey and this was just taking place at the time of this inspection.

In the last 12 months, the service had received eight compliments and seven complaints. Compliments were from patient's families and professionals and complaints were from patient's families, a local resident and staff. Actions were recorded by the registered manager and collated into "Have your say" reports.

Engagement with other stakeholders and organisations had previously been positive for the service, including volunteers working in the service, but this had been affected by the pandemic and restrictions imposed on care settings.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We had concerns about the senior oversight and management of this service. There was no effective system to assess and monitor this service with scrutiny and overall responsibility for this service at a board level or equivalent. The registered manager did not assess, monitor or act on information relating to the quality and safety of this service. The registered manager did not escalate concerns appropriately. There were no systems and processes to identify where quality and/or safety were being compromised. There were no systems and processes which identified and assessed risks to the health, safety and welfare of patients who use the service. The service had not reviewed records relating to patients care and treatment to ensure these were complete, accurate and up to date.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not all trained in basic life support and managing violence and aggression. Staff had not completed mandatory training as required. There was no induction process for agency staff. Staff were not receiving appropriate ongoing supervision.

This section is primarily information for the provider

Enforcement actions

We had concerns about the use of an agency supplying staff to Monet Lodge and this agency is not on the provider framework.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment was not being provided in a safe way.

Premises and equipment were not safe nor well maintained.

Infection prevention practice was poor.

The premises were not clean.

Medicines were not managed safely.

Risks were not effectively assessed nor mitigated.

We saw unsafe moving and handling practice.

Assessments of patient care did not include all relevant health and safety concerns.

Patient risk assessment tools were not always completed correctly.

Drinks thickeners were not stored safely.