Elysium Healthcare (Acorn Care) Limited

# The WoodHouse Independent Hospital

## 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? | Insufficient evidence to rate |
| Are services caring? | Inadequate |
| Are services responsive to people's needs? | Insufficient evidence to rate |
| Are services well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The Woodhouse Independent Hospital provides services for people with a learning disability or autism in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service specialises in providing care for autistic people and people with forensic histories.

The CQC expects 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.

This inspection, which commenced on 28 February 2022, was an unannounced, focussed inspection to see what improvements the provider had made. Our inspection focussed on the concerns we raised to the provider following our previous inspection. We did not look at all of the key lines of enquiry.

Due to the seriousness of our concerns following our 1 March 2022 site visit, we wrote to the provider to inform them we were considering urgent enforcement action under Section 31 of the Health and Social Act 2008. The letter identified our significant concerns with staff conduct towards people using the service, inappropriate and disproportionate use of restraint and the investigation of incidents. We invited the provider to urgently complete and send an action plan detailing how they had already addressed or planned to immediately address our concerns. The provider responded with an action plan of sufficient assurance and we did not pursue urgent enforcement action. We returned to the hospital on 8 March 2022, and our findings provided us with further assurance to the immediate actions and the plan in place to protect people using the service from the risk of avoidable harm.

Despite improvements seen in some areas of the service since our previous inspection, we remain concerned about the way some staff have treated people who use the service and the robustness of governance arrangements in the service to always protect people. We have rated the service inadequate and placed it in special measures. Prior to the publication of this report, we issued the provider with a Warning Notice served under Section 29 of the Health and Social Care Act 2008. This notified them that they were failing to comply with Regulation 12 (1), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and must demonstrate compliance by 11 November 2022. Details of the notice can be found at the end of the report.

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

- The service did not always provide safe care. Staff did not always follow plans or use approved physical intervention techniques with people who used the service. We saw staff tormenting, goading, lifting and dragging people when responding to incidents or behaviour that challenged.
- Staff did not always manage safety incidents well. Staff did not recognise all incidents that needed to be reported and some incidents continued to be reported inaccurately. Existing processes to use closed circuit television camera footage in the investigation of incidents had not been sufficiently robust to protect all people who used the service from avoidable harm.
- The provider's action to assess for the presence of a closed culture had not identified similar concerns to those we observed during our inspection. Staff did not always treat people who used the service well during incidents and staff failed to identify or report practice or conduct of colleagues that was inappropriate or abusive.

# Summary of findings

- Not all governance processes appeared sufficiently robust or established to ensure safety and quality for all people who used the service and particularly those most vulnerable.
- The service continued to experience staffing challenges during the COVID-19 pandemic. Staff absences as a result of COVID-19 and the provider's use of temporary staff during the pandemic had sometimes negatively impacted on the care and treatment of people who used the service.
- Environmental improvements to Moneystone had not sufficiently softened or reduced noise on the unit.
- There were concerns about excessive weight gain for some people who used the service. It was not always clear how effective the provider's actions were to support people to remain healthy.

However,

- The provider's response to the concerns raised to them following the inspection was immediate, robust and provided us with assurance risks to people who used the service would be mitigated.
- Many of areas of the service had improved to meet the requirement notices issued following our previous inspection. This included equipment to meet the sensory needs of people on Moneystone unit and improved medicines management practices.
- The provider had supported the hospital manager's decisions to support safety and quality at the service as the COVID-19 pandemic progressed. There was additional leadership in the service. People who used the service and staff spoke positively about the visibility and approachability of the service managers.
- Many units provided people who used the service with their own apartment. Staff supported people to be independent and personalise their accommodation. The provider had invested in new furniture that was suitable for people who used the service and maintained communal and outdoor areas well.

As this service has been rated inadequate it will be placed into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

# Summary of findings

## Our judgements about each of the main services

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

# Summary of findings

## Contents

# Summary of this inspection

## Background to The WoodHouse Independent Hospital

The Woodhouse Independent Hospital is an independent mental health hospital provided by Elysium Healthcare (Acorn Care) Limited. The hospital provides services for people with a learning disability or autistic people in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service specialises in providing care for autistic people and people with forensic histories; including sexual offending, highly complex and severe challenging behaviour.

We previously inspected The Woodhouse Independent Hospital in June 2021. This inspection was carried out to follow up concerns identified at our October 2020 inspection as well as to respond to new information of concern received about the safety and quality of the service. Our June 2021 inspection gave The Woodhouse Independent Hospital an overall rating of 'requires improvement' and rated the safe domain as 'inadequate'.

Due to the seriousness of the concerns identified during our previous inspection, on 4 August 2021 we used our powers under Section 29 of the Health and Social Care Act 2008 to issue a warning notice to the provider notifying them they failed to comply with Regulation 18 (1) (2), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for The Woodhouse Independent Hospital on our website at www.cqc.org.uk.

The hospital is located on a rural site in Cheadle, Staffordshire. The service has eight units and can accommodate up to 39 males and females under 65 years old who have a learning disability or autism. However, when we inspected, the provider had closed two units reducing maximum occupancy to 28 people.

- Hawksmoor is a locked rehabilitation unit for up to five females. Accommodation is provided in single occupancy self-contained apartments.
- Whiston is a locked rehabilitation unit for up to four males. Accommodation is provided in single occupancy self-contained apartments.
- Kingsley is a locked unit for up to four males with autism and complex or challenging behaviours. Accommodation is provided in single occupancy self-contained apartments.
- Moneystone is a locked unit for up to eight males with autism and complex or challenging behaviours.
- Highcroft is a locked rehabilitation unit for up to four males with autism. Accommodation is provided in single occupancy rooms with en-suite facilities.
- Farm Cottage is a locked rehabilitation house for up to three males. Accommodation is provided in single occupancy rooms with en-suite facilities.
- Lockwood a locked rehabilitation unit for up to eight males. When we inspected this unit was closed.
- Woodhouse Cottage is a locked rehabilitation house for up to three males. When we inspected this unit was closed.

When we inspected, the hospital had 23 people admitted. All patients were detained under the Mental Health Act 1983. There was a CQC registered manager in post.

The Woodhouse Independent Hospital is registered to provide the following regulated activities:

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

# Summary of this inspection

- Treatment of disease, disorder or injury.

**What people who use the service say**

Over the course of three days we spoke with 12 people who used the service. While some told us the service had enough staff, two people told us there wasn't always enough staff to meet the needs of their care package or to support community visits. Many spoke positively about staff using words like 'fantastic', 'kind' and 'fun'. They believed staff helped to keep them safe and all identified someone in the service they could speak with if they had a concern. Three people were less positive about temporary staff at the service. They found working with temporary staff challenging, reporting they didn't talk much and sometimes spent too much time on their phones. Two people told us staff could be better at following their care plans and could be more consistent in their actions.

We spoke with four family members or carers to people who used the service. Three of those believed their relative to be safe at the service. We received positive comments about staff being respectful, polite and caring. One told us staff always used positive language about their relative even when discussing more challenging issues, and another spoke positively about the progress their relative had made since being placed at the Woodhouse Independent Hospital. Overall, those we spoke with felt communication between themselves and the service was satisfactory. However, one felt staff were often too busy to talk, and they'd like opportunities to be more involved in their relative's care. We received one concern specifically about their relative's weight gain at the service.

## How we carried out this inspection

This was an unannounced focussed inspection to see how the provider had improved the service since our previous inspection in June 2021. Our inspection focussed on the concerns raised at our previous inspection. We did not look at all of the key lines of enquiry.

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.

**Action the service MUST take to improve**:

- The provider must ensure staff understand their individual responsibilities to prevent, identify and report abuse or ill treatment of people in their care. (Regulation 12).
- The provider must ensure staff use recognised interventions and techniques to manage incidents and behaviour that challenges with people in their care. (Regulation 12)
- The provider must ensure governance systems are robust and work effectively to ensure safety and quality in the service. (Regulation 12)

**Action the service SHOULD take to improve:**

# Summary of this inspection

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The provider should continue with actions to ensure sufficient numbers of suitably qualified, skilled and experienced staff are deployed to meet the needs of people who use the service.
- The provider should continue to assess and seek solutions to soften and reduce noise on Moneystone unit.
- The provider should demonstrate how weight monitoring and local health initiatives are supporting people who use the service to remain healthy.

# 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 | Insufficient evidence to rate | Inadequate | Insufficient evidence to rate | Requires Improvement | Inadequate |
| **Overall** | Inadequate | Insufficient evidence to rate | Inadequate | Insufficient evidence to rate | Requires Improvement | Inadequate |

Inadequate

# Wards for people with learning disabilities or autism

| | |
|---|---|
| Safe | Inadequate |
| Effective | Insufficient evidence to rate |
| Caring | Inadequate |
| Responsive | Insufficient evidence to rate |
| Well-led | Requires Improvement |

## Are Wards for people with learning disabilities or autism safe?

Inadequate

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

**Safe and clean care environments**

**The service was clean and well maintained. The provider was improving environments with the addition of new lighting, furniture and sensory equipment. However, we saw further improvements could be made. Staff made regular checks of clinic room and emergency equipment to ensure they remained safe for use.**

**Safety of the ward layout**

Individual units accommodated males or females only. This complied with national guidance and expectations about governing the provision of single sex accommodation.

Staff completed and regularly updated thorough risk assessments of all clinical areas. We saw environmental risk assessments were up to date and included fire, lone working and COVID-19. Staff completed personal emergency evacuations plans for people using the service and updated them when necessary. For example, if people moved units during their admission.

The provider had installed convex mirrors to manage blind spots and assist staff to observe all parts of the service.

Units had anti-barricade doors. Anti-barricade systems varied across the site, however the provider displayed information on each unit about the anti-barricade system in use. The provider trained staff on anti-barricade doors during induction.

The provider had closed-circuit television cameras (CCTV) in communal areas of the hospital and externally. We saw some people using the service had chosen to have CCTV in their apartment. The individual could choose when this was in use or switched off. The provider displayed signs to inform people of the presence of CCTV. Our review of CCTV footage showed not all areas of units where incidents occurred were sufficiently covered by CCTV cameras. On raising this to the provider, they responded immediately with plans to make improvement.

Senior staff completed regular assessments of potential ligature anchor points in the service. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. Unit offices displayed a ligature map of the environment and a ligature file containing information of the identification and management of ligatures.

Staff had easy access to alarms and patients had easy access to nurse call systems.

**Maintenance, cleanliness and infection control**

Since our previous inspection the provider had closed two units, with an overall loss of 11 beds. The provider planned to refurbish both units and also to review the model of service delivery these units provided.

Staff made sure cleaning records were up-to-date and the premises were clean. The provider employed dedicated housekeeping staff who worked daily.

Following our previous inspection, we told the provider they must ensure Moneystone unit had equipment and furnishings to meet the sensory needs of people staying there. We saw the provider had taken positive action towards this. The provider had developed and was implementing a refurbishment plan. When we inspected, phase one of the refurbishment plan had been completed. We saw changes to communal areas including redecoration, new brightly coloured furniture suitable for people using the service, dimmer switches to overhead lights, a projector, a sensory wall with hanging art, and portable sensory equipment for individual use. Phase two of the refurbishment was to focus on the unit's central corridor and bedrooms doors. As the provider recognised this work to be noisy and potentially disruptive for people in the service, they planned to complete it when weather allowed people to be off of the unit for longer periods. However, the refurbishment completed to date had done little to soften or reduce noise on the unit. We experienced this during the inspection, and one person using the service and their relative told us they continued to find the unit noisy.

Following our previous inspection, we told the provider they should ensure furniture was well maintained and fit for purpose. During this inspection we saw evidence of investment from the provider. All units had a lot of new furniture that was brightly coloured and suitable for people using the service. This included dining furniture, bean bags and slouch chairs.

Following our previous inspection, we told the provider they should ensure maintenance faults were logged appropriately and timely action was taken to resolve the faults. The provider had an electronic system in place to raise maintenance requests. Staff we spoke with were familiar with this system, however maintenance staff told us it was not always used. For example, in an emergency or outside or working hours. The hospital manager met with maintenance staff weekly to review and prioritise maintenance requests. The provider employed a maintenance team that was on site during working hours and on-call during nights and weekends. Staff told us they received a good response to maintenance requests they raised.

The practice of staff to adhere to infection prevention and control principles had improved. Following our previous inspection, we told the provider they should ensure staff embed good infection prevention and control practices. On arrival to the hospital, staff asked the inspection team for evidence of a negative COVID-19 test completed that day. Staff had access to sufficient supplies of personal protective equipment (PPE), hand sanitiser and waste bins for the disposal of used items. The provider displayed information about using PPE correctly and during the inspection we saw staff doing so. Our reviews of closed-circuit television cameras (CCTV) footage in the service further confirmed that staff used PPE correctly. We also saw the provider displayed social distancing and safe room occupancy information.

Inadequate

# Wards for people with learning disabilities or autism

**Clinic room and equipment**

Units had small clinic rooms primarily used for the storage and administrations of medications.

During our previous inspection, we found staff did not always monitor clinic room and fridge temperatures to ensure medications remained safe for use. We found this had improved, records showed staff checked and recorded clinic room and fridge temperatures daily.

Staff had access to physical health monitoring equipment to use with people using the service. This included pulse oximeters and an electrocardiogram. Staff checked, maintained, and cleaned equipment.

Resuscitation equipment was accessible across the site, including oxygen and automated external defibrillators. Some units shared resuscitation equipment. Staff made regular checks of resuscitation equipment to ensure it remained in working order.

**Safe staffing**

**The provider had made improvements to ensure the service had enough nursing and medical staff, who knew the people who used the service and received basic training to keep people safe from avoidable harm. However, the provider's use of temporary staff during the COVID-19 pandemic had remained high and this sometimes negatively impacted on the care and treatment of people who used the service.**

**Nursing staff**

Following our previous inspection, we told the provider they must ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff working to meet the needs of people using the service. We found the provider had taken a number of actions to meet this requirement.

Vacancy rates for registered nurses had improved. The service required 26 whole time equivalent nurses, of which only two positions were vacant.

The number of support workers the service required fluctuated depending on the needs of people admitted. For example, people's care packages identified the number of staff required to meet that person's individual needs or to access the community. At the time of our inspection, the service required 162 whole time equivalent support workers, of which 51 positions were vacant. However, the provider had recently recruited 23 support workers and were undertaking pre-employment checks.

The provider continued to recruit to vacant roles across the site. The hospital manager ran recruitment events that had continued virtually during the COVID-19 pandemic. The provider also had overseas recruitment in place and financial incentives for staff to return early from maternity leave.

Senior leadership staff and members of the multidisciplinary team worked during the day Monday to Friday and were supernumerary to unit based staff. This included unit managers, physical health co-ordinators and allied health professionals. Staff from these groups supported units during incidents and, when necessary during the COVID-19 pandemic, they supported safe staffing requirements.

Inadequate

# Wards for people with learning disabilities or autism

The provider planned staffing to meet the needs of people's care packages. At our previous inspection we found 30% of shifts had not met planned staffing numbers but had met safe staffing requirements determined for the service. Safe staffing meant prescribed observations of people using the service were maintained, but staffing was not always sufficient to meet the needs of an individual's care package. Between July 2021 and February 2022, from a total of 3,868 shifts we found 84% of shifts met planned staffing levels. In the same period, 14% of shifts had not met planned staffing numbers but had met safe staffing requirements. When staffing did not meet planned levels, staff told us people using the service had limited or shorter access to leave, community activities and outdoor hospital based activities.

Between July 2021 and February 2022, 1.6% of shifts had fallen below safe staffing requirements. For example, staffing for Hawksmoor unit on 8 January 2022 had planned staffing of eight but actual staffing of only four. Records showed where members of the leadership team or multidisciplinary staff had supported staffing across the site.

To support safe staffing across the site, managers made the decision to pause admissions to the service and the provider supported this. This occurred in September 2021 as COVID-19 related absences of staff showed increase. In February 2022, the provider reduced the capacity of the site by eight beds with the closure of Lockwood unit. This allowed staff to be redeployed across the service. Managers consulted people who used the service, family members and commissioners in the decision to close Lockwood unit.

At the time of our inspection, we found actual staffing met planned staffing across the site. Staff reported improvements in staffing numbers across the previous four weeks, identifying fewer COVID-19 related absences and staff redeployment from the decision to close Lockwood unit. People using the service were generally positive about staffing numbers, also noting an improvement in recent weeks.

We found staff access to uninterrupted breaks had improved. Following our previous inspection, we told the provider they must ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff working to allow staff to take uninterrupted rest breaks in line with the provider's policy and working time regulations. In consultation with staff, managers had reduced the total time staff took as a break during a shift. The goal being to make planning and taking breaks more manageable, particularly when staffing fell below planned requirements. During our inspection, we saw staff breaks planned and staff taking breaks. Staff reported access to breaks had improved, particularly in the previous four weeks. Staff reported benefits to morale and well-being as result of being able to take breaks during their working day.

As part of the staffing requirements imposed on the provider following our previous inspections, we also said staff must have a knowledge of the people they were supporting. The service continued to deploy bank and agency nurses to cover sickness, absence or vacancies, particularly during the COVID-19 pandemic. Between July 2021 and February 2022, shifts with 50% or more agency staff accounted for 24% of all shifts in the service. This was an increase of 2% from our previous inspection. In the same period, 72% of all shifts included at least one agency staff member. This was the same as reported at our previous inspection.

Where possible, managers used bank and agency staff familiar with the service and the people using it. They told us bank and agency staff received a handover and induction before commencing a shift. Bank and agency staff also accessed one page profiles with key information about the people they were supporting. However, governance records identified the presence of unfamiliar staff contributed to increased incidents for some people who used the service. In our conversations with people who used the service and with staff, some concerns were raised about the ability of some agency staff to engage well with people who used the service. Managers recognised this concern and had actions in place to support improvement for people using the service and for staff.

Inadequate

# Wards for people with learning disabilities or autism

Following our previous inspection, the service experienced high levels of staff sickness during the ongoing COVID-19 pandemic. Between July 2021 and January 2022, the Woodhouse Independent Hospital had an average staff sickness rate of 8.3%. Monthly staff sickness absence fluctuated, with January 2022 recording a staff sickness rate of 11.3%.

As of February 2022, the provider recorded a staff turnover rate of 4% in the service.

Following our previous inspection, we told the provider they must ensure handovers contained sufficient detail to provide staff with the information they needed to begin their shift. We found the provider had made improvements. All staff we spoke with said handovers provided the necessary information to deliver patient care. Staff also knew where to access site wide information and lessons learned.

Following our previous inspection, we told the provider they must ensure there were robust systems in place to ensure staff working during a night shift were appropriately undertaking their roles. We found improvements had been made. Night service managers were on duty every night and their role was supernumerary to unit staffing. Night service managers completed night site reports for review in the multidisciplinary morning meeting. Where necessary, night site reports included staff practice concerns. We reviewed night site reports between 20 February 2022 and 26 February 2022 and found no staff practice concerns had been notified. Other records showed the provider took appropriate action when concerns were raised about staff practice or conduct during night shifts.

The provider had acted in response to concerns about staff cliques in the service. The actions, including resource reviews and rotation of staff in core teams, helped to monitor where cliques might occur. However, three staff members told us they still had concerns about cliques or staff friendship groups in the service, although two were aware of the provider's actions to address concerns.

**Medical staff**

The service employed two consultant psychiatrists. One position was vacant but had been filled by a locum since December 2021. Both contributed to overnight and weekend on-call cover.

**Mandatory training**

The provider ensured mandatory training was available to all staff. The provider's completion target for mandatory training was 85%. At the time of our inspection, the provider reported an overall staff completion rate of 92%. Courses included in the mandatory training for the services appeared appropriate and included those aimed at keeping people who used the service safe.

Managers monitored mandatory training and alerted staff by email and letter when they needed to update their training.

**Assessing and managing risk to patients and staff**

**Staff continued to not always follow plans or use approved physical interventions when managing incidents or behaviour that challenged with people who used the service. However, staff had made improvements to completing body maps in the event of any physical intervention being used. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, for a person cared for in long-term segregation.**

**Use of restrictive interventions**

Inadequate

# Wards for people with learning disabilities or autism

We found the provider had not made sufficient improvement to ensure when the use of physical intervention was required, staff always utilised approved techniques. During our review of incidents reported in the service against corresponding closed-circuit television cameras (CCTV) footage we identified further concerns about the way some staff used physical interventions with people who used the service. In one incident we saw two staff use an unapproved physical intervention to lift and drag a person to their room.

We were not assured staff always followed the care and treatment plans of people who used the service. This was a concern shared by staff who commissioned care and treatment at the service and January 2022 governance records in the service also recorded concern about staff's adherence to care plans. Our review of incidents reported in the service against corresponding CCTV footage showed staff present did not always follow plans to de-escalate and safely manage behaviour that challenged. We saw examples where staff blocked doorways to prevent a person who used the service from leaving a room, and where staff used closed or intimidating body language during incident. In another piece of CCTV footage, we saw the conduct of staff present appeared to torment or goad the person who used the service during an incident of behaviour that challenged. Staff had failed to identify and report this conduct as an incident in the service.

At the time of our inspection, the provider had suspended and was investigating the conduct of one staff member during a restraint. This increased following CQC and provider review of CCTV. Following our inspection and with the provider's increased reviews of CCTV, seven incidents of staff practice or conduct concerns had been identified. The provider had identified eight staff directly involved in these incidents, five of which were agency staff. The hospital manager acted to stop or suspend these staff working in the service.

Between July 2021 and February 2022, the provider recorded 3,026 incidents in the service. Of these, 1,538 recorded staff use of physical interventions. Moneystone unit recorded 454 incidents with physical intervention, followed by Hawksmoor unit with 335. Only Farm cottage recorded no incidents with physical intervention. The provider included 'friendly come along' interventions in their recording, these accounted for 684 interventions in the service. This described low level interventions applied by one or two staff members to redirect a person from potential harm.

Between July 2021 and February 2022, the provider recorded four incidents of prone, face down, restraint in the service. The provider noted staff either disengaged or turned the individual back to supine, face up, if it was unsafe to disengage.

Between July 2021 and February 2022, the provider recorded 19 incidents of rapid tranquilisation (RT) in the service. During the inspection we observed one incident of RT. We saw staff monitored the person's physical observations following administration of RT and completed detailed records of the incident.

Between July 2021 and February 2022, the provider reported one episode of long term segregation (LTS) in the service. This commenced in January 2022 and remained in place at the time of our inspection. The person subject to LTS was awaiting transfer to a higher security hospital. The provider had a plan in place that included the reason why LTS was started, access to occupational therapy and activities and gave consideration of what the individual needed to achieve for LTS to be terminated. Records demonstrated appropriate internal reviews and monthly review by a psychiatrist not involved with the case. The person subject to LTS had access to a secure outdoor space, a bathroom, a bedroom and a lounge area. During the inspection we saw the person regularly accessed the hospital grounds with staff, this provided opportunities to socialise with other people using the service. The person talked to us about community activities they'd enjoyed whilst subject to LTS.

Following our previous inspection, we told the provider they must ensure staff complete body maps in the event of any physical intervention being used. We found this had improved. Staff we spoke with knew when to complete body maps

and where to record this information. In January 2022, staff audited the completion of body maps in the service and this demonstrated good outcomes. Senior staff reviewed all incident reports during daily morning meetings. Where omissions were found, including body maps, they returned the report for completion by the responsible unit team. Our review of incidents reported in the service against corresponding CCTV footage demonstrated that when staff recorded the use of physical interventions as an incident, they had also completed a body map for the person involved in that incident.

Staff completed audits of restrictive practices in the service. The audit identified the impact of the restriction to people who used the service and actions to eliminate or reduce the restriction. For example, for people with limited or no access to the internet, the introduction of internet safety education proposed to reduce this restriction.

The provider required staff working directly with people who used the service to complete management of violence and aggression (MVA) training. At the time of our inspection, the provider recorded a completion rate of 89%. Prior to working shifts, the provider ensured agency staff had MVA training that aligned with their own.

**Safeguarding**

**Staff had training on how to recognise and report abuse, but it was not clear how they applied it. Staff had not always identified and escalated abuse or improper treatment of people who used the service. However, the provider took immediate and appropriate action to the concerns we raised to them.**

The provider required staff working in the service to complete adult and child safeguarding training. Staff competed safeguarding training that was appropriate to their role in the service. When we inspected the service recorded a staff completion rate of 90%. The provider had an identified safeguarding lead in the service.

We were not assured staff always identified and escalated concerns of abuse or improper treatment of people who used the service. We asked staff what they would do if they had a concern about the way a colleague used physical interventions with people who used the service. All identified they would escalate the concern to a manager. However, during our review of reported incidents against corresponding closed-circuit television cameras (CCTV) footage, we saw staff present, but not directly involved in the incident, had not identified or raised safeguarding concerns about colleagues' treatment of a person who used the service. Staff from the local authority safeguarding team shared this concern. They too questioned the ability of staff to identify and escalate potential safeguarding concerns from colleagues' practice or conduct with people who used the service.

In response to our concerns immediately raised to the provider, managers had implemented actions to protect people using the service from further ill treatment. This included immediate identification and removal of staff from the service, escalation of the concerns internally and externally to the provider, the identification of the most vulnerable people in the service and additional actions to protect them.

**Medicines management**

**Medication management at the service had improved. The service used systems and processes to safely prescribe, administer, record and store medicines. Staff knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).**

Inadequate

# Wards for people with learning disabilities or autism

Following our previous inspection, we told the provider they must improve to ensure staff followed systems and processes to safely administer, record and store medications. During this inspection we found staff practice had improved.

We reviewed medication charts from all units. We found them in good order, staff maintained a completed record of medication administered and recorded the allergies or drug sensitivities of people using the service.

Staff stored medications safely. When required, staff recorded and labelled medications with an opening date and the expiry date for that medication once opened.

The provider commissioned an external pharmacist to audit the medication management at the services. The audit was most recently competed in March 2022 and rated the standard of medication management as good.

Between July 2021 and February 2022, the provider recorded 17 medication errors in the service.

Our discussion with the responsible clinician confirmed the service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

**Track record on safety**

**Staff still did not always recognise incidents and report them accurately. Some processes to review incidents in the service were not robust enough to ensure safety and quality for people who used the service. However, once identified the provider took immediate action to respond to our concerns.**

Following our previous inspection, we told the provider they must ensure staff report all incidents, including the correct and appropriate information. During this inspection, our review of incidents reported in the service against corresponding closed-circuit television cameras (CCTV) footage showed staff still did not always report all incidents that occurred, and some incidents reported were still not an accurate account of the event.

During the inspection we reviewed incident forms completed by staff against the corresponding CCTV footage for that incident. We looked at incidents reported in the service from 21 February 2022 onwards, of the 10 reviews completed we found seven incidents recorded accurately by staff. In one example not recorded accurately, staff reported attempted verbal redirection with a person who used the service during an incident of behaviour that challenged. Our review of the corresponding CCTV to this incident did not support what staff had reported. During this review we also identified a concern that had not already been identified or reported in the service. The concern was about the conduct of staff to safely manage behaviour that challenged with a person who used the service. During our return to site on 8 March 2022, we reviewed five more incidents reported in the service and found all had been recorded correctly and appropriately when compared to the corresponding CCTV footage.

When we inspected, arrangements to review incidents against CCTV footage had not been sufficiently robust to protect all people who used the service. Managers reviewed only a random sample of CCTV footage for incidents that identified no harm or low harm to the person involved in the incident. Prior to our review of CCTV footage and identification of concerns, managers had told us about plans to implement a daily rota for managers in the service to randomly sample and review live CCTV footage in the service. The value to identifying safeguarding concerns in the service was noted. The

provider responded promptly to our concerns identified during the inspection and additional reviews of CCTV footage were introduced. This included random sampling of CCTV footage throughout the 24 hour period and CCTV footage review of all incidents recorded with people in the service identified as being the most vulnerable. During our return to site on 8 March 2022, we reviewed six episodes of CCTV footage and identified no staff practice or conduct of concern.

Between July 2021 and February 2022, the provider recorded 3,026 incidents in the service. The provider categorised the incidents as 2,332 violence and aggression, 365 self-harm and 129 environmental. Of the 3,026 recorded incidents, 1,667 were categorised as Level 1-no harm and 1,236 as Level 2-low harm. For example, a Level 2-low harm incident might require staff to provide some first aid to the person involved.

Multidisciplinary staff and managers met daily at morning meetings. The meeting included review and sign-off of all incidents reported in the service the previous day. Incidents reports with insufficient details or missing essential information were returned to ward staff for completion. Senior staff also met weekly for an incident analysis group. Records showed the group reviewed incidents reported for each person who used the service, noting increases or decreases and factors that might have contributed to changes. In some instances where an increase in incidents was identified, we saw details of additional staff actions to better support that individual.

Staff received feedback and learning from investigation of incidents. Managers circulated emails to all staff with learning and changes to practice identified from incident investigations. When we returned to site on 8 March 2022, staff we spoke with confirmed managers had communicated our concerns and shared immediate learning. Staff also identified learning was shared from incident investigations that occurred in the provider's other locations.

## Are Wards for people with learning disabilities or autism effective?

Insufficient evidence to rate

**Best practice in treatment and care**

**Staff supported people to make healthier choices but weight gain for some people who used the service was a concern. Staff participated in the provider's programme of clinical audit.**

The provider employed two dedicated physical health co-ordinators at the service. Staff supported people who used the service to access physical healthcare in the community, this included registration with a local general practice. The service had accessed dental and chiropody services specialist in meeting the needs of people with a learning disability.

Prior to the inspection, concerns were raised directly to CQC about excessive weight gain in some people who used the service. During the inspection we saw similar concerns recorded in commissioner feedback and one family member spoke specifically about their relative's weight gain. Managers told us wherever possible staff monitored the weight of people who used the service and developed healthier living plans with people. The provider had recently reviewed menus to give people more healthier choices and plates to support portion control had been ordered. Staff recognised weight gain as a concern in the service and told us they supported people to make healthier choices whenever possible. Clinical governance meetings in the service included discussions on actions to monitor and promote healthier living in the service. One person who used the service told us they wanted to lose weight and received staff support to work towards their goal.

Inadequate

# Wards for people with learning disabilities or autism

During our previous inspection, people who used the service and staff told us there were not enough vehicles and drivers in the service to facilitate Section 17 leave and access to the community. The provider had four vans and three cars available in the service. Two staff we spoke with felt the service continued to have too few vehicles and one person in the service told us it was sometimes challenging to find a designated driver. The provider was recruiting to four driver roles, recently created in the service. The role proposed assistance for staff travelling to and from the service, and additional support for people using the service to access the community.

Staff took part in clinical audits. We saw the outcome of the service's infection prevention and control audits and medicine management audit supported our observations of practice during this inspection. Staff completed observation and engagement audits supported random sampling of closed circuit television camera (CCTV) footage. Where audits identified shortfalls in practice, they were accompanied by actions to support improvement.

**Skilled staff to deliver care**

**The service had access to the full range of specialists required to meet the needs of people using the service. Managers had improved access to specific training in supporting females and access to supervision. Managers took appropriate action when poor staff performance was identified.**

The Woodhouse Independent Hospital had access to a full range of specialists to meet the needs of the people using the service. This included occupational therapists, psychologists, physical health co-ordinators and a speech and language therapist.

Following our previous inspection, we told the provider they must ensure all staff working on the female unit (Hawksmoor) were provided with specific training in supporting females. Staff now told us they had accessed training specific to supporting females and knew how to access updates and further training.

During our previous inspection, the provider reported a staff supervision completion rate of 67%. We told the provider they must ensure all staff, including agency staff, received regular supervision in line with their policy. The hospital manager reported it had been a challenge to provide regular and structured supervision during periods of the COVID-19 pandemic. We saw improvements had been made for permanent staff, and staff we spoke with reported access to regular supervision. In March 2022, the provider recorded a completion rate of 86% for permanent staff. Managers had updated the services supervision structures to include bank staff and the agency staff who worked most regularly at the service. The provider's policy detailed the frequency of supervision for permanent and temporary staff. As at March 2022, the provider recorded a completion rate of 45% for temporary staff.

Managers took appropriate action when poor staff performance was identified. This included allegations of ill treatment of people using the service, conduct during physical interventions and sleeping when on duty. During the inspection, when we identified concerns about staff conduct with people who used the service, managers acted immediately to identify those staff, suspend them from duty and escalate the concerns both internally and externally. We were assured by managers immediate actions to protect people using the service from further ill treatment.

**Multi-disciplinary and interagency teamwork**

**Feedback from teams with people placed at the service was not always positive and supported concerns we identified during our inspection. However, we also saw positive feedback particularly about the progress some people placed at the service had made.**

Inadequate

# Wards for people with learning disabilities or autism

Following the onsite inspection, we spoke with members of the local authority's safeguarding team. They told us it was not always easy to obtain information from the service. They identified an over reliance on external organisation to identify concerns in the service and concern over the number of safeguarding incidents related to staff practice and conduct with people using the service. They questioned if all staff recognised concerns about practice or conduct as a safeguarding incident and knew what action to take to protect people in the service.

Following the onsite inspection, we spoke with the commissioning team of one person using the service. This was the team of the person for whom our review of closed-circuit television cameras (CCTV) footage had identified concerns. Their review of the same CCTV footage identified staff had not followed the persons plan to manage or de-escalate behaviour that challenged. They too were concerned of the ability of staff to recognise practice or conduct concerns as a safeguarding incident and the service's reliance on external organisations to identify concerns.

We reviewed feedback from other commissioning services with people placed at the service, recorded between October 2021 to February 2022. Some commissioners reported positively identifying few concerns, good understanding of individual needs and good progress for the person placed there. However, we also saw concerns recorded about the failure of staff to identify or escalate practice or conduct concerns they'd observed, incidents as a result of a lack of staff supervision and processes to review closed-circuit television camera footage not being robust.

## Are Wards for people with learning disabilities or autism caring?

Inadequate

Our rating of caring went down. We rated it as inadequate at this inspection.

**Kindness, privacy, dignity, respect, compassion and support**

**Some staff did not always treat people who used the service with compassion and kindness. However, many other staff knew people as individuals and treated them well. They supported people to express themselves as individuals and supported positive expression of sexuality.**

Staff did not always treat people using the service with compassion and kindness. We reviewed closed-circuit television camera (CCTV) footage of 11 incidents that occurred in February 2022. We saw examples of unprofessional behaviour and ill treatment of one person who used the service in the CCTV footage of three incidents. This included staff not following plans to manage behaviour that challenged, staff behaviour that looked like tormenting or goading of the person who used the service, an inappropriate use of force to manage behaviour that challenged, dragging and lifting the person who used the service during incident. We also saw some staff demonstrated impatience when they responded to behaviour that challenged and demonstrated closed or intimidating body language. This included folded arms and standing over the person who used the service. The conduct of one staff member, present in all three incidents, and was of particular concern to us. We also noted that staff present, but not directly involved in the incidents, had not identified or raised safeguarding concerns about their colleagues' treatment of the person who used the service.

However, our observations of staff conduct and behaviour with people using the service during the inspection was more positive, including positive engagement and interactions. People who used the service knew the staff supporting them. Many were keen to tell us about the care and kindness of staff, reporting staff "look after me", "help me" and "go out with me". We heard staff asking people if they wanted help and offering people choices. People knew their plans for the day, and we saw staff encouraging people to be involved. Staff knew individuals' hobbies and preferences.

We saw staff knew and supported people using the service as individuals. Many people using the service had a strong sense of identity in keeping with their age, gender and culture. Individualism was important and staff enabled them to express themselves through fashion, hairstyles and jewellery. People told us staff supported privacy and access to resources that allowed them to express their sexuality. This was of particular importance to some young men using the service.

We saw many people accessing the community with the support of staff. This included shopping, leisure, health appointments and family visits.

**Involvement in care**

**Staff involved people to provide feedback and be involved in decisions about the service. Staff also ensured people had easy access to independent advocates.**

Where appropriate, the provider invited people who used the service to be involved in decisions about the service. One person using the service told us about how they'd been involved in and enjoyed local recruitment events and staff interviews.

Records from the service's clinical governance meeting demonstrated regular involvement by people who used the service.

The provider completed regular 'My Care' questionnaires with people who used the service. The questionnaire was in an accessible format and asked about feeling safe, being listened to and relationships with staff. The January 2022 questionnaire received 13 respondents. Of those, seven felt happy and safe at the service, eight felt involved in decisions about their care and nine reported staff asked them what they would like to do. Respondents were most positive about being supported to keep in touch with family and friends.

The hospital manager had introduced a weekly virtual meeting with people using the service. People using the service knew about this meeting and told us they looked forward to it. Following our inspection, the manager introduced conversations about feeling safe and what to do if they didn't feel safe.

People using the service had access to independent advocacy. The local authority commissioned the advocacy service and the provider purchased an additional resource to support people using the service at meetings and multidisciplinary reviews. We spoke with a member of the advocacy team, they were positive about the service's leadership team including their approachability, openness and responsiveness to staff practice and conduct concerns. The advocate felt listened to and able to offer challenge. However, they believed staff did not always follow plans for people using the service and did not always treat people well. The advocate questioned the ability of staff to identify and escalate safeguarding concerns arising from colleague's practice and conduct with people using the service.

**Involvement of families and carers**

Inadequate

# Wards for people with learning disabilities or autism

**The provider had made changes to improve communication and involvement of the family members and carers to people who used the service.**

Following our previous inspection, we told the provider they should ensure families and carers were provided with regular and timely information on their relative and were communicated with effectively. We saw the provider had made progress towards this. In December 2021, the provider created a family liaison role in the service. With the permission of the person using the service, they provided a point of contact for family and carers including updates, arranging visits and information about incidents. Staff told us the role was developing and embedding within the service. Of the four family members and carers we spoke with, two were familiar with the family liaison role.

Of the family members and carers we spoke with, three reported the service involved them in the care of people using the service. This included involvement in meetings and providing information on request. However, one felt staff could be more proactive in offering information rather than the family member or carer having to request it. One family member found the service difficult to contact and felt uninvolved in their relative's care. They told us that when they were invited to meetings, the invitation was often received at short notice and left them unable to attend.

The provider helped families and carers give feedback on the service. We saw the provider made feedback forms available to family members and carers visiting the service. The provider offered an annual family, friends and carers survey, which was most recently completed in May 2021. Of the nine respondents to the 2021 survey, six reported staff kept them up to date with information about their friends or relatives care.

## Are Wards for people with learning disabilities or autism responsive?

Insufficient evidence to rate

### Access and discharge

**The provider managed access to the service to help ensure safety and quality. When the needs of people who used the service changed, staff worked with external teams to find more suitable services for them.**

### Bed management

In September 2021 the senior leadership team decided to temporarily suspend admissions to the service. The decision was taken to support safe staffing as COVID-19 related absences increased in the staff group. At the time of our inspection, admissions continued to be suspended.

Between July 2021 and February 2022, staff had supported 13 people to discharge from the service. Many people had been discharged to services with fewer restrictions.

Between July 2021 and February 2022, the provider had served notice to the commissioning teams of two people using the service. The needs of both people had changed, and they had been assessed as suitable for more intensive and secure services. Staff worked with commissioners and NHS England and Improvement to identify suitable placements. At the time of our inspection, no suitable service had been found and both people remained at The Woodhouse Independent Hospital.

### Facilities that promote comfort, dignity and privacy

Inadequate

# Wards for people with learning disabilities or autism

**The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom There was access to outside spaces and quiet areas for privacy.**

Each person using the service had their own bedroom or self-contained apartment. We saw people had chosen to personalise their bedrooms and apartments to meet their own preferences. Staff supported people to do this. For example, assisting people to paint their bedroom in a colour of their choice.

All units had access to outside spaces. Many people accommodated in ground floor self-contained apartments had access to their own private gardens. We saw people chose to use their gardens in different ways. For example; one person had their own trampoline, and another planned to grow their own flowers and vegetables.

Each unit, including those with self-contained apartments, had communal areas where people using the service could meet, dine and participate in activities together.

The provider had installed a visitor's cabin in the hospital grounds to support family and professional visits during the COVID-19 pandemic. The cabin was heated, comfortably furnished and provided views of the countryside surrounding the service.

Many people using the service accessed their own mobile device to make calls from. Those without them told us they could use the service's facilities to make calls from and staff provided them with privacy to do so.

People using the service told us they were provided with meal choices, but they found the quality of food was not always good. The hospital manager met weekly with people who used the service and food was a standing agenda item for discussion. People told the hospital manager what they had enjoyed or when they had concerns about food. In response to feedback, staff had recently reviewed menus and tasting events were planned for people who used the service and staff. Staff also supported and encouraged people to plan and prepare their own meals.

**Patients' engagement with the wider community**

**Staff supported patients with activities outside the service, such health and leisure and family relationships.**

People using the service could choose to be involved in paid site based work opportunities including van maintenance and staffing the hospital's shop. Staff told us they were seeking more community based activities as COVID-19 infections and restrictions reduced. This included local education and voluntary opportunities.

Our conversations with people who used the service, confirmed staff helped them to stay in contact with families and carers. This position was also supported by family members and carers.

**Listening to and learning from concerns and complaints**

**People who used the service knew how to complain or raise a concern.**

In our conversations with people using the service, we specifically asked four if they knew how to complain or to raise concerns. All responded positively and felt confident about raising a concern.

Inadequate

# Wards for people with learning disabilities or autism

Between July 2021 and February 2022, the provider recorded seven formal complaints in the service. We saw the service had received complaints from family members, commissioners and an advocate. Staff managed these complaints appropriately and with oversight from the service quality and compliance manager. Staff consulted with complainants around any delay in responding to the concern raised.

The provider maintained a record of all complaints made in the service, including those raised verbally. Staff met at clinical governance meetings to discuss themes or trends arising from complaints in the service.

## Are Wards for people with learning disabilities or autism well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement at this inspection.

**Leadership**

**Staff experience of leadership in the service had improved. The provider had invested in leadership at the service and supported local decisions to support safety and quality during the COVID-19 pandemic.**

Following our previous inspection, we told the provider they must ensure managers were visible and approachable for people who used the service and staff. We found this had improved. The provider had recruited a combined deputy hospital manager and lead nurse. The deputy hospital manager and unit managers were now accommodated in clinical areas rather than the service's administration building. During the inspection we saw managers were visible and approachable to all. People who used the service knew managers well, we saw managers gave them time and knew them individually. Staff feedback on the visibility and approachability of all managers was positive.

Between December 2021 and February 2022, senior managers made six out of hours unannounced visits to the service. However, there was no identified frequency to the visits. Out of hours visits supported managers visibility and accessibility in the service and also provided an opportunity to observe staff practice and conduct.

The hospital manager made decisions to support safety and quality at the service. To support safe staffing during the COVID-19 pandemic the hospital manager paused admissions and later closed one unit, deploying the staff to teams across the service. Following our previous inspection, the hospital manager agreed to monthly engagement with CQC to monitor performance and improvement in the service. The provider supported the hospital manager's decision.

**Culture**

**Staff now felt respected, supported and valued. They felt confident to raise concerns and described an open culture at the service. However, the provider's audit and the experience of staff of the service's culture did not support all of our observations during this inspection.**

All staff we spoke with felt respected, supported and valued. This had improved since our previous inspection. Staff identified the hospital manager supported staff and regularly thanked staff for their work.

Inadequate

# Wards for people with learning disabilities or autism

Following our previous inspection, we reported the service must ensure there is a robust system in place that was adhered to, for staff to raise concerns, including verbal and written, without fear of retribution. This had improved. Staff we spoke with knew how to raise concerns in the service, felt confident to do so without fear of retribution. The service had a concerns tracker in place that clearly identified when, how and to who concerns had been raised to. The tracker demonstrated staff sometimes did identify and escalate concerns about the practice or conduct of colleagues with people using the service. Since January 2022, we saw two concerns categorised as staff conduct concerns.

In December 2021, the provider audited the service with a tool designed to support identification of warning signs of a closed culture. A closed culture is a poor culture in health or care services that increase the risk of harm. The audit had identified one area of high risk, poor and weak management and leadership, and one area of medium risk, the use of restrictions and restraint. Many staff we spoke with described an open culture at the service. However, during the inspection, we saw evidence to support the presence of a closed culture including ill treatment from staff and failures to speak up or report ill-treatment observed towards a person who used the service.

**Governance**

**Not all governance processes had ensured safety and quality in the service, particularly for the most vulnerable. However, the provider took immediate actions to the concerns we identified during the inspection.**

At the time of our inspection, some processes did not appear sufficiently robust or established to ensure safety and quality for all people who used the service and particularly those most vulnerable. Concerns remained about the way some staff managed incidents or behaviour that challenged, including not always following individual plans and not always using approved physical intervention techniques. Staff sometimes failed to identify and escalate all incidents in the service, particularly concerns about the practice or conduct of colleagues, and incident reports made were not always a true and accurate account. One commissioning team told us they had identified and raised similar concerns to the provider in 2021, the provider's resulting actions had not been robust enough to protect one particularly vulnerable person who used the service. However, when raised to the provider the response to our concerns was immediate, robust and provided assurance. This included plans to address closed-circuit television camera (CCTV) blind spots in the service, monitor live CCTV footage, additional reviews of incidents reported in the service and staff support to identify and challenge practice concerns of colleagues.

During this inspection, we also saw the provider demonstrated improvement and progression to meet many of the warning notice and requirement notices issued after our previous inspection. They described the challenge of managing safety and quality during the COVID-19 pandemic. Staff deployment and supervision rates had only recently been improved as COVID-19 absences in the staff group had reduced. Staff had also been challenged to meet the needs of two people who required more intensive and secure services but remained at The Woodhouse Independent Hospital.

The provider operated established governance processes at the service. Senior leadership and multidisciplinary staff met monthly at a clinical governance meeting. Records of the January 2022 meeting included safeguarding, incident analysis, audits and risk. The hospital manager also attended a regional governance meeting. Records demonstrated information was shared back and forth between local and regional governance meetings.

**Management of risk, issues and performance**

Inadequate

# Wards for people with learning disabilities or autism

The provider held a risk register for the service. Managers reviewed and updated it during monthly clinical governance meetings. In January 2022 the highest risks identified in the service were COVID-19, quality issues identified in the previous CQC inspection, staffing, culture and people placed inappropriately at the service. The provider had also identified the risk of abuse by staff or by another person using the service, and risk of weight gain for people who used the service.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved. In particular:**<br><br>We found staff did not always use recognised interventions and approved physical intervention techniques to manage incidents and behaviour that challenged with people who used the service.<br><br>We found staff present but not directly involved in incidents where colleagues ill-treated people in their care, had failed to identify and escalate concern in what they had observed.<br><br>We found not all governance systems were sufficiently robust or always worked effectively to ensure safety and quality in the service. |