Making Space

Monet Lodge

Inspection report

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Date of inspection visit: 11 and 12 August 2021
Date of publication: 25/10/2021

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?	Requires Improvement

Summary of findings

Overall summary

We have issued a warning notice for a breach of regulation to ensure that swift action is taken and plans put in place to maintain improvements.

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

The service was not safe. It did not use systems and processes to safely prescribe, administer, record and store medicines. An external audit completed in March 2021 had recognised many of the issues we found at our inspection in August however, these had not been acted upon sufficiently. We found emergency medicines which were out of date, prescription charts not completed correctly and staff giving patients medication without waiting the required time between doses as instructed on the prescription charts.

Despite an improvement in the environment from our last inspection, we found that new environmental issues had not always been picked up via internal audits.

Our findings from the safe key questions demonstrated that governance processes did not operate effectively at team level.

The service did not meet legal requirements relating to the safe prescribing, administration, recording and storage of medicines and we issued a warning notice meaning we could not give it a rating higher than inadequate.

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

- The service was not safe. It did not use systems and processes to safely prescribe, administer, record and store medicines. An external audit completed in March 2021 had recognised many of the issues we found at our inspection in August however, these had not been acted upon sufficiently. We found emergency medicines which were out of date, prescription charts not completed correctly and staff giving patients medication without waiting the required time between doses as instructed on the prescription charts.
- Despite an improvement in the environment from our last inspection, we found that new environmental issues had not always been picked up on or acted on following identification in internal audits. These included bugs in the light fittings on the corridors, a ripped mattress being used as a crash mat and garden shears in a box in the garden that patients could easily access. Our findings from the safe key questions demonstrated that governance processes did not operate effectively at team level. Audits did not identify all new issues and managers did not make all the necessary improvements to keep patients safe.

However:

- The senior leadership team were committed to improving safety and governance at the hospital. They had an ongoing action plan that addressed the issues we found with the environment, we could see a timeline of work planned out, with costings, risk assessments and agreed contractors.
- We could see evidence of how the board had oversight of the issues at Monet Lodge and were meeting regularly to monitor the progress.
- The consultant admiral nurse was coaching staff in order to ensure that patient care was more person centred, taking into account the patients' life story in their care plans.

Summary of findings

- All qualified staff had completed or were booked onto a leadership course since our last inspection.

The service will remain in special measures. Services placed in special measures may 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 16 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 February 2021 and the service was rated as Inadequate overall.

This inspection was to follow up on the progress made from that 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 interactions in the main lounge area throughout our inspection and found interactions to be kind, caring and dignified. We also observed a lunchtime meal service, we saw staff explaining to patients what food they were eating, sitting with them on the same level and ensuring that spills were cleaned quickly to maintain patients' dignity. This was improved from the last inspection where we observed very little meaningful interaction between patients and staff.

How we carried out this inspection

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

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

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 clinical lead, the executive director of operations, the executive director of quality and compliance , head of quality and co-production, the mental health law manager, the consultant admiral nurse and the regional operations manager

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

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

• looked at 16 medicines administration charts and completed a full review of medicines management, this included observing a medicine round

• spoke to seven carers

• looked at cleaning records

• looked at maintenance records

• reviewed the duty rota and staffing arrangements

• reviewed six staff files.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

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 assessments of environmental risks 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 that they follow their own policies in relation to relatives working together

The service must ensure that qualified staff are competent to carry out their role, especially in relation to dispensing medicines. (Regulation 18 (1)).

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	Requires Improvement	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Requires Improvement	Inadequate

Inadequate

Wards for older people with mental health problems

Safe	Inadequate
Well-led	Requires Improvement

Are Wards for older people with mental health problems safe?

Inadequate

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

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. At our last inspection we found this was not the case, during this inspection we found the environment to be much improved. The corridors had been redecorated, at the of each corridor there was a quiet area. These had been decorated in different themes, one was a seaside theme with shells, windmills and seaside pictures on the walls. Another was a bird theme with pictures of different birds, there were plans to add speakers to play bird songs through for patients to listen to. There had been several dementia friendly wall murals installed. There was a florist and a post office. The florist had sensory items (flowers) for patients to look at and touch. The post office had a post box where patients could put letters and cards for the service to post to family and friends. There was still a large action plan ongoing for improvements to the environment, we were able to see when these improvements would take place over a planned period. These were done in stages so as not to disrupt the running of the hospital and patients. The main lounge was going to be split into two, in order to create a quieter space with a more homely feel. The garden was being redesigned to make it a much more accessible space, this included new pathways and a sensory garden. However, we did still find some minor environmental issues on this inspection. We found that there were bugs in the light fittings in the corridors, although these had been identified for removal this had not yet been completed. We also saw a ripped mattress in one of the bedrooms being used as a crash mat, this had not been identified as an infection control risk, it was however, removed as soon as our inspectors raised it with the staff.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. However, we did find that in some instances new risks had not always been identified and rectified. For example, we found a ripped mattress in one of the bedrooms, a bed with peeling laminate and garden shears in a box in the garden that patients could easily access. These were quickly removed once our inspectors raised this. For the most part, risks had been identified appropriately and were being reviewed daily, weekly and monthly by the designated person.

Staff could not observe patients in all parts of the wards, the ward did have some blind spots. However, this was mitigated by regular observations of patients carried out by the staff and regular reviews of risk.

The ward was not single sex but complied with guidance on mixed sex accommodation. There was a separate corridor for male and female patient bedrooms, a female lounge and the bedrooms all had an ensuite toilet.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We did see that some of the beds required a plug in pressure relieving mattress. As the plug sockets in some bedrooms were part way up a wall, this meant that the wire for the mattress was hanging down the side of the bed. At feedback we raised this with the provider. The wires were on the ligature risk assessment but the possibility of trunking to cover these wires had not been explored. For patients who were confused and sometimes agitated, there could be a risk that they could become entangled inadvertently.

Staff had easy access to alarms and patients had easy access to nurse call systems. At our last two inspections, we had raised the fact that the nurse call system was not fit for purpose. The alarms had sensors which sounded whenever a patient was in their bedroom. This meant that the alarms were constantly ringing all day, as a consequence staff did not respond to these in a timely manner. These could not be switched off or isolated if there was no risk associated with the patient being in their bedroom. At this inspection we found there was a new nurse call system installed. This was not sounding all the time as with previous visits.

Maintenance, cleanliness and infection control

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

However, staff were not completing cleaning records. The records should have been signed twice per day, we saw most weeks had at least two days of signatures missing. There had been some sickness in the cleaning team and agency staff had been used, this may have explained some of the missing signatures as the agency staff may not have been fully aware of the procedures. However, we did not find this had an impact on the cleanliness of the environment, it smelt fresh despite high levels of incontinence and there was no evidence of dust or dirt.

Staff followed infection control policy, including handwashing. We did observe the morning medication round and found staff were not bare below the elbow when handling medication at times. We also found the service were not using single use medicine pots. The medicine pots were being washed in a sink in the dining room, this was not a high enough temperature to manage cross infection. We raised this with the provider at our feedback session, they explained that they did have single use pots available and would ask staff to use these instead.

Clinic room and equipment

We looked at the clinic room in detail. We found that the taps had been replaced on the sink so that staff could turn them on and off without touching them. The clinic room floor had been replaced since our last inspection. There was one cupboard door that was off its hinges, this cupboard contained medication. Although the clinic room door was always locked, it did mean if this was not locked inadvertently by staff patients could have accessed medications. However, the clinic room was due a full refurbishment on the environmental upgrade plan, this was due to be completed by October 2021. Cupboards would all be replaced during this work.

The clinic room was fully equipped, with accessible resuscitation equipment. However, we checked the emergency drugs and found that the medication for anaphylaxis had been out of date since December 2020. This was ordered and received whilst we were on inspection. The suction machine end was open to the air and dirty. There were emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. We saw clean labels on items such as the hoists and commodes.

Safe staffing

Inadequate

Wards for older people with mental health problems

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

Nursing staff

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

The service had reducing vacancy rates. Since our last inspection, there had been a large recruitment drive to fill posts and reduce agency use. The salary for qualified nurses had been increased to try and attract new staff.

The service had reducing rates of bank and agency nurses. This was much improved since our last inspection when we saw some shifts fully staffed by agency staff. At this inspection we found there were no agency staff working on the day we arrived and there were nine staff on duty.

The service had reducing rates of bank and agency nursing assistants. There were still quite high levels of patients needing one to one care. Agency staff were sometimes required to staff these extra levels of care needed; however, the levels were reducing as patients moved onto lower observation levels.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates.

Managers supported staff who needed time off for ill health.

Levels of sickness were reducing. We saw evidence of several staff who had been on long term sick being supported back to work with the assistance of Human Resourses. This was sensitively managed with lots of support on their return.

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

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

Patients rarely had their escorted leave, or activities cancelled, even when the service was short staffed. At our last inspection we found that section 17 leave was limited to medical appointments in the main. At this inspection, we found that patients were utilising leave in the hospital grounds for leisure purposes with staff. We also found that some patients were able to use leave to spend time with family outside of the hospital, this appeared to be working very well.

The service had enough staff on each shift to carry out any physical interventions safely.

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

Medical staff

Inadequate

Wards for older people with mental health problems

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

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

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

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

Managers monitored mandatory training and alerted staff when they needed to update their training. At our last inspection we did not find this to be the case. We found that the training matrix was out of date and figures held for training were not added up correctly, meaning some courses looked like staff had completed but in reality, lots were out of date.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

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

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Inadequate

Wards for older people with mental health problems

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

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

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.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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.

Staff access to essential information

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

Records were stored securely. The hospital was imminently moving to an electronic records system, this also came with handheld devices for staff so they can sit with patients more easily to complete care plans and risk assessments.

Medicines management

The service did not use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medications on each patient's mental and physical health.

Staff did not follow systems and processes when safely administering, recording, and storing medicines. We found staff had failed to follow detailed care plans to administer medicines in a covert (hidden) manner. Medicines were not always given by the person signing the prescription chart, which is not good practice. Staff did not record when fluid thickening powder was added to a drink for people with swallowing difficulties, so we could not be assured this was done correctly. It was unclear whether people had had their topical medicines applied as staff signed once for multiple topical medicines rather than signing for individual medicines. Body maps were not always available to guide staff on where the topical medicine should be applied; one body map guided staff to apply it to a different area advised by the prescriber. 'When required' medicine care plans did not always guide staff when a 'when required' medicine should be used.

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. We found topical medicines were stored in some peoples' rooms and there was no risk assessment to check whether this was safe to do. One resident had a topical medicine in their room, which belonged to another person.

We found when reviewing medicines charts that there were a lot of gaps where medicines should be signed for. This meant that staff could not be assured that patients had been given the medication they were prescribed and needed.

As well as this, we found incidents where paracetamol had been given to patients with less than a four hour gap in between doses. Although the prescription charts stated the minimum time between doses must be four hours, staff were not always following this instruction. This practice potentially put patients at significant risk.

We did find prescription charts and the controlled drugs register were stored securely when not in use in the medicines room which was locked.

Staff did not always follow current national practice to check patients had the correct medicines. We found medicines out of date in the medicines room, one of which had expired in 2016. Emergency medicines (Jext – emergency treatment of anaphylaxis) were out of date. This meant that the provider could not be assured that staff had access to effective medicines a patient may have needed in the event of a potential life threatening emergency.

Staff completing medicines audits did not identify all new issues or act when issues were identified. The external March 2021 audit had identified significant issues that had not been rectified in the five months following the audit.

Track record on safety

At our last 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. During this inspection we found this to be much improved. There had been a vast improvement of the environment with more work still being carried out during our inspection, with a view for this to continue for the next few months. However, we did still find some more minor issues had not been picked up on the internal environmental audit. We also found that a medicines audit carried out by an external auditor had found many of the issues we found during our inspection, the audit was completed in March 2021. This meant that the provider had five months to implement an action plan and make improvements. We did see an action plan that listed the issues found in the March audit. However, it did not give deadlines for when actions should be completed and often actions were not allocated to one person to complete.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised most incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, we found when reviewing medicines charts that there were a lot of gaps where medicines should be signed for. As well as this we found incidents where paracetamol had been given less than four hourly. We did not find many medicine related incident reports when reviewing the hospitals log. Therefore, we were not assured that staff had recognised and reported what constituted a medicines error and acted upon them appropriately.

Staff raised other concerns and reported incidents and near misses in line with provider policy.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong.

Inadequate

Wards for older people with mental health problems

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

Staff met to discuss the feedback and look at improvements to patient care.

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

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership.

At our last inspection we found that there was a lack of leadership at the hospital. The registered manager had significantly reduced on-site support during the pandemic and were absent from the service in the months prior to inspection. The clinical lead was present at the service four days per week. We found that the senior leadership team had based themselves at the service, in order to support the clinical lead and drive improvements forward from the last inspection findings. We were able to see how the senior leadership team were committed to making improvements at the hospital. The environmental action plan had been planned well to ensure maximum benefit for patients with the least amount of disturbance possible. The service had employed a new temporary manager who was due to start work the month after our inspection, this person had a good track record in improving services and worked alongside the rest of the senior team to improve the skills of the staff at the hospital, provide leadership and scrutiny of the service. We were able to see how staff performance was being managed when required, in order to improve patient care as well as the leadership skills in the qualified nurses. All qualified staff had completed or were booked onto a leadership course since our last inspection.

Team meetings were now taking place. At our last inspection these were being done via a “team brief” and staff had no input into the agenda. This was sent out via email and the expectation was that staff read this although there was little assurance around this. At this inspection we found this to be much improved. Team meetings were taking place face to face, although some earlier ones were done via zoom call. We were able to see that staff received the agenda in time to read it and add items to it if they wanted to. Staff we spoke to told us that they also got the link to join via zoom if they could not be there in person. We did not see any evidence of any recurring issues that were not actioned, we did find this at the last inspection.

At our last inspection we found that supervision was not happening as often as the company policy required (no less than every 3 months). We found this to be much improved with six out of six staff files containing supervision each month. We could see that the agenda for supervision was robust and gave staff time to discuss both work and personnel issues, as well as any performance management issues that needed addressing.

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

Vision and strategy

Staff knew and understood the provider’s vision and values and how they (were) applied to the work of their team.

Inadequate

Wards for older people with mental health problems

Culture

Staff felt respected, supported and valued. This was markedly improved from our last inspection. Staff morale was better, and staff told us they enjoyed their jobs and felt proud to work at the hospital. Staff felt listened to and respected, again this was not the case at the previous inspection. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear, we saw evidence in staff meeting minutes where this had happened as well as in individual supervision.

At our last inspection we were concerned that there were elements of a closed culture that had developed in the service. 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. The service was 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. At this inspection we found that visiting had now recommenced, with the use of lateral flow testing and temperature checks. We spoke to carers as part of our inspection, there was a lot of positive feedback about the care they felt their loved ones had received.

Governance

Our findings from the other key questions demonstrated that whilst some governance processes operated effectively this was not always the case, therefore, risk was not always effectively managed. We found that often audits were not always picking up on new issues or when they were picked up, action wasn't being taken quickly enough to improve the situation. A medicines audit had been carried out by an external agency in March 2021, where significant issues had been highlighted. During our inspection in August 2021, we found the same issues were still occurring. Although we did still find some new environmental issues that audits had not picked up, this was to a much lesser extent and we found on the whole the environment was significantly improved.

At our last inspection we found that staff were covering alarm sensors in patient bedrooms with files and photographs in order to stop them constantly ringing out. The system was not fit for the purpose it was used and at our previous inspection in 2019 we had been told this system was being replaced. At this inspection we found there was a new nurse call system installed. This worked much better for the patient group, allowing alarms to be switched on and off in individual bedrooms. This meant that for patients who liked to spend more time in their bedrooms, the alarm did not activate every time they got out of bed or walked across the room.

Management of risk, issues and performance

We found that the provider was not always following their own policy on relatives working together. We found evidence of relatives carrying out clinical supervision for a close relative and working together on the same shift in a supervisory role. This was in direct conflict with the providers own policy which stated that close relatives should not work together in a supervisory role or on the same shift. This meant there was a potential for a closed culture to develop without having an objective view from someone who is not related to the staff member, assessing their work.

Staff did not act in a timely way to resolve risks that could impact on the delivery of care. The external March 2021 medicines audit had identified significant issues that had not been fully rectified in the five months following the audit. Audit results had been reviewed by senior managers, but actions had not been followed up.

Inadequate

Wards for older people with mental health problems

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.

Feedback from patients and carers was in the form of a “have your say” feedback form. These were given out to visitor and feedback was collated by the team. We reviewed six of these during inspection and found feedback to be positive in the main. One person had commented that communication had not always been good during the pandemic, at a time when they could not visit their relative. However, other carers said they were happy with the level of communication and had regular skype calls with their loved one.

Engagement with stakeholders had improved since our last inspection. At our last inspection we found that due to the pandemic, commissioners had not been regularly meeting with the service. Although face to face visits had not yet commenced, we found that monthly virtual meetings had taken place to review progress on the action plan created following our inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the provider was not always following their own policy on relatives working together. We found evidence of relatives carrying out clinical supervision for a close relative and working together on the same shift in a supervisory role. This was in direct conflict with the providers own policy which stated that close relatives should not work together in a supervisory role or on the same shift. This meant there was a potential for a closed culture to develop without having an objective view from someone who is not related to the staff member, assessing their work.

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 The service must ensure that qualified staff are competent to carry out their role, especially in relation to dispensing medicines.

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
Diagnostic and screening procedures Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service was not safe. It did not use systems and processes to safely prescribe, administer, record and store medicines. An external audit completed in March 2021 had recognised many of the issues we found at our inspection in August however, these had not been acted upon sufficiently. We found emergency medicines which were out of date, prescription charts not completed correctly and staff giving patients medication without waiting the required time between doses as instructed on the prescription charts. • Despite an improvement in the environment from our last inspection, we found that new environmental issues had not always been picked up on or acted on following identification in internal audits. These included bugs in the light fittings on the corridors, a ripped mattress being used as a crash mat and garden shears in a box in the garden that patients could easily access. Our findings from the safe key questions demonstrated that governance processes did not operate effectively at team level. Audits did not identify all new issues and managers did not make all the necessary improvements to keep patients safe.