ASC Healthcare Limited

The Breightmet Centre for Autism

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Model of Care and setting that maximises people's choice, control and independence

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

SUMMARY

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

- People's care and support was not provided in a safe, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs.
- People were not protected from abuse and poor care. The service did not have sufficient, appropriately skilled support staff to meet people's needs and keep them safe.
- People were not supported to be independent and have control over their own lives.
- The service did not provide care, support and treatment from support staff who were trained and able to meet people's needs.
- People did not receive kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People did not have their communication needs met and information was not shared in a way that could be understood.
- People's risks were not assessed regularly and managed safely. People were not involved in managing their own risks whenever possible.
- People's care, treatment and support plans, did not reflect their sensory, cognitive and functioning needs.
- Staff did not follow the requirements of the Mental Capacity Act 2005 in relation to assessing capacity and making decisions in people's best interests.
- People did not receive care, support and treatment that met their needs and aspirations. Care did not focus on people's quality of life and did not follow best practice. Staff did not use clinical and quality audits to evaluate the quality of care.
- Staff did not support people through recognised models of care and treatment for people with a learning disability or autistic people. Governance processes did not help the service to keep people safe, protect their human rights and provide good care, support and treatment.

However

- There had been improvements in the management and investigation of complaints.
- People were in hospital to receive active, goal oriented treatment. People had plans in place to support them to return home or move to a community setting.

Summary of findings

- If restrictive practices were used, there was a reporting system in place and there were comprehensive reviews to try and reduce the use of these practices.
- People made choices and took part in activities which were part of their planned care and support.
- Managers ensured that staff had regular supervision and appraisal.
- People and those important to them, including advocates, were actively involved in planning their care. A multidisciplinary team worked well together to provide the planned care.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983.
- Staff worked well with services that provide aftercare to ensure people received the right care and support when they went home.

This service was placed in special measures in March 2022. Following a further inspection in December 2022 where we found insufficient improvements we took action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. As a result of concerns found at the our inspection of the service on 12,13,14 and 15 December 2022 we served a Notice of Proposal, the provider submitted representations against this proposal and following review of these representations, a Notice of Decision to cancel the provider's registration was served. This was not appealed by the provider. The service was deregistered on 9 May 2023.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to The Breightmet Centre for Autism

The Breightmet Centre for Autism was registered with the Care Quality Commission on 15 August 2013.

It is registered for the following regulated activities:

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

Treatment of disease, disorder or injury.

At the time of the inspection there was a nominated individual in post who was also the executive director as well as consultant psychiatrist. They had been in post for five weeks.

There was no registered manager in post, the hospital manager had been in post since the second week of October 2022, they had started the process of applying to be the registered manager.

The controlled drugs accountable officer was the previous registered manager who had moved to manage another hospital linked to the provider.

This was the twelfth inspection of the service. The last inspection was in March 2022. The service was rated inadequate overall with every key question rated inadequate. The service was placed in special measures. The service was served five warning notices for Regulation 9, Regulation 12, Regulation 13, Regulation 17 and Regulation 18.

What people who use the service say

What people told us

We spent time with all 12 people at the service, spoke with seven people directly and completed eight short observations for inspection 2 (SOFI2 is a structured observation which captures people's experience of care).

People told us that staff did not follow their care plans in relation to assistance with eating and drinking. People said the food was not varied. There were problems with the vehicles which impacted on peoples opportunity to go on leave.

People told us and we observed staff laughing at people.

People said and rotas confirmed there was a lot of bank and agency staff supporting them.

People told us and we observed disproportionate use of restraint.

During the night people told us staff could be loud and this disrupted their sleep.

People told us and we observed that they were supported by staff from the opposite gender which was not in line with their support plans.

Summary of this inspection

Of the four people who were able to answer the question, three people said they were not involved in their care and that staff did not help them. One person said that staff help them.

People told us and we observed that they spent the majority of time in their rooms and the main activity they did was to go shopping.

We asked the service for evidence of any feedback from people. They shared a you said we did poster, with one example of a takeaway being arranged one night per month. A blank feedback questionnaire was shared with us, with none completed or any results shared.

What families told us

We spoke with eight family members.

Six family members said things had improved since the occupational therapist, speech and language therapist and new doctors had started and different management.

Seven family members told us they were not regularly updated about their loved one and if they couldn't attend the meetings, they did not receive a copy of the minutes. Families said they used to receive regular updates, however this had stopped.

Four family members said the service was not responsive and proactive to the physical health needs of their loved one.

Two family members said they had not heard back from their complaint or the action the service said they were going to take following the complaint had not happened.

Two family members told us actions from meetings were not implemented.

A lack of consistency with staff was a concern of family members, especially when their loved ones valued routine and structure.

A lack of activities was concerning for family members, with the main activities being a van drive or going to the shops.

Three family members told us the service was not meeting the dietary needs of their loved ones.

Two family members said the bedrooms are not welcoming and individualised. All other family members we spoke with said they were not allowed onto the wards to see their loved one's room or the environment where they were living.

Two family members said the service were not specialists in autism informed care, with no ideas suggested by the service, it was family members making the suggestions.

We asked the service for any evidence of feedback from families and carers. The service told us that feedback requests have been sent to families and carers in September 2022 and in December 2022, however they had not received any responses.

Summary of this inspection

How we carried out this inspection

We carried out this inspection in line with CQC's "Guide to special measures Independent healthcare" which states inadequate rated services will be inspected within six months of the report being published. We inspected to follow up on the warning notices issued on 24 March 2022.

The inspection team comprised three inspectors on site and remote support from an inspector, on site support from a pharmacist specialist, a nurse specialist adviser, an occupational therapist specialist advisor, a psychologist specialist adviser and an expert by experience.

Prior to and following the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including commissioners and advocates.

During the inspection visit, the inspection team;

- visited all three wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for people
- spent time with all 12 people at the service, this included talking with people and observing their care
- conducted eight short observations for inspection 2 (SOFI2 is a structured observation which captures people's experience of care) observations were at different times of the day and in evenings
- observed three activities, one occupational therapy activity, a psychology activity and the Christmas market
- spoke with eight family members
- spoke with the manager and nominated individual
- spoke with 22 other staff members; support workers, registered nurses, doctors, occupational therapists, psychologists, speech and language therapist, administrative staff and leads for department, maintenance and housekeeping staff
- received feedback about the service from four commissioners and an advocate
- attended and observed three morning meetings, three handovers and a discharge planning meeting
- reviewed six care and treatment records of patients including care plans, risk assessments and Mental Health Act documentation
- reviewed six prescription cards and associated health records
- reviewed eight physical health records
- reviewed eight staff files
- looked at a range of policies, procedures and other documents relating to the running of the service.

This inspection was unannounced and covered all key questions.

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action the 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.

Summary of this inspection

Action the service MUST take to improve:

- The provider must ensure they prescribe medicines safely. (Regulation 12)
- The provider must ensure staff follow infection prevention control guidance, including being bare below the elbow. (Regulation 12)
- The provider must ensure that people are cared for in the least restrictive way and use physical intervention as a last resort. (Regulation 13)
- The provider must ensure that peoples' risk assessments accurately reflect peoples' risks and that these are reviewed and updated in line with the providers policy.(Regulation 12)
- The provider must ensure they maintain the environment and furnishings to ensure they protect people's privacy and dignity, are safe and promote recovery and wellbeing. (Regulation 15)
- The provider must ensure that staff, including agency staff receive an induction which is appropriate to meet the needs of people using the service. (Regulation 18)
- The provider must ensure that they provide person centred care, including a range of treatment and care for autistic people based on national guidance and best practice to meet their individual needs. (Regulation 9)
- The provider must ensure that care records are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of people.(Regulation 17)
- The provider must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure that staff receive training in how best to communicate with people including their preferred communication method.
- The provider should ensure that its policies and procedures reflect current legislation.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

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

Is the service safe?

Inadequate

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

Safe and clean care environments

People were not cared for in wards that were safe, well equipped, well furnished, well maintained and fit for purpose. Although wards were clean, they were very bare and stark. In ward 4, there was a section of the wall that had black chalk paint on and there was scribbled out writing on it for the whole of the inspection. In ward 1, there was a window without a privacy screen on and in ward 3 there was a ripped privacy screen on a window. This did not protect people's privacy and dignity as people from outside the building would be able to see into the building. There was a health centre and houses neighbouring the service. In ward 1 there was a stained sofa and ward 3 had a ripped sofa in the lounge. There was bits of paper and other items in the TV surround on ward 1 and a stain on the TV in ward 4. We reviewed the maintenance log to see if any work had been requested, however there were no current requests for these jobs. This meant the provider had not planned to improve the environment and facilities.

People were cared for in wards where staff had completed risk assessments of the environment and removed or reduced any identified risks. Environmental risk assessments had been completed for each ward and ligature points identified for staff to mitigate these risks, this was usually by observation.

People had easy access to nurse call systems and staff had easy access to alarms. Nurse call alarms were in each person's bedroom.

Staff used personal protective equipment (PPE) effectively and safely. We saw staff use gloves when assisting people with personal care.

The service's dress code policy was up to date and stated that staff must be bare below the elbow. We observed that staff were not bare below the elbow, they were wearing long sleeved tops and jackets and had jewellery, wrist watches and painted nails and gel nails on. There was a daily walk around completed which showed that managers identified staff were not bare below the elbow and reminded staff, however staff continued to not follow the guidance. This meant staff were not following guidance and were putting people at risk.

Inadequate

Wards for people with learning disabilities or autism

The service supported visits for people in line with current guidance. There was a family room where the majority of the visits took place.

All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food. Records showed 82% compliance.

Staff did not check, maintain, and clean all equipment. There were three defibrillators within the service. One of them did not have pads on them, this had not been identified by the service. We alerted the managers who ordered replacement pads during the inspection. The medicines fridge in ward 4 was freezing, staff had recorded readings as low as -1 degree and no action had been taken by the service. This meant the equipment was not safe for intended use and the medicines stored in the fridge may not be as effective.

Safe staffing

The service had enough nursing and medical staff, who knew the people and received basic training to keep people safe from avoidable harm. There was high use of bank and agency staff, however the majority were regular bank and agency staff. There was 34 vacancies for support workers.

The service had enough staff, including for one-to-one support for people to take part in activities.

The numbers and staff skill mix matched the needs of people using the service. All permanent, bank staff and in house agency staff received Autism awareness as part of their induction.

Staff recruitment and induction training processes did not promote safety. There was no induction checklist in place to ensure staff were orientated to the service, including where to locate emergency equipment and how best to support people. They have had 20 new staff join the service since the last inspection with no evidence of what their induction covered to show that they were familiar and knowledgeable of the service.

Staff did not know how to take into account people's individual needs, wishes and goals. Although there was guidance in people's care records, staff were not following these in relation to communication, facilitating requests, meeting personal hygiene needs and food preferences.

Managers did not arrange shift patterns so that people who were friends or family did not regularly work together. Staff told us they recruited friends and encouraged recommendations for applicants. We observed handovers and saw that at the end of the handover staff were very familiar with each other, fist bumping and hugging each other. During the observations we saw staff talking to each other about their home lives. This meant staff were not fully independent and the risk of a closed culture developing was high. Closed cultures may lead to breaches of human rights including abuse or significant harm.

Some people's care records contained a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them. However, these were not in place for all records reviewed.

Managers did not make sure all bank and agency staff had a full induction and understood people's needs before starting their shift. Agency staff did not complete the corporate induction. There was no agency induction checklists in use, with no evidence of what they received in relation to orientation in the service. This meant staff may not know how best to support people and how to respond in an emergency. However, managers had identified that this needed to improve and had planned for members of the multidisciplinary team to be involved in this.

Managers ensured there were enough support staff to be able to facilitate people's enhanced observations. There was one registered nurse on each shift, and we observed it was difficult for them to oversee the service as they were responsible for 12 people across three wards.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed. This was due to the enhanced observations people were on, so they had at least one member of staff with them at all times.

Staff shared key information to keep people safe when handing over their care to others. We observed three handovers and saw that staff shared the activities that people had done and any incidents.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. There was a responsible clinician and speciality doctor who were at the service the majority of the time and the responsible clinician was on call out of hours. If they were on leave, then other consultant psychiatrists were able to cover. There was also an on call rota which was facilitated by hospital managers and clinical leads of this service and another neighbouring service to offer out of hours support.

Staff had completed and kept up to date with their mandatory training. However, the training programme did not meet the needs of people and staff. There was no training offered in communication methods that people used, for example Makaton. This meant staff could not communicate effectively with people. Registered nurses did not attend training in Immediate Life Support, we asked the provider for training information and none was provided. However following the inspection, we were told four nurses had completed Immediate Life Support Training. This meant not all staff were trained to respond to people who were restrained or had rapid tranquillisation and may have an adverse reaction.

Assessing and managing risk to patients and staff

People did not live safely and free from unwarranted restrictions because the service did not assess, monitor and manage safety well. Of the six records we reviewed, one did not include an individual risk assessment. People's movement was restricted, we observed a person being told to sit down whenever they came out of their room, another person was asked to move from the communal corridor where they were relaxed to the quiet room. All people at the hospital were on enhanced observations. Four people were on 1:1, four people were on 2:1, three people were on 3:1 and one person was on 4:1.

Support staff did not consider less restrictive options before limiting people's freedom. Staff surrounded people when they came out of their room. We observed whenever a person would come out of their bedroom, all of their observing staff would surround them and encourage them back into their room or follow them. This meant people could not move freely around the ward.

Care plans did not say that staff should do this, people could be intimidated by the behaviour and were discouraged from leaving their rooms. There was no positive and proactive interaction that we observed between support staff and people.

People were not involved in managing risks to themselves and in taking decisions about how to keep safe. People said they tried to explain to staff about their needs and that they do not respect their preferences. We observed people who should not have been supported by male staff, having men on their observations.

People, including those unable to make decisions for themselves, did not have as much freedom, choice and control over their lives as possible because staff did not manage risks to minimise restrictions.

Inadequate

Wards for people with learning disabilities or autism

People's care records did not help them get the support they needed because it was not easy for staff to access and keep high quality clinical and care records. Staff did not keep accurate, complete, legible and up-to-date records, a person's risk assessment had not been reviewed in over six months, three of the six records reviewed had care plans that should have been reviewed monthly and had not been reviewed for up to four months. This meant staff did not have access to current information and staff were not following the providers clinical risk assessment and management policy which stated they should be reviewed monthly.

However, staff did store records securely in a locked office.

The service helped keep people safe through formal and informal sharing of information about risks. This occurred through handover.

People had detailed positive behaviour support plans in place, however we observed that staff did not follow these plans and did not seem to know how to support them to minimise the need to restrict their freedom to keep them safe.

Each person's positive behaviour support plan included ways to avoid or minimise the need for restricting their freedom.

Staff did not make every attempt to avoid restraining people. We observed disproportionate use of restraint, which did not follow the guidance of the person's positive behaviour support plan. The person became more distressed as a result of this. This was raised with the provider who raised a safeguarding alert and were investigating this.

All restrictions of people's freedom were documented and monitored. Any restraint was recorded in incident forms, a body map was completed and an ABC chart. This was then shared with the nurse in charge and senior staff.

Staff did not know about risks to each person, support staff we spoke with were not all aware of people's individual risks including the risk people posed to themselves.

Staff were trained in the use of restrictive interventions, the training provider was certified as complying with the Restraint Reduction Network Training standards.

The service did not have a seclusion room and there were no recorded episodes of seclusion in the 12 months prior to the inspection.

If staff restricted a person's freedom, by the use of physical intervention, they took part in post incident reviews and considered what could be done to avoid the need for its use in similar circumstances. Records showed debriefs took place following incidents including what could have been done differently.

Staff had training on how to recognise and report abuse and they knew how to apply it. Safeguarding adults training compliance was 80%.

Staff followed clear procedures to keep children visiting the ward safe. The family room was used for visits and this was off the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital manager was the lead for safeguarding, we saw they kept records both electronically and in paper to include the referral, any investigation, action taken and any recommendations.

Staff had easy access to clinical information, files were stored in the locked office on each of the wards. Registered nurses were responsible for updating care records. However, there were occasions where one nurse was working, if this did happen they were busy supporting each of the wards and would not have had very much time to review care records.

The ward staff did not have regard to Mental Health Unit (Use of Force) Act 2018 and its guidance and did not comply with requirements. Although they had a Management of Behaviours that Challenge and Least Restrictive Practice Policy and Procedure, there was no reference to the Use of Force Act 2018. There had been an information leaflet created for people regarding the Use of Force, however this was all in word format with no accessible communication version for those who would find that helpful.

Medicines management

We reviewed six prescription cards and associated health records.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. People had STOMP care plans in place.

People could take their medicines in private when appropriate and safe. This included in their bedrooms.

The clinic rooms were not managed safely. Medicine fridges were unlocked. On ward 4, the medicine fridge was frozen, and the melting ice was wetting the emergency medicines. We reviewed records of fridge temperatures where medicines were stored and saw that staff did not always record the temperature. Staff did not take action when fridge temperatures fell outside the recommended range (2-7C) so the service could not be assured that medicines were safe to use.

We saw food supplements that were not labelled. This meant staff may not know who they were prescribed for and could be given to the wrong person.

Emergency bags were not sealed and there was no contents list to determine if the correct items were in the bags. There was no policy in relation to emergency medicines.

We observed there was incorrect stock count of medicines for two people.

Four people's medicines were unavailable on dates in October and November 2022, therefore, they did not receive their medicines as prescribed.

A person was prescribed buccal midazolam, a rescue medicine for seizures. However, there was no medicine in stock for them, this meant if they had a seizure that required rescue medicine, it would not have been available.

People did not always receive their medicines as prescribed. We reviewed six peoples medicines administration records (MARs) and associated health records and saw there were gaps in administration including one person who had missed doses of their antibiotic. This meant that the medicines may not have been as effective.

Inadequate

Wards for people with learning disabilities or autism

People with long term conditions were not always monitored as recommended in their care plans. For example, we looked at records of a person with diabetes, and saw that their blood sugar levels were not monitored correctly. This meant that their treatment could not be tailored correctly, which could have significant impact on their health.

We saw that clinic supplies of bandages were out if date in November 2022. This meant they may not be as effective if used.

Track record on safety

Minutes showed that lessons learnt were discussed at staff meetings.

The service did not manage incidents affecting people's safety well. There were high levels of restraint with 70 episodes in April 2022, 66 episodes in May 2022, 56 in June 2022, 94 in July 2022, 102 in August 2022, 47 in September 2022, 77 in October 2022 and 65 in November 2022. Staff completed incident reports and then they were shared with the nurse in charge for review before being processed by the administrator leading on incidents. We saw that two of the four incident reports we reviewed had not been signed off by nurses and senior managers. This meant they did not have oversight of the incidents occurring.

When things went wrong, staff apologised and gave people honest information and suitable support. The hospital manager understood the duty of candour and their role in relation to this, they gave examples of duty of candour incidents at a neighbouring service however there were no duty of candour incidents at this service.

Staff raised concerns and recorded incidents and near misses and this helped keep people safe.

Records showed that staff discussed their concerns in team meetings too.

The service recorded any use of restrictions on people's freedom, in the form of physical intervention, this included on incident forms, body maps and ABC charts. However, managers did not review the use of restrictions to look for ways to reduce them. They also did not review the staff approach of surrounding people when they came out of their rooms and alternative approaches to this.

Staff did not review all use of restraint, there were gaps on some incident forms where the nurse and senior manager had not reviewed them. Although a monthly incident report was created, this was a numerical report and did not include narrative or themes.

Is the service effective?

Inadequate

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

Inadequate

Wards for people with learning disabilities or autism

Assessment of needs and planning of care

Staff did not complete a comprehensive assessment of each person's physical and mental health either on admission or soon after. One of the care records we reviewed was for a person admitted to the service on 6 October 2022, the main care plan in use was the 72 hour care plan which was created as an interim care plan until the more detailed care plans had been created, there was no risk assessment in the care record. Other care plans were in progress and there were no easy read versions in the person's file.

People did not have care and support plans that were personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. One person had sleep apnoea and no care plan was in place for this and during completion of a side effects review was identified as having constipation, there was no care plan in place re how to support them. Another person had physical health needs which were not included into a care plan, therefore staff did not know how best to support people.

Care plans did not reflect a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. However, communication grab sheets had been developed for people. One person's care plan said they had no issues around eating and drinking, however they had a dysphagia care plan in place. Care plans had the same text in for different people, as if they had been copied and pasted. One care record had the wrong persons names in.

Staff did not ensure people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills. Three of the six care records reviewed had care plans that were not reviewed in line with the providers policies which stated they should be reviewed monthly. Some people's care plans had not been reviewed since July 2022. This meant staff did not have access to current information and people's records did not reflect their current presentation.

There were no clear pathways to future goals and aspirations, including skills teaching in people's support plans. Care plans were task focused, for example "staff will monitor dietary intake and help with healthy food options".

Best practice in treatment and care

Staff did not support people with their physical health and did not encourage them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills. One person was diabetic and their diabetic blood sugars were not being recorded twice a day as advised. There were gaps on 2, 3, 4, 6, 7, 10 and 11 December 2022. Another person should have had her weight recorded, however records showed this was not happening, the last weight recorded on the weight monitoring sheet was on 24 March 2022. This meant the service were not meeting people's physical health needs.

Senior staff were aware of the principles of Right support, right care, right culture, however they were new in post and at the time of the inspection and the service were not following best practice.

People had detailed positive behavioural support plans in place, including a functional analysis of their behaviour, the psychology team led this. However, staff did not follow the plans. We observed disproportionate use of physical intervention. A person's plan said "when agitated keep a safe space if necessary and allow me to calm down" however, staff were not following their plan, they were using more restrictive physical intervention.

Inadequate

Wards for people with learning disabilities or autism

Staff made sure people had access to physical health care, including specialists as required. There was a centralised record of physical health appointments including dentist, opticians and annual health checks. However, three family members we spoke to were concerned that the service did not meet the physical health needs for their loved one, they did not ensure appointments went ahead, prioritise physical health investigations and did not prompt and encourage their loved one to use their aids and adaptations until they had complained.

Staff mostly met people's dietary needs and assessed those needing specialist care for nutrition and hydration. Records showed dieticians input to the care of people. The clinical lead had been trained to administer nasogastric feeds. Two people had accessed nasogastric feeds in the previous months. However, feedback from families was that staff did not facilitate the specific dietary requirements of their loved ones.

Staff did not help people live healthier lives by supporting them to take part in programmes or giving advice. There was a person who would benefit from mindfulness to reduce their anxiety, staff told us, and records confirmed this was not happening.

Staff took part in clinical audits, medicine audits were completed fortnightly by the clinical lead. However, when the findings showed areas for improvement, the actions were not always completed, which meant managers did not always use the results from audits to make improvements.

Skilled staff to deliver care

Managers supported staff through regular, constructive clinical supervision of their work. The providers supervision policy stated that staff should receive supervision at least every eight weeks.

The providers figures showed that permanent staff were at 100% compliance and bank staff were at 98% compliance. Staff we asked, told us they received supervision.

People were not supported by staff who had received relevant and good quality training in evidence-based practice. This current training did not include the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions. The senior managers acknowledged that the induction needed to be improved and had plans to involve the members of the multidisciplinary team in the revised induction. Staff had not received training in Makaton when four people used Makaton, this meant staff could not communicate with these people effectively.

Support staff we spoke with, who delivered the majority of the care, did not have a good understanding of Autism. They could not describe how their training and personal development related to the people they supported.

There was a training database in use which highlighted when staff required refresher courses.

If people were assessed to lack capacity to make certain decisions for themselves or had fluctuating capacity, staff did not always make decisions on their behalf which were in their best interests.

People did not benefit from reasonable adjustments to their care to meet their needs, for example a female was supported by a male member of staff when her care records said she should be supported by female staff.

Staff were not knowledgeable about and committed to using techniques which reduced the restriction of people's freedom. People had high levels of observations and we observed staff restricting people's movement by being told to sit down or being guided back into their bedroom.

Staff received support in the form of continual supervision, appraisal and recognition of good practice. Appraisal completion levels were 83%. Staff told us they felt more supported following the changes in senior management at the service.

The service had clear procedures for team working and peer support, the professional boundaries policy included the expectations of staff. However, there was no training in relation to this.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. There was a full multidisciplinary team including occupational therapist, psychologist and speech and language therapist. They attended the morning meeting to discuss people and aims and objectives.

The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. We observed a discharge planning meeting where positive working relationships were evident.

People had health actions plans or health hospital passports that enabled health and social care services to support them in the way they needed.

Multidisciplinary team professionals were involved in or made aware of support plans to improve care. The speech and language therapist created the my communication plan, the psychology team created the positive behavioural support plan. The OT team created the joining in and living a good life care plan.

Staff shared clear information about people and any changes in their care, including during handover meetings.

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

Staff understood their roles and responsibilities and were able to explain people's rights to them. Permanent and bank staff received training in the Mental Health Act during the induction with 100% completion.

People had easy access to information about independent mental health advocacy. The advocate details were displayed, including a photograph and when they visited, however there was no contact details for the advocate so people would not be able to contact them in between visits.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician or the Ministry of Justice or both.

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

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed. These were stored in the administrators office who was the Mental Health Act administrator.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. These were discussed at the clinical governance meetings.

Inadequate

Wards for people with learning disabilities or autism

Good practice in applying the Mental Capacity Act

Staff did not support people to make decisions on their care for themselves. They did not assess and recorded capacity clearly for people who might lack the mental capacity to make certain decisions for themselves. For one person, their capacity assessments did not include how they had engaged the person and made the information accessible to them, the outcome was inconclusive. Their autism care plan stated they did not have capacity, however there was no capacity assessment to support this.

For another person, there was a best interest decision for them to have the flu vaccination however there was no capacity assessment to support the need for a best interest decision.

They were assessed as not having capacity to consent to family and carer communication, contribute to care planning and instruct an independent advocate, however there was no best interest decision in place.

Another person had had nasogastric feeds, their care plan stated consideration to use restraint when administering the feed however there was no capacity assessment or best interest decision to support this.

Another person's record stated that they lacked capacity about making decisions about their care and wellbeing. However, there was no capacity assessment to support this.

We found a best interest decision documented for a person who required an invasive examination.

We did not see examples of staff empowering people to make their own decisions about their care and support and did not obtain people's consent in an inclusive way.

Permanent and bank staff received training in the Mental Health Act during the induction with 100% completion.

Staff were not aware of people's capacity to make decisions through verbal or non-verbal means, this was not well documented.

For people that the service assessed as lacking mental capacity for certain decisions, staff did not clearly record assessments and any decisions made on their behalf in their best interests.

Staff did not follow best practice on assessing mental capacity, supporting decision-making and best interest decision-making. Records did not consistently include capacity assessments and best interest decisions.

Staff did not assess and recorded capacity to consent clearly each time a person needed to make an important decision.

Is the service caring?

Inadequate

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

Inadequate

Wards for people with learning disabilities or autism

Kindness, privacy, dignity, respect, compassion and support

Staff did not treat people with compassion and kindness. They did not respect people's privacy and dignity. We completed eight SOFI2's. (SOFI2 is a structured observation which captures people's experience of care). On 12 December 2022 during an evening SOFI2 in ward 4, there were five staff (3 male and 2 female) sat in the corridor observing three people. Staff were talking amongst themselves, laughing, discussing personal lives including schools, and that they don't get annual leave as they are not permanent. They also discussed Chinese burns and how they were painful. This meant staff were not engaging meaningfully with people and were talking about inappropriate topics and did not adhere to the provider's professional boundaries policy which states: "Gossip'' or hearsay should not feature as an aspect of service culture and should be actively discouraged in the workplace."

Later in the same observation, a person was asking for a shower, staff did not respond, when the shower was not facilitated, they were getting louder and more anxious. Staff turned to another staff member and said, "it's your turn". Staff were laughing at the person outside their room when they were saying, "I'm trying to have a shower here and you won't turn the water on". Staff responded with, "in a minute", which for autistic people is not a helpful form of communication as people may take the saying literally. Staff went off to get a towel and went into their room without knocking. This meant they were not protecting the persons privacy and dignity.

At 20:00pm, staff were using ward 4 as a cut through, it was shift changeover and there were signs saying don't use the ward as a cut through. Staff disregarded this and walked through the ward, not respecting this was the people's home at that time.

During the SOFI2 in the evening of 12 December 2022 on ward 1, there was no interaction attempted with people. During the SOFI2 in the evening of 12 December 2022 on ward 2, when a person came out of their bedroom, observing staff all stood up and were confrontational towards them.

During the morning SOFI2 on 13 December 2022 on ward 4, one person walked by their open door naked on two occasions, a staff member talked to her impatiently then walked away, leaving her in need of support, which another support staff responded to. Staff referred to a person as a "good girl" which was patronising as all people at the service were adults.

We conducted a SOFI2 in the afternoon of 13 December 2022 on ward 1. A person was asking to go out in the car. They later asked for a drink, three staff were talking amongst themselves and ignoring them.

In the evening of 13 December 2022, the SOFI2 observation showed that staff spoke abruptly to people, including "take your coat off" and then proceeded to repeat this in an irritable way when the person did not take their coat off.

On 14 December 2022 on ward 1, during a lunch time SOFI2 observation, a person was eating pizza in the dining room, staff stood there not talking to them. Another person was in their room saying they wanted some crisps, staff were sat in the corridor laughing at them and said amongst themselves they have Jaffa Cakes. Staff said, "do you want Jaffa Cakes", they said "I just want crisps." The person was becoming quite upset that their needs were not being met and staff did not respond in a sympathetic way.

On ward 1, on 14 December 2022, another person came out of their bedroom and the staff were sat in the corridor, staff said "sit down", a few minutes later they came out of their room again and staff said "sit", a few minutes later they came out of their room again and staff said "sit down, I'll get you some snacks". There was no positive interaction, from staff, this person responded well to intensive interaction which staff did not provide, staff just sat outside his room talking to themselves. Staff were not following the persons' positive behaviour support plan.

On ward 1, another person came out of their room, staff followed and ignored them. A little later they were sat in the dining room and staff were stood at the doorway ignoring them. They then went into the quiet room, staff opened the door and gave them food and did not interact with them. Staff were not engaging meaningfully with people.

On 14 December 2022 on ward 4 during a SOFI2, a person was settled in the corridor sat with staff and then a staff member suggested they went in the quiet room, there was no reason for this. The staff on their observations included two females and a male support worker. Their care plan says they should not be supported by males except in emergencies.

Support staff who delivered the majority of the care, did not provide kind and compassionate care and did not use positive, respectful language at a level people understood and responded well to.

We saw one staff member using a Makaton sign and intensive interaction with one person, this person responded well to this, however the rest of the staff supporting them did not use these communication methods which meant they were not being supported in an individual, person centred way.

People we spoke with, did not feel valued by staff and they did not show interest in their well-being and quality of life.

Staff did not show warmth and respect when interacting with people. Staff were usually sat on chairs along the corridor outside people's bedrooms. When people did come out of their room, staff were dismissive of them and focused more on talking amongst themselves and we saw staff ignore people and restrict their movements and activities.

Each person had a moving on plan, which did not include any involvement of the person or goals to achieve. Records were not consistent, one person's moving on plan says they like outdoor activities and riding a bike, however there is no reference in their joining in and living a good life care plan which focuses on activities.

Staff we spoke with, felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. Staff told us things had improved since the changes in senior leadership.

Staff followed the policy to keep people's information confidential. Records were a mixture of paper and electronic files and were stored in the locked office.

Involvement in care

Staff did not involve people in care planning and risk assessment and did not seek their feedback on the quality of care provided. There had been a feedback questionnaire completed with the use of facial expressions, however there were not completed ones. There was an example you said we did which was for monthly take aways.

Although there was a poster for the advocate, there was no contact details for the advocate and the poster said they visited on a Monday, this was mainly to attend ward rounds. Therefore, people could not easily access the advocate.

People told us, since the changes in senior managers and additional members of the multidisciplinary team, they were listened to, given time and supported by staff to express their views. However, this did not happen with the support staff.

We saw that members of the multidisciplinary team took the time to understand and develop a rapport with people. However, they had limited time to spend with people as they worked across the hospital.

Inadequate

Wards for people with learning disabilities or autism

We did not see that people were enabled to make choices for themselves. Snacks were brought for people, without staff asking people what they wanted. Staff told people to sit down and go into certain rooms, their movement was restricted.

Staff did not respect people's choices, including those relevant to protected characteristics – for example, due to cultural or religious preferences. We overheard a conversation between a person and their support staff, the person said they wanted to be baptised, staff were derogatory and said they needed to be baptised and would come back a new man. We raised this with the service who raised a safeguarding alert and were investigating it.

Fortnightly community meetings took place on each ward. We reviewed the minutes and found that people were not empowered to make decisions about the service, however people did feedback on their care and support. Including that staff were discussing topics that people found triggering. Concerns regarding the noise that night staff made was raised in September 2022, also concerns about staff entering their room whilst getting ready. The noise level of staff was an action in the minutes. This was not followed up at the next meeting as the minutes said they couldn't locate the previous minutes. We reviewed the team meeting minutes and found that it was not discussed with the staff. This meant people's concerns were not acted upon. This was still a concern for people at the inspection.

Staff supported people to maintain links with those important to them. Family visits took place and staff supported people to communicate with family via the phone and WhatsApp.

Staff introduced people to the ward and the services as part of their admission. However, the welcome guide that had been created was not accessible, it was mainly words. It also had incorrect information in about legislation, it referred to "Care Standards Act 2000 as amended by the Health and Social Care (Community Health and Standards) Act 2003" This meant people were not being given accurate information in an accessible format.

Staff did not make sure people understood their care and treatment (and found ways to communicate with people who had communication needs). Several people did not use speech to communicate, some people used Makaton. There was no training for staff in Makaton, this meant staff could not communicate effectively with people.

Staff had started to inform and involve families and carers appropriately. We spoke with eight family members.

Six family members said things had improved since the occupational therapist, speech and language therapist and new doctors had started and different management.

Seven family members told us they were not regularly updated about their loved one and if they couldn't attend the meetings, the did not receive a copy of the minutes. Families said they used to receive regular updates, however this had stopped. Four family members said the service were not responsive and proactive to the physical health needs of their loved one. A lack of consistency with staff was a concern of family members, especially when their loved ones valued routine and structure. A lack of activities was concerning for family members, with the main activities being a van drive or going to the shops. Three family members told us the service were not meeting the dietary needs of their loved ones. Two family members said the service were not specialists in autism informed services, with no ideas suggested by the service, it was family members making the suggestions.

We asked the service for any evidence of feedback from families and carers. The service told us that feedback requests have been sent to families and carers in September 2022 and in December 2022, however they had not received any responses. The service had also introduced an email address for families to give feedback about the service.

Inadequate

Wards for people with learning disabilities or autism

Is the service responsive?

Requires Improvement

Our rating of responsive improved. We rated it as requires improvement.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people did not stay in hospital longer than needed, and discharge was rarely delayed for other than a clinical reason. We observed a discharge planning meeting where the service were actively involved and received positive feedback from other agencies regarding the progress the individual had made.

Managers did not regularly review people's length of stay to ensure they did not stay longer than needed. This was not discussed in any of the senior meetings.

If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate. We saw visits being arranged and facilitated with families. There was a Christmas fair during the inspection, which some families attended.

Staff supported people when they were transferred between services. Offers of support were given to the new placement for a person, to have staff supporting them who were familiar to them as part of the process.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not support people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. However, the wards were very stark with no decorations to make them more welcoming. In ward 4, there was a section of the wall that had black chalk paint on and there was scribbled out writing on it for the whole of the inspection. There was privacy screening on the windows. In ward 1, there was a window without a privacy screen on and in ward 3 there was a ripped privacy screen on a window. This did not protect people's privacy and dignity. In ward 1 there was a stained sofa and ward 3 had a ripped sofa in the lounge. There was bits of paper and other items in the TV surround on ward 1 and a stain on the TV in ward 4. Each ward had a main corridor with the bedrooms, dining room and lounge off. The corridors were lined with chairs for the observing staff. There were no activities or sensory areas in the communal areas for people to engage in.

There were quiet rooms on each ward, some people used these however the majority of people spent time in their rooms. The food was of a variable quality, however there were changes happening in the catering team and we did see the chef being responsive when staff asked them to provide a soft diet for one of the people.

People could not make hot drinks and snacks at any time. Each person had a store of snacks they had purchased which was stored off the ward in a communal kitchen, people needed to be escorted to this area to access this. Staff usually made drinks for people or people could be escorted to the communal kitchen to make a drink.

The service's design, layout and furnishings did not support people and their individual needs. There were alarms that went off regularly and for prolonged periods of time. We observed a 10 minute and two seven minute episodes of the

alarms going off continuously, they could be heard throughout the building, including the wards. People were sensitive to noise and staff did not turn the alarms off as soon as possible and the service had not explored the possibility of turning the volume down or silencing alarms in certain areas. This meant the service were not meeting people's sensory sensitivities.

However, we did see one person's room was dimly lit as was their preference. Another person had chalk walls so that they could write on their walls. A sensory room had been developed for another person.

The service had a family room where people could meet visitors in private.

People could make phone calls in private.

The service had an outside space, however people had to be escorted to access this space.

Patients' engagement with the wider community

Staff supported people with family relationships.

Staff supported people to take part in their chosen social and leisure activities. The majority of the activities that people did was shopping, walks and going out in the van for a drive.

Activities that people pursued on the ward included using the computer, watching TV, playing board games, drawing, the majority of the time they spent in their bedrooms.

Staff gave people person-centred support with self-care and everyday living skills. However, we observed staff delaying their support when one person requested a shower.

There was no evidence of people being encouraged and supported by support staff to reach their goals and aspirations. The majority of the time, support staff sat in the corridors and people were in their bedrooms, not having any interaction. There was no activities that were meaningful to support their recovery.

People who were living away from their local area were able to stay in regular contact with friends and family using the telephone, online voice or video calls, and social media.

There were moving on plans in people's records however these did not involve the person and were no placement goals developed with commissioners to enable people to move back to their local community as soon as possible.

Staff did not support people to try new things and to develop their skills. Activities were focused on being risk averse, the van drives provided containment, walks were usually in parks with large open spaces so that risks were reduced.

We observed an OT led and psychology led activity, people engaged well with the activities, however the support staff stood on the periphery and were not involved in the activity.

Support staff did not initiate activities with people, activities that took place were led by the multidisciplinary team.

Staff were not committed to encouraging people, in line with their wishes, to explore new social, leisure and community-based activities. Activities were repetitive for people.

Inadequate

Wards for people with learning disabilities or autism

Meeting the needs of all people who use the service

The service did not meet the needs of all people – including those with a protected characteristic. Staff did not help people with communication, as they had not received training in communication.

Staff did not use person-centred planning tools and approaches to discuss and plan with people how to reach their goals and aspirations.

People did not learn everyday living skills, washing and cooking was completed for them and the majority of external activities were accessed by the service vehicle.

Staff identified people's preferences, however we observed male staff supporting a person who should only be supported by female staff.

Staff did not offer choices tailored to individual people using a communication method appropriate to that person. In the morning meeting, when the introduction of a new piece of furniture was discussed for a person, there was no suggestion of the use of a social story or images to prepare the person, staff just said they will replace the furniture.

Staff did not ensure people had access to information in appropriate formats, the service user guide was mainly words and there was no information on display in the wards, which was accessible to people.

Staff did not provide information using objects/photographs/ gestures/symbols/other visual cues to help people know what was going to happen during the day and who would be supporting them. There was no visual staff rota showing who was working. We saw staff swop observations whilst people were in their rooms, therefore they would not know there was different people supporting them until they came out of their room.

People had communication care plans in place and how people communicated, and their preferences was also included in their hospital passport.

Staff had little awareness, skills and understanding of people's individual communication needs. We saw one example of a staff member communicating with a person using Makaton and their individual sounds. All other staff communicated with people verbally. Staff had not received training in communication skills and how best to communicate with the people they were supporting.

There was a speech and language therapist who worked at the service part time, they had been focusing on completing communication assessments and care plans for people. The provider had recently approved the purchase of a symbol package to enable the development of bespoke communication aids.

Staff were not trained and skilled in using personalised communication systems.

There was no information displayed for people on the wards. The service user guide included information on rights and how to complain, however this was not in an accessible format.

The service did not have information leaflets available in languages spoken by people and the local community. The information was in English.

Managers made sure staff and people could get help from interpreters or signers when needed. Interpreters had been used for a family whose first language was not English.

The service provided a variety of food to meet people's dietary and cultural needs.

Listening to and learning from concerns and complaints

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. The hospital manager had developed a system to oversee the complaints management process. This included a spreadsheet with complaints, when they were received, the nature of the complaint and when it was concluded. We saw thorough investigations into complaints took place. We saw acknowledgement letters were sent to complainants and outcome letters to provide feedback from managers after the investigation into their complaint.

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

The service did not clearly display information about how to raise a concern in areas used by people. There was no information on display on the wards. The service user guide included information about how to complain however the document was not accessible. Other ways that people could feedback was when they were having their section 132 rights explained to them under the Mental Health Act, during their ward rounds and care planning meetings, advocate visits and during community meetings.

There was a complaints policy in place however it was out of date and referred to the Mental Health Act Commission. The timescales of the policy was to issue an acknowledgement within 5 days and an outcome within 30 days. These dates were met in the complaints we reviewed, for one where there was a delay, the complainant was informed of the delay in writing.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Managers shared feedback from complaints with staff, and learning was used to improve the service. Complaints and their outcomes were discussed at team meetings and clinical governance meetings.

When we spoke to families, two family members said they had not heard back from their complaint or the action the service said they were going to take following the complaint has not happened. When we reviewed the complaints, one action of sending out a monthly letter as an update and to ask for feedback had not been implemented.

In the six months prior to the inspection, the service had received 16 compliments, mainly about the progress people were making. These were shared at clinical governance meetings and team meetings.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

The leaders had changed in the couple of months prior to the inspection. There was a new hospital manager and a new director in post who was also the responsible clinician. They were very person centred and visible in the wards. They had a clear understanding of the areas of improvement needed within the service.

Inadequate

Wards for people with learning disabilities or autism

Leaders had started to work hard to instill a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. The leaders had identified that support and training was needed for the support staff to embed the change.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.

Leaders and senior staff were alert to the culture in the service and had acknowledged they needed to address the culture and send time with staff/ people and family discussing behaviours and values.

Managers worked directly with people and led by example. Managers were visible on the wards and people told us they spent time talking with them, however nothing seemed to have changed in relation to the role of the support staff.

Managers promoted equality and diversity in all aspects of running the service.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team. The values were discussed in team meetings and staff gave examples of how they had been met. The values previously were accountability, understanding, teamwork, innovation, selflessness and make a difference. They had recently changed to compassion, accountability, respect and engagement.

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible. The new director had clear aims for areas for improvement including communication with people and enhancing staffs skills, knowledge and benefits, medicines, environment and nursing associates.

Managers set a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives. They had recently involved support workers in the morning meetings, to listen to them and involve them in decision making as they were delivering the majority of the care.

Culture

Staff told us things had changed since the new hospital manager and executive director had started, they felt respected, supported and valued. The executive director had negotiated a pay rise and additional training for staff in communication aids, staff said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The provider was planning additional training to meet the needs of all people using the service. They had made links with another organisation who had agreed to provide training to staff in talking mats which is a communication aid to enable people to share their views and make choices.

Staff felt able to raise concerns with managers without fear of what might happen as a result. Team meeting minutes showed staff had raised issues with managers.

Staff said since the changes in senior staff, they felt respected, supported and valued by senior staff, this had started to improve the culture.

Inadequate

Wards for people with learning disabilities or autism

Governance

Governance processes were not effective and did not hold staff to account, keep people safe, protect their rights and provide good quality care and support. Care records were not consistent, there was an example where a person had a dysphagia care plan due to presentation and overloading their mouth. However, their hospital passport said they had no issues with eating and drinking. This meant records did not reflect the individual's needs and were giving incorrect information to staff providing the support.

Governance policies, procedures and protocols were not current and did not include current legislation, therefore they were giving staff out of date guidance.

The provider did not keep up to date with national policy to inform improvements to the service. The environment, activities and training for staff did not reflect best practice for autistic people.

Staff did not use recognised audit and improvement tools to good effect, there was no examples of these in use during the inspection.

Although staff completed medicine audits, if the findings showed areas for improvement, the actions were not always completed, which meant managers did not always use the results from audits to make improvements. The environmental walk arounds completed daily which showed staff were not complaint with infection prevention control guidance did not drive improvements, as there continued to be staff not complying on future audits and during the inspection.

The management of care records showed they were not complete and contemporaneous. Three of the six care records reviewed had care plans that were not reviewed in line with the providers policies which stated they should be reviewed monthly. However, they were stored safely.

The service did not ensure that care was delivered in line with care plans. One person was not having their blood sugars taken and recorded as required and another person was not being weighed as required to ensure their physical health was being monitored an appropriate action taken if needed.

The provider's governance framework did not ensure that the provider was complying with the Mental Health Units (Use of Force) Act 2018 and its guidance. The Management of Behaviours that Challenge and Least Restrictive Practice Policy and Procedure, did not reference the Use of Force Act 2018. There had been an information leaflet created for people regarding the Use of Force, however this was all words with no accessible communication version for those who would find that helpful.

Governance processes did not ensure the service were meeting schedule 3 of the Health and Social Care Act Regulated Activities Regulations 2014. We reviewed eight staff records and found that two files only had one reference, two files did not have evidence of qualifications or proof of professional registration. Six files did not have a full work history. Two files did not have a completed appraisal. Two files did not have a completed health screening. This meant the service could not be assured that staff they recruited were fit and proper as there was no oversight of staff records and the records did not meet the requirements of the Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were files for six current drivers and a previous driver who worked at the service, the main transport for people was in the hospital's vehicles. We reviewed the staff files regarding drivers to ensure necessary checks had been

completed and found that they did not have a copy of the driving license for one current and one previous driver. Another driver had an Irish driving license which showed they were registered as living in Ireland. This meant the service was not assured that staff could drive and did not have points on their license or whether their license was current. They were also not following the hospital drivers policy which stated that staff should have a full manual driving licence.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care. Records were out of date and contradictory with the information. This meant staff did not have clear guidance of how to support people effectively.

Senior staff did not understand and demonstrate compliance with regulatory and legislative requirements. The service continued to be in special measures. Since the last inspection in March 2022, there had been improvements in relation to multidisciplinary team involvement and information sharing with staff via team meetings, and management of complaints, there continued to be significant concerns in the safety of the service and the care provided.

Staff were able to explain their role in respect of individual people without having to refer to documentation. They were able to explain what support they provided, however support staff saw their role as observing people, not providing meaningful engagement.

Staff did not act in line with best practice, policies and procedures. They did not have any policies and procedures for care planning and documentation. This meant staff were not given clear guidance and expectations to work to.

The providers risk register included some of the risks identified during the inspection including infection prevention control and historical CQC inspection findings and enforcement.

Information management

Staff did not collect and analyse data about outcomes and performance and did not engage in local and national quality improvement activities.

Engagement

People and those important to them did not work with managers and staff to develop and improve the service. However, since the changes in senior leadership, people said they felt more listened to. The executive director had plans to involve people and their families in the development of the service.

The provider had started to seek feedback from people and those important to them to develop the service. We asked the service for evidence of any feedback from people, they shared a you said we did poster, with one example of a takeaway being arranged one night per month. A blank feedback questionnaire was shared with us, with none completed or any results shared. We asked the service for any evidence of feedback from families and carers. The service told us that feedback requests have been sent to families and carers in September 2022 and in December 2022, however they had not received any responses.

The service did not have any formal listening events for family and friends to share their views and discuss issues with staff. Although they had invited families to the Christmas fair and three families attended the event and spent time with their loved one.

The service had improved their relationship with commissioners, we received feedback from four commissioners, they said they had seen improvements at the service since the increase in the multidisciplinary team and changes in senior

leadership. They had seen positive progress for the people they commissioned the service for. The areas for improvement included the care records and documentation that had not been reviewed, communication and the length of time this can take, and that the service worked in a reactive rather than proactive approach. Activities, environment and poor staff interactions were also raised.

Managers engaged with other local health and social care providers and participated in the work of the quality assurance improvement meetings.

Staff did not engage in local and national quality improvement activities.

There had not been any formal feedback gathered from staff since the last inspection, there had not been any staff surveys completed, feedback had been informal.

Learning, continuous improvement and innovation

The provider, with the new chief executive kept up-to-date with national policy to inform improvements to the service. Improvements had been identified as a result of this including in relation to communication and staff training.

The provider invested sufficiently in the service, embracing change and delivering improvements. This had happened since the changes in senior leaders and agreement had been made for the introduction of an electronic care record system and pharmacy provision including the provision of clinic checks and audits.

The new senior leadership team had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible. There had been contact made with local universities regarding offering student placements and exploring the nursing associates role.