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?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this service went down. We rated it as inadequate overall and decided to place it in special measures.

The Care Quality Commission took immediate enforcement action and issued the provider with five warning notices for Regulation 9, Regulation 12, Regulation 13, Regulation 17 and Regulation 18. Summaries of the warning notices are available in the enforcement section of the report.

When a warning notice is issued, this normally limits the key question rating to inadequate.

When an independent healthcare service is in special measures it is the provider's responsibility to improve it. We expect the provider to seek out appropriate support to improve the service from its own resources, and from other relevant organisations or oversight bodies or both.

We will inspect the service again within six months of the report being published. If insufficient improvements have been made to justify a higher rating than inadequate overall or for any key question or core service, we will consider whether it is appropriate to extend special measures for a further six months, or whether to begin the process of preventing the provider from operating the service.

Special measures will give people who use the service the reassurance that the care they get should improve.

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.

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

- People were not protected from abuse and poor care. The service did not have enough, appropriately skilled staff to meet people's needs and keep them safe. Staff did not meet infection control precautions that were required to minimise and control the spread of seasonal respiratory infections or follow systems and processes to safely administer, record and store medicines.
- People were not supported to be independent and have control over their own lives.
- People did not always receive kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs.
- People's risks were not assessed and reviewed regularly. People were not involved in managing their own risks whenever possible.
- Comprehensive reviews were not completed to identify and reduce all restrictive practices in the service.
- People did not make choices and take part in activities which were part of their planned care and support. Staff did not support them to achieve their goals.
- People's care, treatment and support plans, did not reflect their sensory, cognitive and functioning needs.
- 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 follow best practice. Staff did not produce effective clinical and quality audits to evaluate the quality of care.

Summary of findings

- The service did not provide care, support and treatment from trained staff and specialists able to meet people's needs. The mandatory training and induction programmes were basic, and the service had not identified all training courses needed to meet the needs of autistic people and staff. Many staff had no prior experience of working with autistic people.
- Autistic people and those important to them were not actively involved in planning their care. The multidisciplinary team lacked consistent input from occupational therapy, psychology and speech and language therapy roles.
- Autistic people did not have all their communication needs met.
- People in hospital were not receiving active, goal-oriented treatment. Staff did not always work well with services that provided aftercare.
- Staff did not support people through recognised models of care and treatment for people with a learning disability or autistic people. Leadership and governance processes did not help the service to keep people safe, protect their human rights and provide good care, support and treatment.
- Autistic people, and those important to them, did not work with leaders to develop and improve the service.

However:

- Autistic people's care and support was provided in a clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- Managers had ensured that staff, including regular agency and bank, had regular supervision and appraisal.
- Advocates were actively involved in reviewing autistic people's care.

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

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Summary of this inspection

Background to The Breightmet Centre for Autism

The Breightmet Centre for Autism is an independent hospital which is provided by ASC Healthcare Limited. It is situated in the Breightmet district of Bolton, Greater Manchester. The provider is registered to deliver the following regulated activities from this location:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

The centre provides enhanced services and support to adults with a learning disability or autism, who are either detained under the Mental Health Act or admitted informally. The hospital takes admissions from across the country.

The hospital has a registered manager who had been in post for four months.

The hospital accommodation is divided into four separate wards across two floors. Each ward has four or five-bedrooms with en-suite facilities and shared communal spaces.

The wards interconnect and link to an annex which contains staff offices and further shared spaces such as the activity room, sensory and family room.

There were 17 autistic people staying at the hospital during the inspection. All patients were detained under the Mental Health Act.

The hospital was registered with the Care Quality Commission in 2013. There have been eight previous inspections. The last inspection was in November 2020. We rated the provider good overall, and in the effective, caring, responsive and well led domains. We rated the safe domain requires improvement and issued one requirement notice. This was because:

- The hospital was not following government guidance in the way in which it was managing infection prevention and control.
- It was not always clear from staff duty records that the service had enough support staff to ensure that observations of autistic people were carried out to the prescribed levels.

During this unannounced inspection, we checked that actions which related to previous requirement notices had been carried out. We found that the actions around managing infection prevention and control had not been met but that staff allocations for observations had improved.

What people who use the service say

We spoke with five autistic people using the service, six families or carers and one advocate. We reviewed community meeting minutes and patient and carer surveys.

Feedback from patients was mixed. One patient had positive feedback about the consultant psychiatrist and occupational therapy assistant but found other staff unsupportive. They did not like how staff spoke to them and did not like the service. Another patient said that staff laughed at them and talked about things that triggered them. When asked if they knew how to raise concerns the patient replied, 'Yes but they wouldn't listen anyway'.

Summary of this inspection

Another patient said that they were generally happy in the service, felt safe and that staff tried their best.

Feedback from families and carers was poor. All six families described issues with communication. They described communication as 'appalling'. Two families described how the service did not provide updates when their relatives tested positive with covid and all families and carers said that staff did not respond to emails or phone calls.

Five of six families described staff as being defensive when issues were raised and said they were made to feel unwelcome on the wards. One family member said, 'When causes of concern arise their reaction is to deflect the complaint and to cover themselves'.

Two families said that staff, 'have no understanding of autism' and that the quality of care was 'atrocious' or 'very poor'.

Three families raised concerns about the lack of ethnic diversity of staff because of how this impacted on communication. Many staff spoke English as a second language. Families said their relatives struggled to understand what staff were saying.

All six families that we spoke with, one advocate and one patient said there was a lack of therapeutic activities on the ward. One relative told us, 'If they do go out, they only go to the local shop nearby to buy food'; Another said their relative does not, 'do activities apart from a walk to the local park, and they are there, and back, within ten minutes.' Another said that the only activity they knew of was baking.

All six families shared concerns over staffing. One family said that the service was, 'heavily reliant on bank staff especially at weekends when incidents happen'. Another three families said that the service, 'runs on support staff' and there was a lack of continuity of care. All families said that there had been no occupational therapist or speech and language therapist for months and that there was limited input from a qualified psychologist.

One family said that their relative was desperate to get out of the service.

However, two families did say that their relatives did have positive relationships with some of the staff and one family said that there had been an improvement in their relative's mental health since being admitted.

How we carried out this inspection

We inspected this service in response to safety concerns that had been raised about the care and treatment of people using the service. We initially focused on the safe domain and areas of the effective domain but extended the inspection to include all five key questions.

The team that inspected the service included three CQC inspectors, one assistant inspector, one nurse specialist advisor and one expert by experience.

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for feedback or information about the service.

During the inspection visit, the inspection team:

Summary of this inspection

- Looked at the quality of the environment and observed how staff were caring for people using the Short Observational Framework (SOFI) tool
- Spoke with five people who were using the service and one advocate
- Spoke with six families or carers of people who were using the service
- Spoke with the registered manager and the executive director of clinical services and governance
- Spoke with 19 other staff members; including nurses, support workers, occupational therapy assistants, chef, IT support, clinical lead and the consultant psychiatrist
- Spoke with 14 commissioners and received feedback from eight referring organisations, commissioners and the host commissioner
- Attended and observed one handover meeting and one multidisciplinary team meeting
- Looked at eight patient care and treatment records
- Reviewed close circuit television footage (CCTV)
- Carried out a specific check of the medicines management; and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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

Action the service MUST take to improve:

- The service must ensure that staff take all infection control precautions to keep autistic people safe. (Regulation 12 (2)(h)).
- The service must ensure that staff follow systems and processes to administer medicines safely, complete medicines records accurately and keep them up to date. The service must ensure that clinic rooms contain all expected equipment, are organised and that audits identify any issues. (Regulations 12 (2)(g)).
- The provider must ensure that all staff receive appropriate training in safeguarding adults and children suitable to their role so that staff can identify and take action when safeguarding's occur. (Regulations 13 (2)(4)(b)).
- The provider must ensure that there are enough suitably qualified, skilled and experienced staff to meet autistic people's needs. (Regulations 18(1)).
- The provider must ensure that staff receive an induction which is appropriate to meet the needs of autistic people within a specialist autism service. (Regulations 18(1);17(1)(2)(a)).
- The provider must ensure that patients' risk assessments accurately reflect patients' risks and that these are reviewed and updated in line with the providers policy. (Regulations 12(2)(a)).
- The provider must ensure that staff undertake effective functional assessments when assessing the needs of autistic people. The provider must work with autistic people, families and carers to develop individual care and support plans and update them as needed. (Regulations 9(3)(b)).
- The provider must ensure that care plans are contemporaneous, accessible, personalised, holistic and strengths based and reflect the assessed needs of the patient.(Regulations 17(1)(2)(a)(c); 9(3)(b)).
- The provider must ensure that prescribed observations are delivered in a way that meets best practice guidance and the providers policy. (Regulations 17(1)(2)(a)).

Summary of this inspection

- The provider must ensure that restrictive practices are regularly reviewed and documented in a collaborative way with autistic people, carers and all staff groups involved in care. (Regulations 17(1)(2)(a)).
- The provider must regularly review and reflect on incidents of restraint to ensure that autistic people's human rights are being upheld. (Regulations 17(1)(2)(a).
- The provider must ensure that lessons learnt on safeguarding, incidents, complaints and reflective practice is shared with staff. (Regulations 17(1)(2)(a).
- The provider must ensure that they provide a range of treatment and care for autistic people based on national guidance and best practice to meet their individual needs. (Regulations 9(3)(b)).
- The provider must ensure that they create a culture where autistic people, carers, families and professionals are able to speak up, share concerns, raise complaints and feel listened to. (Regulations 16(2); 17(1)(2)(e)).
- The provider must ensure that autistic people and their families or carers, when appropriate, contribute to all aspects of care and treatment. (Regulations 17(1)(2)(a); 9(3)(b)).
- The provider must ensure that governance processes operate effectively at team level and that performance and risk are managed well. (Regulations 17(1)(2)(a)(b)(f)).

Action the service SHOULD take to improve:

- The service should ensure that the on-call rota process is reviewed.
- The provider should ensure that staff receive debriefs following incidents on the wards.
- The service should ensure that staff participate in effective clinical audits, benchmarking and quality improvement initiatives.
- The provider should ensure that they work collaboratively and involve autistic people, carers and families in decisions about the service.
- The provider should continue to work on creating open, positive working relationships with external teams and organisations.
- The service should ensure families are given information about carers assessments.

The provider should consider having support workers attend ward rounds and multidisciplinary meetings.

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	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not safe. Staff did not meet infection control precautions that were required to minimise and control the spread of seasonal respiratory infections.

However, wards were clean, suitably furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. The service kept clear environmental records that were updated regularly.

Staff could observe patients in all parts of the wards. Staff were allocated to each patient on observations.

There was no mixed sex accommodation. There were separate male and female wards. However, staff completing observations or restraining autistic people were not always the preferred gender. A number of male staff were seen to be observing female patients. Families and carers shared their concerns about how this did not protect their relative's privacy and dignity. Patients were not always fully clothed and although staff encouraged autistic people to wear clothes some chose not to. Staff told us that when male staff restrained female patients, female staff would ensure that autistic people were covered. This was visible in the care plan. Additionally, another patient on the ward responded more positively to male staff so their preferred gender was being met.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. Environmental assessments included photographs of potential ligature risks in the hospital environment to support staff understanding. Ligature cutters were accessible to staff.

Staff had easy access to alarms and the response team always arrived quickly. One member of staff from each ward was allocated to the response team as was the nurse on duty.

Inadequate

Wards for people with learning disabilities or autism

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. The service had created a low stimulus environment with suitable lighting. Corridors were wide and allowed enough space for staff to observe and for patients to move freely.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff did not follow the infection control policy, including handwashing. This was identified as an issue at the last inspection in November 2020 and had not improved. Following the last inspection, the provider's action plan stated that all staff including those in non-clinical areas should be wearing masks. However, we saw that staff in reception, on wards and in office areas were not wearing masks. This included managers, administrative staff, qualified nurses, support workers and cleaners on all the three dates of the inspection. Staff in offices were not wearing masks and were not social distancing. Staff also wore masks incorrectly; below the nose and under chins. Staff were not observed to use hand gel when moving between wards and were not bare below the elbow. CCTV reviews also showed that staff did not always wear masks in line with guidance. The provider policy, last updated 24 February 2022, stated that masks must be worn in clinical areas and that hand hygiene procedures were still required. The policy also recognised that patients in the service were clinically vulnerable. In January 2022, the registered manager told the Care Quality Commission that the service expected staff to wear masks correctly and that senior staff would enforce this. Following the inspection on 8 and 9 March 2022, the registered manager gave assurance that all staff would wear masks appropriately. However on 22 March 2022 on a return visit, we continued to observe staff not wearing masks when escorting a patient to hospital; 11 staff in the main reception not wearing masks, five staff in the handover meeting were not wearing masks and the only nurse on duty, who was covering all four wards, was not wearing a mask. This meant that staff were potentially exposing vulnerable patients to avoidable risk of infection.

Clinic room and equipment

Clinic rooms were not fully equipped. The clinic rooms were missing some expected items and the room cupboards were disordered and disorganised.

Clinic room cupboards were messy and labels on the doors did not reflect the contents inside. There was a lack of order for stock medications, archived medicines charts, medicines pots and syringes. The controlled drug cupboard stored lorazepam and there were unnecessary items including a screwdriver in one of the cupboards. One of the two sharps bins was undated and unnamed. The clinic room sink was unsuitable because the plug and overflow were covered. There was not the full array of expected equipment available. The clinic room did not have a measuring tape, clinell wipes, opthalmoscope/auroscope or Snellen chart. We observed that there was a bottle of cola stored in the medicine's fridge on both days of the inspection. This had not been removed after we raised this issue on the first day. Following the inspection, the provider confirmed that the missing clinic room items were accessible elsewhere within the hospital.

However, the service had accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff also checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing staff with the appropriate training to keep autistic people safe from avoidable harm. However, some staff knew the patients well.

The service did not have enough numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. There were not enough nurses on shifts, and the service did not have a full multidisciplinary team. The service relied heavily on their own agency and bank staff to meet autistic peoples' needs.

Inadequate

Wards for people with learning disabilities or autism

Nursing staff

The service did not have enough nursing and support workers to keep people safe. Managers did not accurately calculate and review the number and grade of nurses for each shift. There were two qualified nurses on each day shift and one qualified nurse at night covering four wards with up to eighteen patients. The Care Quality commission reviewed night shift rotas from 01 February to 28 February 2022 (excluding 5 February as this rota was not provided); 24 night shifts had one qualified nurse on duty and three shifts had two across this period. Staff told us that there were not enough qualified nurses to manage patient care when completing other administrative duties. The executive director of clinical services and governance explained that the service was recruiting an additional administrator and another three clinical leads to support staff on day and night shifts. This was in response to two nurses that had resigned due to work pressures.

The service had high rates of bank and agency support staff. The service used its own agency to staff the service and fill the staffing gaps. Managers said that where possible, they used agency and bank staff that were familiar with autistic people in the service. The provider considered their own agency staff as bank staff. Families described staff interactions as mixed and said that staff at the weekends did not know their relatives. Staff said they needed more nurses and described how some agency workers were unmotivated and would not turn up to shifts. Two members of staff said that although recruitment was ongoing, staff did not stay long.The Care Quality Commission had also received complaints that some agency staff had fallen asleep while on patient observations and that they did not wear masks on shifts.

We reviewed a selection of rotas from 5,6 and 8 March and saw one registered nurse, 18 agency staff, 10 bank staff and 4 permanent support staff on one of the night shifts. The service had one registered nurse, 16 agency staff, three bank staff and four permanent support staff on another night shift and two registered nurses, 15 agency staff, nine bank staff and six permanent support staff on the day shift.

On 24 March 2022, we requested a breakdown of bank and agency usage over the previous three-month period, however the service did not provide this until 26 days later, on 19 April 2022. The staffing breakdown provided showed that permanent staff worked the following percentage of shifts:

Day shift:

- January 2022 - 30%.
- February 2022 - 33%.
- March 2022 - 28%.

Night shift:

- January 2022 - 21%.
- February 2022 - 22%.
- March 2022 - 19%.

All other staff on these shifts were covered by bank staff, the provider's own agency or to a lesser extent, other agencies. In January, February and March external agency worked 17%, 9% and 6 % of day shifts and 6%, 1% and 2% of night shifts in the same period.

Following an incident in the service, we requested personnel information for two members of agency staff. One of the staff members, whose name had changed since starting employment, had applied to the provider's agency many years

before and we were informed that their record had been archived. However, since the staff member had only started working at the Breightmet Centre for Autism in August 2020, we could not confirm that all appropriate checks had been completed as there was no staff details available. Following the inspection, the provider shared the personnel files, with appropriate checks in place.

Staff, including the registered manager, told us that agency and bank staff did not always turn up for shifts. One staff member described how they had been left to observe a patient when there was not enough staff to meet the prescribed observations levels. They felt unsafe.

The registered manager explained that recruitment was ongoing, but that staff preferred the flexibility of working via the agency and bank. They explained that the service had recently increased pay and overtime rates for permanent support workers to encourage staff to take on permanent roles. The registered manager understood that permanent staff would ensure more accountability and consistency and overstaffed at higher risk points such as bank holidays and weekends in case staff did not turn up for shifts.

Managers made sure all bank and agency staff had an induction and were familiar with the service before starting their shift. All agency and bank staff were expected to complete the same training and induction as permanent staff. New starters had five days of classroom learning followed by one week of shadowing before working on the wards. The induction started with a half-day session on autism and learning disability, however the quality of this training was poor. Induction sessions also covered safeguarding, first aid, the Mental Health Act, the Mental Capacity Act, record keeping and three days of training in a recognised restraint approach. One member of staff said that a longer induction would be beneficial. Another said that they had not received specific in-depth information and described their induction as background information. They said that some staff received basic Makaton sign language and that how to sign sheets were available on the wards.

The service had high turnover rates. Two registered nurses had recently resigned due to work pressures and there was ongoing recruitment and induction for permanent staff including support workers.

The manager could adjust staffing levels according to the needs of the patients. The service had their own agency and could always access additional staff at short notice. At night, ward staff would call the rota coordinator/trainer to escalate staffing needs.

Autistic people had regular one- to-one sessions with their named nurse.

People using the service rarely had their escorted leave or activities cancelled, even when the service was short staffed, but the service did not always respond so that activities could be completed. Staff said that van drives could not always be accommodated because the demand was high and there were not enough drivers.

The service had enough staff on each shift to carry out any physical interventions safely. Staff were allocated to the response team each shift and all staff, including bank and agency were trained in a recognised restraint approach.

Staff shared information to keep people using the service safe when handing over their care to others. Handovers shared basic information such as mood, food and fluid intake, medicines taken, risk, incidents, physical health and trips out.

The on-call arrangements did not enable staff to maintain a good work life balance. Administrative staff, managers and clinical leads were on call every day. Staff would contact the rota co-ordinator/trainer to resolve staffing issues, the clinical lead for nursing issues and the registered manager for escalation or management issues out of hours.

Medical staff

The service had enough daytime and night-time medical cover; a doctor was available to go to the ward quickly in an emergency. However, one commissioner and one family said that there had been three different psychiatrists in post in the previous six months. The current psychiatrist had been in post since November 2021.

Managers used a locum that was familiar with the service when they needed additional medical cover. Managers made sure that the locum staff had a full induction and understood the service before starting their shift. The service had an associate doctor who covered the out of hours care and attended the service five hours each week as well as a locum psychiatrist to cover annual leave.

Mandatory training

The mandatory training programme provided was not of appropriate quality and the service had not identified all training courses needed to meet the needs of autistic people and staff.

We reviewed the autism training provided to staff and found it to be below the expected standard. Slides referred to people with autism where the recognised and preferred description is autistic people. Training slides provided did not explain the impact on individuals; behaviours that staff may see or why and how staff could respond and support people effectively. The training slides did not reference the Autism Act or the guidance, Think Autism, Equality Act. The training did not include Oliver McGowan training or reflect two of three main domains of an autism diagnosis in the international classification of diseases, social interaction and rigidity/focal repetitive interests. Multiple slides referred to children and education. For example, 'going back to class' and 'barriers to learning' yet the service is a specialised autistic service for adults. Training slides specified that the service was creating an environment that mimicked the community to prepare patients as quickly and as safely as possible. However, this was not seen to be the case.

Following the inspection, we asked the service if there were additional or different autism training materials that could be provided. We also asked for clarity on how the provider's autism training package met the Oliver McGowan training and autism best practice standards. The registered manager said that training met the requirements but that presenter notes were not written down as the trainer knew the content. No additional evidence was submitted.

The provider did not provide Positive Behaviour Support (PBS) training to staff. Positive behaviour support is a multi-component framework for delivering a range of evidence-based supports to increase quality of life and reduce the occurrence, severity or impact of behaviours that challenge. Staff use the framework to understand the meaning of behaviour for an individual and the context in which the behaviours occur. This understanding assists staff to design more supportive environments and to better support individuals in developing skills that will improve their quality of life. Although care records were written in a positive behaviour support manner, they lacked the in-depth information required to enable a formulation of risk and need. However, the service did use Antecedent, Behaviour, Consequence (ABC) charts to review behaviours and two staff members were able to provide a full description of patient care when asked. Following the inspection, the provider shared three new Positive Behaviour Support plans that were co-created with the patients, assistant psychologist and new psychologist in post after the inspection.

The provider had not identified and provided the correct level of safeguarding adults training and did not provide safeguarding children's training.

The service did not record the completion of Mental Capacity Act training out with induction or ensure that staff had regular refresher training. The quality of training delivered in the induction was poor and did not cover all the required learning from the Act.

Staff had completed and kept up to date with their mandatory training. Managers monitored and alerted staff when it needed updating. New starters had a three-month period to complete mandatory training.

Assessing and managing risk to peoples and staff

Staff assessed risks to people and themselves well but there was limited ongoing review and discussion of risk. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support peoples' recovery. The provider did not have a restrictive interventions reduction programme but had worked to reduce restraint.

Staff did not have the training to develop and implement robust and detailed positive behaviour support plans, however, they did anticipate, deescalate and manage challenging behaviour. Staff did attempt to avoid using restraint and seclusion by using de-escalation techniques but moved quickly to restraint on occasions.

Assessment of people risk

Staff completed risk assessments for each autistic person on admission, using a recognised tool. However, there was limited information in the formulation of risk sections, and we saw that monthly reviews frequently read 'no change'. One patient's record was most recently updated in November 2020 and the patient's views section was blank.

Management of risk

Staff knew about risks to each autistic person but there was limited planning and discussion to review and reduce risks. We reviewed eight ward round meeting minutes from 7 and 21 February 2022. Meeting minutes did not show a detailed discussion of risk. For example, patients' risk and incidents sections specified that their risk assessments and choking assessments were up to date and asked the nursing team to ensure care plans were in place. There was no discussion surrounding new risks or review of existing risks. Another patient had seven incidents recorded for the month, but the only additional comments said that incident charts were to be reviewed and there were no safeguarding concerns currently.

We reviewed six days of handover notes for 18 patients and although risk incidents were shared, we saw no plans for how to minimise risks on the next shift. The summary sheet on all sets of handover notes highlighted no change to risk, but in the patient information sections we saw that one patient's risks had increased and needed to be discussed with the consultant psychiatrist. There were other examples of risk relating to hostility towards staff, self-harm or periods of instability and agitation but an approach to minimise these was not recorded.

Staff could observe autistic people in all areas of the wards. Staff were allocated to each patient to complete prescribed observations. For the 18 patients using the service in January 2022, there were seven patients with three staff observing them, five patients with two staff, four patients with one staff member and two patients that were on hourly checks on day shift. On night shift there were five patients with three staff observing, seven patients with two staff observing, two patients with one staff member and four patients on hourly checks.

During the inspection we saw staff observing patients. Staff were allocated to observe autistic people for three hours at a time and breaks for day staff were allocated between 11.00 and 17:00. National Institute for Health and Care

Excellence (NICE) guidance recommends that staff do not undertake a continuous period of observation above the general level for longer than two hours. If observation is needed for longer than two hours, ensure the staff member has regular breaks. The allocation of observations was for longer than the recommendations and some staff worked eight hours without a break.

Staff followed the service's policies and procedures when they needed to search autistic people or their bedrooms to keep them safe from harm. Staff only searched rooms when they had concerns about risky items.

Use of restrictive interventions

We reviewed the service's restrictive practice audit tool and found restrictions were not continually reviewed. Some restrictions were not identified. The audit tool specified that kettles had been removed from the wards due to risks, property damage and injuries and that staff made hot drinks for patients on request. Staff said that there were restricted items on the wards, including glass, cups, mugs and kitchen forks, knives and spoons due to risk of harm. We observed plastic cups in use. These restrictions were not listed on the audit and managers were unclear what a blanket restrictions register was when we requested it.

Record keeping for individual patient restrictions was poor. We observed restricted practices on the ward that were not clearly recorded in patient care plans. One patient's bedroom was cleared of risky items, including the patient's drawers, but care plans did not record the decision making around this. Another patient had wanted to buy a laptop. This was declined due to risk, but the rationale for this restriction was not documented in the patient's care plan and the mobile phone care plan, which had a similar risk, was generic, undated and unsigned.

Some commissioners and visiting professionals said that they were not allowed to see patients on the wards and instead were limited to the family room when visiting the service.

Staff did not keep clear records and follow best practice guidelines when patients were placed in de-facto seclusion. The provider had no seclusion room, but we did see one instance where staff locked, and held the door closed, to keep a patient in their bedroom twice during an incident. We completed a CCTV review of four specific restraints and completed three spot checks. One incident showed staff dragging a patient to their room twice. Over a five-minute period, staff locked the door and held the door shut with their foot twice while other staff were in the room with the patient. Staff on shift did not raise this incident as a safeguarding referral. When this incident was raised with the provider, they acknowledged that staff holding the door shut was not acceptable practice and that one member of staff had moved the patient in a way that met the threshold for abuse and police involvement. The police did not take further action on this incident. The manager explained that after the incident, they reviewed the incident with staff and emphasised the expected standards and behaviours.

Staff did attempt to avoid using restraint by using de-escalation techniques, but staff did not always restrain only when these failed and in order to keep people in the service safe.

We observed one incident where staff behaviours escalated the restraint. Staff grabbed at the patient while they were running away, and four unnecessary staff surrounded the patient when the response team were restraining them. One member of staff was visibly agitated by the incident. We also observed staff appropriately deescalating an incident on ward one. Staff verbally redirected and minimised any use of their hands on the patient.

Staff did not participate in the provider's restrictive interventions reduction programme, but the executive director of clinical services and governance had shared a presentation on restraint reduction. This resulted in improved monitoring and documentation relating to incidents.

Levels of restrictive interventions were reducing. Staff described how prescribed observation levels and restrictive interventions reduced alongside patient risk. The provider monitored incidents of restraint including staff, position or type of restraint and duration etc. The provider also monitored and reported on the use of verbal de-escalation.

Staff followed NICE guidance when using rapid tranquilisation and usage was monitored by managers.

Safeguarding

Staff did not understand how to protect autistic people from abuse. Staff did not have the required training on how to recognise and report abuse, and they did not apply it. The service had a close relationship with the local safeguarding authority.

Staff did not receive training on how to recognise and report abuse, appropriate for their role.

The provider did not fully understand the training required or provide the correct levels to staff, appropriate for their role. Although staff kept up to date with their safeguarding training, the training level did not meet the expected levels for all staff. The provider told us that the online safeguarding adults training completed by staff was the equivalent of levels two to five and that all staff groups, including bank and agency completed this course. Best practice guidance stipulates that e-learning is appropriate for levels one and two but for levels three and above, it is expected that at least 50% of indicative education, training and learning time is of a participatory nature. For example, formal teaching/ education, conference attendance and group case discussion.

Additionally, the service did not provide safeguarding children training to staff as part of its mandatory training package in line with best practice guidance.

The provider had not embedded a safeguarding culture among staff. Since September 2021 the Care Quality Commission had been contacted by three families, three care professionals, one advocate and one patient all alleging disrespectful or poor treatment by staff. Two commissioners said they moved their patients to an alternative provider after safeguarding concerns were identified.

Most staff could not give examples of recent safeguarding within the service and one did not know what safeguarding was. However, some staff clearly described how to recognise adults and children at risk of, or suffering harm. They described the signs and told us they would escalate concerns to the senior support worker or nurse on duty.

Staff followed clear procedures to keep children visiting the ward safe. Children were only allowed in the family room on the ground floor.

Managers took part in serious case reviews and had close relationships with the local safeguarding authority. The local authority team visited the wards.

Staff access to essential information

Staff did not have easy access to clinical information, and it was not easy for them to review and maintain high quality clinical records – whether paper-based or electronic.

Patient notes were not comprehensive, and staff could not access them easily. All patient paper care records were stored in a locked cabinet on ward one. Staff told us that the ward nurse had the keys to unlock the cabinet. This meant patient records were not available to staff on each ward when needed. During the inspection, there were delays in accessing care records and both members of the inspection team reviewing patient documentation struggled to navigate the record keeping system.

The service did not keep accurate, complete, contemporaneous records. The service used a combination of electronic and paper files. There were paper care records stored on ward one and electronic patient documents that were stored on the shared drive. The executive director of clinical services and governance said that paper records were the master copies, and that all electronic documents were printed and attached to the paper records. We did not find this to be the case. We reviewed eight care records and found that staff did not keep records up-to-date and complete. Information in electronic and paper files differed. For example, one patient had different numbers of epileptic seizures recorded on the paper and electronic files. Care plans did not record when they were last updated. This was identified as an action following a Mental Health Act monitoring visit which took place on 19 July 2021. Communication, psychology and functional assessments were undated, but had an electronic 'last updated' tag from March and April 2021. These had not been updated since. One patient's record showed a review of four care plans in September and October 2021. The January 2022 entry stated no change and there was no narrative or discussion to evidence a full review.

Staff told us they updated the electronic files because they could access them. They told us they reviewed the paper care files on induction when shadowing and then relied on handovers for updated information.

Two members of regular agency staff were not aware of the patient's one-page profile and told us that they didn't often look at the care plans. Another had no previous experience of working with autistic people and said that they had not received any training on how to communicate with patients. However, they were able to describe actions that triggered patients.

Commissioners said that when patients transferred to a new service, there were delays in staff accessing their records and sharing information.

Medicines management

Staff did not follow systems and processes to safely administer, record and store medicines. However, staff did safely prescribe and regularly review the effects of medications on each person's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

We reviewed five prescription charts on ward one.

Staff did not follow systems and processes to administer medicines safely. Staff did not complete medicines records accurately and keep them up to date. We observed one qualified nurse administer controlled drugs with no witness or second signature. The qualified nurse removed the medicines book from the clinic room so that another member of staff could countersign after the medicines had been administered. The nurse did not complete a medicines count.

However, staff followed national practice to check patients had the correct medicines when they were admitted or moved between services and stored and managed all medicines and prescribing documents safely. Consent to treatment documentation was complete. Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). All prescribed medicines, including 'use as required' medicines, were within the safe prescribing range.

Staff reviewed the effects of each person's medication on their physical health according to NICE guidance. Staff reviewed patient medicines regularly and the consultant psychiatrist provided advice to autistic people about their medicines. All prescription cards were written in line with the organisational policy and there were no missing signatures or initials. Cards were stored securely and although messy and disordered, there were medicines information leaflets accessible.

We were unable to find a paper copy of the controlled drugs policy, but staff said this was available on the shared drive.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed safety incidents with autistic people well.Staff mostly recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave autistic people honest information and suitable support.

Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff completed a paper incident form that was reviewed by the clinical lead and investigated by the registered manager. Incident details were then scanned and transcribed to a spreadsheet and reviewed by the data manager.

Staff mostly raised concerns and reported incidents and near misses in line with the service's policy. When we informed the provider of a safeguarding incident that had not been reported, the manager spoke with staff to reinforce the service's expectations, action taken and potential performance management implications.

Managers investigated incidents. Autistic people and their families were involved in these investigations when appropriate. There was evidence that changes had been made as a result of feedback.

Staff understood the duty of candour. They were open and transparent and gave people and families a full explanation when things went wrong.

Staff said that they did not receive debriefs following incidents on the wards.

Lessons learnt information was limited. Although we saw that the manager completed a lessons learnt and reflective practice section when investigating safeguarding incidents, we did not see this shared at team meetings. The service held monthly team meetings to discuss feedback and look at improvements to care. However, meetings were ineffective and did not share all relevant information with staff. Team meetings did not share feedback from investigation of incidents, both internal and external to the service. We reviewed minutes from January and February 2022 and October and December 2021. None of the minutes provided included updates in the management messages, clinical governance or risk register sections and the relevant hospital issues section was blank. This section listed headings for compliments, complaints, concerns, whistleblowing, duty of candour, staff injuries, staffing levels and safeguarding. The

staff updates section had one new item between October and February and the service development, recruitment and vacancies and what we have done well sections were identical across the five-month period. In the supervision and appraisal section the discussion points and staff feedback were the same in all four meeting minutes. Staff told us that no one shared the team meeting minutes because the note taker had moved into a different role.

The service also provided extracts from seven morning meetings from December and January following the inspection in relation to specific safety incidents. We saw that managers asked staff to stay visible on CCTV or to ensure that they were always accompanied when supporting one patient who had made allegations against staff.

The service had no never events on any wards but we saw no evidence that managers shared learning with their staff about never events that happened elsewhere.

Are Wards for people with learning disabilities or autism effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not undertake effective functional assessments when assessing the needs of people who would benefit. They did not work with autistic people and families and carers to develop individual care and support plans and update them as needed. Care plans did not reflect the assessed needs and were not always personalised, holistic or strengths based.

We reviewed eight care records and saw that patients' care planning did not support their individual needs. Staff did not always complete a comprehensive mental health assessment of each person, either on admission or soon after. One patient admitted in June 2021 had no psychology or functional analysis of behaviour report and six of eight care records did not have a recent formulation to fully understand the patients' behaviours.

Although the physical health of autistic people was assessed soon after admission and reviewed during their admission, staff had not created comprehensive care plans for each autistic person that met all their mental and physical health needs. For example, the recording of epileptic seizures was not always correct. One entry did not clearly describe the severity or duration of an episode and it was not included in the epilepsy calendar. The person's physical health record identified their last seizure as 11 years ago and their health action plan was blank. One patient's seizure absence was not care planned even though it was identified on their admission documents. They also did not have epilepsy noted on their health action plan. One undated communication assessment and an undated psychology assessment had an electronic 'date created' tag of April 2021 and an undated functional assessment of behavior had a tag of March 2021. These had not been updated since. One patient's record showed a review of four care plans in September and October 2021. The January 2022 entry stated no change and there was no narrative or discussion to evidence a full review. Care plans did not record when they were last updated. This was identified as an action at the Mental Health Act monitoring visit which took place on 19 July 2021.

Care plans were not personalised, holistic or strengths-based. We reviewed eight care records and saw that patient goals were not always applicable to the patient and that entries were not meaningful when updated. One patient's care record identified being informed of their rights in an easy read format every six to eight weeks as a goal. Another patient's 'Joining in and Enjoying Life' care plan identified taking part in activities as a short-term goal and taking part in

activities and develop new skills as the longer-term goal. There were no specific details as to how staff should support the patient to achieve these goals in the care plan. Four of eight patients did not have one-page profiles or a completed 'about me' section and two of eight patients did not have easy read care plans. These were also identified as actions at the Mental Health Act monitoring visit on 19 July 2021.

Autistic people in the service did not have detailed positive behaviour support plans and staff did not know what positive behaviour support was. One patient profile document only described the negative issues for the patient, not what action to take to prevent the patient going into crisis. We saw one basic care plan that described trigger situations, early warning signs and advice on how to calm the patient down. However, further in-depth information was required to enable the formulation of risk and needs. The service did use Antecedent, Behaviour, Consequence (ABC) charts to review behaviours. These were submitted when reporting incidents.

None of the families we spoke with felt that they were involved in their relative's care and five of the families had not been informed of any future plans for their loved ones.

Best practice in treatment and care

Staff did not provide a range of treatment and care for people based on national guidance and best practice. Access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation was limited. Staff did not participate in effective clinical audits, benchmarking and quality improvement initiatives but managers did have a quality assurance framework in place.

Staff supported people with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff did not deliver all aspects of care in line with best practice and national guidance (from relevant bodies eg NICE). Staffing was not always consistent and predictable, and staff were not appropriately trained in assessing and supporting the needs of autistic adults. The service had high bank and agency usage. We saw limited engagement with the patients' that fostered their autonomy or promoted active participation in decisions about care and support self-management. For example, we saw that staff responded to patients when they made a noise or talked, but otherwise we observed limited or no communication. One CCTV review showed very little interaction prior to an incident. Staff were talking to each other outside the patient's bedroom. National Institute for Health and Care Excellence guidance stipulates that staff should take an active role in engaging positively with patients. We saw limited engagement on the inspection.

Families and carers did not feel involved and the service did not have a complete multidisciplinary team. We did not see a structured and predictable training programme based on behavioural principles to help with the activities of daily living. Although some patients were out on trips and completing shopping activities off the ward, there was not a clear plan or action taken to engage those that were disinterested. This resulted in many patients staying in bed. We reviewed six days of handover notes for 18 patients which indicated that patients spent most time on the wards in their bedrooms sleeping or using mobile phones to listen to music or watch programs. Handover notes did not record onsite activities and there were limited details on what activities were completed off the wards other than home visits, supermarket shopping, park trips or van drives. For example, over six days two patients had no activities offsite or onsite recorded and one patient had only one leave trip recorded and television as an onsite activity. Another three patients over a three-day period all declined leave and had no alternative onsite activities recorded. Weekly activity planners listed

multiple activities on offer including indoor bowling, trampolining, painting, stencil colouring, board games, movie nights, building blocks and play dough. None of these items were recorded in handover notes or witnessed during the inspection. We also reviewed patient observation paperwork and saw two records for the same time period that identified the patient on two different trips.

Staff did not always complete detailed positive behavioural support plans. Further in-depth information was required to enable the formulation of risk and needs but staff did provide the care and support identified in care plans.

Staff identified peoples' physical health needs but did not always create care plans to meet their needs. One patient was lacking an anorexia care plan and another an epilepsy care plan.

Staff made sure autistic people had access to physical health care, including specialists as required. Patients attended GP and hospital appointments regularly with different health professionals.

Staff met peoples' dietary needs and assessed those needing specialist care for nutrition and hydration. On ward four we reviewed the blue patient folders which staff used to record observations, food and fluid monitoring and we saw nutrition and hydration discussed in meeting minutes. However, one person's record did not have a specific anorexia care plan other than instructions on how to tube feed the patient.

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. We saw that families were involved in physical health best interest decisions.

Staff used recognised rating scales to assess and record the severity of peoples' conditions and care and treatment outcomes. Staff used the Liverpool University Neuroleptic Side-Effect Rating Scale (LUNSERS) to monitor medication-induced side effects, the Model of Human Occupation Screening Tool to gain an overview of an individual's occupational functioning and the five Ps model for case formulation.

Staff used technology to support autistic people. Patients accessed tablets, mobile phones and computers. One communication plan emphasised the patient's use of technology to build relationships.

The service completed clinical audits including infection, prevention and control, hand hygiene, medicines, mattress and record keeping audits, but these did not identify all issues that we found during the inspection. For example, differing information regarding epileptic seizures in the paper and electronic files or the disordered clinic room. However, where audits identified issues, we saw that action was taken and improvements were made. The registered manager explained that when the new members of the multidisciplinary team joined, they would review the existing processes and develop new approaches.

Skilled staff to deliver care

The ward team did not include or have access to the full range of specialists required to meet the needs of autistic people on the wards. Managers had not ensured they had staff with the range of skills needed to provide high quality care. The induction programme for new staff did not equip staff with the knowledge and skills they needed to provide safe and effective care.

However, managers supported staff with appraisals, supervision and opportunities to update and further develop their skills.

Inadequate

Wards for people with learning disabilities or autism

The service did not have a full multidisciplinary staff team to provide appropriate care for patients. The service had no occupational therapist in post from December 2021. Prior to December, the occupational therapist had taken a leave of absence. The service had an occupational therapy assistant working during this period and a second occupational therapy assistant had started their first shift two days prior to the inspection. The service had three different psychiatrists in post in the previous six months. The speech and language therapist had taken extended leave in October 2021. The service had no speech and language therapist cover in place but had risk assessed the choking of patients via a speech and language therapy service at another local hospital. One post in a patient's record prior to them leaving acknowledged that the speech and language therapist had not had much time to spend with a newly admitted patient because of their reduced work availability. They explained that the communication plan was based on brief interactions and multidisciplinary team information. The part time consultant psychologist had also further decreased their hours at the end of January and the service was recruiting a replacement when we inspected. The service had an assistant psychologist in post who was supervised by the qualified part time psychologist.

One care record audit identified that the falls, choking and mobility risk assessments as well as the occupational therapy and speech and language assessments had not been completed because there were no staff in post. One patient told us that they had been waiting on a kitchen assessment from the occupational therapist since June 2021. Following the inspection, the provider told us that the patient had been waiting for the assessment from December 2021. They said that it had been rearranged several times with the agreement of the patient.

All six families shared concerns over staffing. They described a lack of continuity of care and said that the service ran on support staff who did not all know their relatives well. All families said that there had been no occupational therapist or speech and language therapist for months and that there was limited input from a qualified psychologist.

Stakeholder organisations told us that there was no continuity in the multidisciplinary team. One person said that Makaton communication had worsened since the occupational therapist had left and that this had impacted on those receiving care. Following the inspection, the provider explained that one patient used Makaton but also used speech and lip reading to communicate.

Managers had not ensured that staff had the right skills and experience to meet the needs of the people in their care, including bank and agency staff. Many staff had no experience of working with autistic people in their previous roles prior to joining the service. This included the registered manager, consultant psychiatrist, one nurse, support workers and agency staff.

Managers had not ensured that staff received all specialist training for their role. The mandatory training programme and induction provided was not of appropriate quality and the service had not identified all training courses needed to meet the needs of autistic patients.

Managers recognised poor performance and could identify the reasons but did not always effectively manage these issues. For example, staff on the wards had been asked repeatedly to wear masks correctly but staff continued to disregard this rule even during the inspection.

However, managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work and provided regular, clinical supervision. All staff, including bank and agency, had regular supervision. We reviewed team meeting minutes from January and February 2022 and October and December 2021 and saw that supervision and appraisals statistics had been updated.

Managers identified some of the training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. One member of staff said they had applied to complete a Makaton course.

Multi-disciplinary and interagency teamwork

There was not enough staff from different disciplines that supported each other to ensure autistic people using the service had no gaps in their care. Staff engaged with external services early in the admission to plan discharge, however ward teams did not always have effective working relationships with staff from services that would provide or arrange aftercare.

Staff held regular multidisciplinary meetings to discuss autistic people and improve their care, but meetings were ineffective. The service held daily multidisciplinary team meetings and fortnightly ward rounds. In addition to attending one daily meeting we also reviewed eight ward round meeting minutes from 7 and 21 February 2022. Meeting minutes did not show a detailed discussion or review of patients and restrictive interventions and restraint were not reviewed. For example, one patient had been involved in an incident the previous day, but this was not reflected or discussed in the ward round. Their current risk and incidents section specified that their risk assessment and choking assessment were up to date and asked the nursing team to ensure care plans were in place. There was no discussion surrounding this. Another patient recorded seven incidents for the month, but the only additional comments said that incident charts were to be reviewed. Meeting minutes showed little or no evidence of discharge planning for autistic people using the service.

Medicines were listed but there was little or no discussion about medicines documented. Medicines updates on all confirmed patients had a pain chart and a LUNSERS on file. One patient was recorded as being on leave so sections pertaining to upcoming appointments, observation levels and section 17 leave were left blank. Other aspects that were recorded were standard statements across all minutes that we reviewed.

We attended the morning multidisciplinary team meeting. The meeting started 20 minutes late and only the nurse and clinical lead attended. Although staff reviewed and discussed each patient, including their incidents, diaries, physical health and leave requests, staff relied on their memories when the laptop battery ran out. Support staff who directly worked with the autistic people in the service told us that they did not attend these meetings.

We saw limited future planning in either the daily or fortnightly multidisciplinary meetings.

However, patients and external professionals were invited to, and/or attended ward rounds. This included commissioners, advocacy representatives and social workers. Internal attendees included the consultant psychiatrist, assistant psychologist and a nurse.

We reviewed six days of handover notes for 17 patients. Handover information was a summary of the shift and included information such as mood, food and fluid intake, medicines taken, risk, incidents, physical health and trips out. We did not see clear information about changes to patient care. Handover notes recorded ‘not applicable’ in the changes to patient care section.

Ward teams did not always have good working relationships with external teams and organisations. Some commissioners and visiting professionals said that they felt unwelcome on the wards, that documentation was poor and that there was a lack of assessments and formulations completed. One commissioner said that they only used the service as a last resort, and another said they would not use the service even then.

However, the service had arrangements with a local hospital to fast track patients through the local acute hospital environment to minimise sensory overload and we saw that other professionals visited the ward.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain peoples' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service had a Mental Health Act administrator, that staff knew, who was easily accessible and provided support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Autistic people had easy access to information about independent mental health advocacy and those who lacked capacity were automatically referred to the service. The advocate attended the wards regularly and had a good working relationship with staff and autistic people in the service.

Staff explained each autistic person's rights under the Mental Health Act in a way that they could understand. Section 132 rights were explained monthly by staff to each patient. This process was monitored by the Mental Health Act administrator.

Staff made sure autistic people could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Leave was a standing agenda item at ward rounds and some patients went on van drives, shopping and trips out.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Assessments were in place to record a patient's capacity to consent to treatment.

Staff stored copies of peoples' detention papers and associated records correctly and staff could access them when needed.

The Mental Health Act administrator made sure the service applied the Mental Health Act correctly by completing audits and sharing the findings.

There were no informal patients on the wards.

Good practice in applying the Mental Capacity Act

The provider did not record the completion of Mental Capacity Act training, including refreshers, and the quality of training delivered was poor. The registered manager told us that Mental Capacity Act training was covered in the classroom induction. One member of staff told us that the provider had recently changed their online training provider,

so this was no longer covered separately. During the inspection we reviewed induction slides and saw that the one slide relating to mental capacity consisted of three learning points. The training did not explain the five key principles associated with the Act or explain that when health providers failed to follow the law (and guidance provided by the associated code of practice) patients may be at risk of inappropriate, or unlawful, treatment and care.

Staff supported people to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

There was a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Record keeping indicated that staff had a good understanding of the five principles.

Staff gave autistic people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Most care files we reviewed recorded capacity to consent or best interest decisions. However, we saw one example where a patient had no best interest's decision recorded for mobile phone use.

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered people's wishes, feelings, culture and history.

Staff assessed and recorded capacity to consent clearly each time an autistic person needed to make an important decision. The guidelines of the Mental Capacity Act were followed by staff and when required best interests' assessments were undertaken. One assessment we viewed did not follow the best interest checklist in a systematic way.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are Wards for people with learning disabilities or autism caring?

Inadequate

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

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat people using the service with compassion and kindness. They did not respect peoples' privacy and dignity. They did not understand the individual needs of people and support them to understand and manage their care, treatment or condition.

We spoke with five people using the service, six carers or relatives, one advocate and 14 commissioners. People using the service and those close to them said staff did not always treat them well or behave kindly. Staff were not always discreet, respectful, and responsive when caring for people. They did not always give people using the service help, emotional support and advice when they needed it.

Inadequate

Wards for people with learning disabilities or autism

One patient and three family members described how some staff had laughed and mimicked autistic people using the service. Another patient spoke positively about the psychiatrist and occupational therapy assistant but said that other staff were unsupportive and that they did not like how staff talked to them. One family shared their concerns about how male staff observed their female relative when she was not always fully clothed. They felt the service did not protect their relative's privacy and dignity.

We did not observe staff proactively interacting with patients on observations on any of the visits. For example, we saw that staff responded to patients when they made a noise or talked, but otherwise there was limited or no communication with people using the service. One CCTV review showed very little interaction prior to an incident with staff talking to each other outside the patient's bedroom.

Staff did not support people using the service to understand and manage their own care treatment or condition. All six families that we spoke with, one advocate and one patient said there was a lack of therapeutic activities on the ward. Three families said that staff did not encourage their relative to be independent. Three families described their relatives staying in bed and said that staff had no real understanding of autism. One family said that there was no encouragement for their loved one to make their own meals.

Although some patients went on trips and completed shopping activities off the ward, there was not a clear plan, or action taken, to engage those that were disinterested.

On the second day of the inspection, late in the afternoon, staff took some patients to a safari park and we saw that there had been previous trips to Blackpool and to bowling. However, these did not engage all the people in the service and on ward therapeutic alternatives were not visible for those that chose not to go. On ward one we saw that staff offered colouring and baking to patients, but patients declined.

Staff did not always understand and respect the individual needs of each patient. Staff said that they reviewed the patient's care plans when they were on induction and then received updated information from handovers. Care plans were not accessible to staff on the wards because they were kept in a locked cabinet on ward one. We reviewed eight care records and saw that patient goals were not always applicable to the patient and that entries were not meaningful when updated. Feedback from four commissioners said there was a lack of assessments and formulations, poor documentation, poor communication and difficulty in accessing the ward for transitions and visits.

However, we did speak with some staff that could clearly describe the individual care needs of people using the service. They explained what triggered the patient and described how the patient had progressed since being in the service.

Staff did not always direct people to other services and support them to access those services if they needed help. Although we saw evidence of physical health care monitoring, five families told us that they had to push the clinical team to get help for physical health complaints for their relatives. Two families described how their relative needed dental treatment but that no appointments were made, and another said they had to email the consultant psychiatrist after raising concerns with ward staff so that their relative could get a GP appointment.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. They said that managers had an open-door policy and staff could go to them to share any concerns.

Staff followed policy to keep patients' information confidential.

Inadequate

Wards for people with learning disabilities or autism

Involvement in care

Staff did not always involve autistic people in care planning and risk assessment and actively seek their feedback on the quality of care provided. However, they ensured that autistic people had easy access to independent advocates.

Involvement of autistic people

Staff did not fully involve patients and give them access to their care plans and risk assessments. Staff did not make sure that autistic people understood their care and treatment. Four patients did not have one-page profiles or a completed 'about me' section and two did not have easy read care plans. This was also identified as an action at the Mental Health Act monitoring visit on 19 July 2021. One autistic person told us they did not understand why their room had been stripped of belongings and we saw no rationale in the care documents we reviewed. Four of the care records we viewed had no patient involvement recorded in the risk assessments and autistic people had not been offered a copy of their care plans.

Some staff found ways to communicate with people who had communication difficulties. Most communication plans were comprehensive, detailed and gave staff examples of how to interact with autistic people. This included using short sentences, preferred names, physical attributes when displaying emotions, preferred topics, pictorial charts as well as 'do's and do not's' for communicating. However, staff did not have easy access to patient's communication care plans as these were locked away. Some staff were trained in Makaton, but one person said that Makaton communication had worsened since the occupational therapist, who was Makaton fluent, had left. Staff said it was better when there were staff who knew the patients well on shift. Some families also fed back that their relatives struggled to understand some staff who spoke English as a second language. The diversity of the workforce did not reflect the patient group and this had been identified as an action at the Mental Health Act monitoring visit on 19 July 2021.

Autistic people could give feedback on the service and their treatment, but staff did not always support them when they did this. We observed one patient raising concerns about staff, but no action was taken to resolve their concerns. One patient told us there was no point in raising issues because the service would not respond. However, the service held monthly community meetings for patients and meeting minutes showed that three patients regularly attended. The questions were in an easy read format and we saw that patients fed back and made suggestions about food, activities and staff. Actions were recorded, assigned and completed.

Autistic people had limited involvement in decisions about the service. For example, we saw that menus and food were discussed at the community meetings, but autistic people were not involved in policy reviews or discussions on restrictive practice and restraint.

Staff introduced patients to the ward and the services as part of their admission. Patients would visit the ward as part of the admission process.

Staff made sure autistic people could access advocacy services. The advocate attended meetings with the multidisciplinary team and spoke regularly with people using the service.

Involvement of families and carers

Staff did not inform and involve families and carers appropriately.

Inadequate

Wards for people with learning disabilities or autism

Staff did not support, inform and involve families or carers. We spoke with six families or relatives of people using the service. None of the families felt that they were involved in their relative's care and five of the families had not been informed of any future plans for their loved ones. This was also identified as an action at the Mental Health Act monitoring visit on 19 July 2021. However, one parent said that their relative's mental health had improved since being admitted to the service.

Staff did not help or encourage families to give feedback on the service. One staff member explained that most conversations were with the registered nurses on shift or the clinical lead. Two parents described the care as very poor or atrocious, one said that staff did not understand their relative and that night staff laughed at them.

We reviewed the two most recent responses to the carer's surveys. Both surveys each received three responses. Comments were positive, but one response commented on high staff turnover, feeling less involved and uninformed and problems with communication. The other survey results were also positive, but two responses felt the service could make improvements in communication and activities and therapeutic interventions.

All six families that we spoke with said that communication and involvement in their relatives' care was poor or non-existent. Families described how they were promised weekly update calls but that these did not happen, they also added that staff did not return telephone calls or emails. Five of six families described staff as being defensive when issues were raised and said they were made to feel unwelcome on the wards. The other family commented that they had only visited the family room. One family said that staff had shouted at them when they raised an issue. Visiting professionals and four commissioners also described the staff as defensive when issues were raised.

The service did not have a carer's group, but the service told us that carers and commissioners were able to attend multidisciplinary meetings remotely and be fully involved in discussion. We also saw that the registered manager had encouraged communication via a separate clinical team email address and suggested that the family attended ward rounds to improve relations.

Four families told us that there was a lack of occupational therapy, speech and language therapy and psychology input and two families raised concerns about the high turnover of staff.

None of the families had been given information about carer's assessments by staff.

Are Wards for people with learning disabilities or autism responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

Staff did not always plan and manage discharge well. Although they liaised with services that would provide aftercare and were assertive in managing the discharge care pathway, relationships with care teams were not always positive. Discharge was delayed due to a lack of suitable placements, but the service served notice to commissioners to ensure placements were found.

Inadequate

Wards for people with learning disabilities or autism

Bed management

Managers made sure bed occupancy did not go above 85% and when autistic people went on home or transition leave, they always returned to their own bedrooms.

Managers reviewed the length of stay for autistic people to ensure they did not stay longer than they needed to. The manager explained that patients were normally admitted to the service for 12 to 24 months. The service had recently started to serve notice to commissioners when patients were ready for discharge to ensure new placements were found. Managers and staff worked to make sure they did not discharge autistic people before they were ready.

Autistic people were only moved between wards during their stay when there were clear clinical reasons, or it was in the best interest of the people. Staff did not move or discharge people at night or very early in the morning.

The service had out-of-area placements because there were limited specialist autistic services available nationally.

Discharge and transfers of care

Managers monitored the number of delayed discharges. They explained that when discharge was delayed, this was normally due to a lack of suitable placements. When this occurred the service increased home leave for autistic people so that they maintained their independence.

Staff did not always work well with care managers and care coordinators to make sure discharge worked smoothly. One commissioner said that poor communication and a lack of discharge documents had impeded discharge for their patient and another described communication as hit and miss. A third commissioner said that they had to chase for information and often found that only the consultant psychiatrist responded.

Staff supported autistic people when they were referred or transferred between services. Patients would visit new services and staff from new services would visit and familiarise themselves with the care autistic people received.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported autistic peoples' treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and they could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and people using the service could access snacks at any time, however they could not make their own hot drinks.

Each person had their own bedroom, which they could personalise. Two patients' bedrooms were bare or had little or no personalisation. Although staff told us that this was due to risk or patient preference, one patient did not agree. They did not understand why their room was bare and we saw no evidence in their care record justifying this restriction.

People using the service had a secure place to store personal possessions and they could make phone calls in private. There were lockable drawers in bedrooms and patients had access to their mobile phones.

Staff used a full range of rooms and equipment to support treatment and care. The service had an activity room for crafts and physical health activities. Patients also used the sensory room on the ground floor and the lounges on each of the wards.

Inadequate

Wards for people with learning disabilities or autism

The service had quiet areas and a room where autistic people could meet with visitors in private. Families were encouraged to use the family room on the ground floor or take their relatives out when they visited.

The service had an outside space that autistic people could access easily. Patients could access the courtyard and gardens from the wards.

Patients could access snacks at any time; however, they could not make their own hot drinks. Some patients could use the activities of daily living kitchen, but staff had to unlock the door. Staff were available to bring patients snacks and drinks.

The service offered a variety of food to patients and individual preferences were taken into consideration. Staff could describe what types of meals patients liked or needed. However, two families said that their relatives bought their own meals as they did not like the food provided.

Peoples' engagement with the wider community

Staff did not support autistic people with activities outside the service, such as work or education but did ensure that autistic people using the service maintained family relationships.

Staff did not make sure people using the service had access to opportunities for education and work. Some patients developed and maintained relationships with others in the service, but we did not see patients engaging with the wider community.

However, staff helped patients to stay in contact with families and carers. Patients video called or telephoned their families frequently and families visited their relatives to take them out on trips. We also saw that patients used home leave regularly when close to discharge.

Meeting the needs of all people who use the service

The service did not meet all the needs of autistic people with protected characteristics. Staff did not all have the communication skills and training necessary to interact fully with patients. However, patients were able to access advocacy and cultural and spiritual support.

The service had not fully supported or made adjustments for disabled people and those with communication needs or other specific needs. Although patients had communication plans in place, these were not easily accessible because they were locked away in the office. Some staff received basic Makaton training. One member of staff told us it was harder to communicate with non-verbal patients because they did not know how to interpret the patient's gestures, so it was best to have staff on shift that knew them. Some families also fed back that their relatives struggled to understand some staff who spoke English as a second language.

Staff made sure people could access information on treatment, local services, their rights and how to complain in languages spoken by the people in the service and local community. There was information on noticeboards and some easy read information on the wards.

Managers made sure staff and autistic people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual people. Staff described how they catered for different diets.

Inadequate

Wards for people with learning disabilities or autism

Autistic people had access to spiritual, religious and cultural support. The service had a basic multi-faith room with religious reading materials and equipment.

Listening to and learning from concerns and complaints

Although complaints were investigated, the service did not treat concerns and complaints seriously, learn lessons from the results, and share these with the whole team and wider service.

Autistic people, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to do this in ward and family areas.

However, the organisational culture regarding complaints was poor. One senior manager described how a visiting professional had "snitched" on them when issues were raised directly with us instead of themselves. Five of six families described staff as being defensive when issues were raised. One family said that a member of the senior leadership team had shouted at them when they raised an issue. Visiting professionals and four commissioners also described staff as defensive when raising issues. One autistic person said that they knew how to raise concerns, but that staff would not listen.

Staff did not understand the policy on complaints or know how to handle them. One staff member explained that although they would be able to discuss general patient care when families visited, most discussions were with the registered nurses on shift or the clinical lead.

Managers investigated complaints and people received feedback following any investigation into complaints. However, two families said that the service was slow to respond to complaints, and another two families said they did not feel confident about raising issues because staff were so defensive. Another family described how the service's responses deflected the complaint to cover themselves.

Staff could give examples of recent complaints. We saw that the manager asked staff to stay visible on CCTV or to ensure that they were always accompanied with one patient who had made allegations against staff.

The service did not share complaints and compliments information to learn, celebrate success and improve the quality of care. We reviewed team meeting minutes from October and December 2021 and January and February 2022. The hospital issues section, that included compliments and complaints was blank in all copies we viewed. However, the registered manager had shared compliments about staff from family members and visiting professionals at engagement meetings with us.

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not have all the skills, knowledge and experience to perform their roles. They did not have a good understanding of the service they managed.

However, managers were visible in the service and approachable for people using the service and staff.

Inadequate

Wards for people with learning disabilities or autism

Although leaders in the service delivered care and treatment to autistic people in their prior roles, they had no experience in leading a specialist service for autistic people. Most leaders came from a forensic background. This included the registered manager, consultant psychiatrist and one of the permanently employed nurses.

The registered manager shared a draft copy of the service's self-assessment for a closed culture which listed indicators, warning signs and risk factors. The manager had not accurately identified the risk level for the indicators of a closed culture based on the patient group, dependency of patients on staff for basic needs, length of stay and restrictive practices.

There was a poor justification for why warning signs were not applicable to the service. They lacked detail and the rationale was contradictory to what we saw on the inspection. For example, the service felt it had an experienced multidisciplinary team when it did not. One warning sign was patients being asked to go to their room and being prevented from leaving which we saw during a CCTV review. One patient also told us they were 'threatened with medication' when they came out of their bedroom. Another warning sign included an increase in complaints and lack of regular communication with families throughout their admission. All families said that communication was poor, and five of six families described staff as being defensive when issues were raised.

Although the review identified registered nurses as the first level of the management team to evidence that the service always had a manager or leader present, out of hours, registered nurses had to contact the rota-coordinator/hospital trainer to resolve staffing issues.

However, staff knew who the most senior managers in the organisation were by name. The registered manager completed a five-p.m. walk round each day, and staff and autistic people in the service knew them well. Staff said that leaders were not present at night. Managers were aware of this and were recruiting two clinical leads to work night shifts.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The provider's vision and values were displayed on team meeting minutes and there were posters on the premises.

Culture

Staff felt respected, supported and valued.

They 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.

Most staff spoke positively about working for the service. They felt supported and described leaders as approachable or okay. Staff felt they worked well as a team and were passionate about the care provided. The service had introduced a £20 voucher for worker of the month, however one staff member said this was only for permanent employees not regular agency staff. Following the inspection, the provider explained that this was to act as an incentive for agency staff to take up permanent posts. Staff felt confident to raise concerns to the management team.

Staff were able to develop in role. For example, the registered manager had previously held a clinical lead post in the service before becoming the registered manager. The service had also introduced a senior support worker role that had increased responsibilities, including staffing allocations for observations and breaks.

Inadequate

Wards for people with learning disabilities or autism

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

The clinic room and medicines audits did not identify that there was a lack of order in the clinic room cupboards and that staff did not adhere to medicines management guidance. Managers did not ensure that staff followed systems and processes to administer medicines safely or complete medicines records accurately and keep them up to date.

Managers did not ensure that all staff working in the service followed infection control precautions as detailed in the provider policy and government guidance. This was identified as an issue at the last inspection in November 2020 and had not improved. Managers did not display good infection prevention and control behaviours.

Managers did not accurately calculate and review the number and grade of nurses for each shift. The provider had not staffed the service with permanent staff. The service had high levels of agency and bank staff working every shift and male staff were seen to be observing a female patient whose preference was for female staff.

Managers had not successfully recruited into vacant posts in a timely way or made effective alternative arrangements in relation to patient care and treatment when posts were out for recruitment. The ward team did not include or have access to the full range of specialists required to meet the needs of autistic people on the wards.

The mandatory training programme provided was not of appropriate quality and the service had not identified all training courses needed to meet the needs of patients and staff. The autism training program delivered to staff fell below the expected standard for a specialist autism service as did the induction programme and training in the Mental Capacity Act and Positive Behavioural Support.

The provider had not embedded a culture of safeguarding on the wards or identified that safeguarding training was incomplete. Staff had not completed the necessary levels of Safeguarding Adults or Safeguarding Children training and staff did not report incidents as safeguarding when they arose.

Managers had not created a culture for the continuous review of restrictive practices. The service had not identified all restrictions in the service and record keeping for individual patient restrictions was poor. Involvement of staff, patients and families was not always evident.

Staff were not familiar with the concept of positive behavioural support and there was limited ongoing review and discussion of risk. The service had not ensured that staff completed effective functional assessments or worked with autistic people and families or carers to develop and update individual care and support plans. The provider did not ensure that therapeutic activities enabled patients to maintain their independence, and activities and learning in daily routines did not build skills for longer term goals.

The on-call arrangements did not enable staff to maintain a good work life balance and observations practice was poor. Staff had limited interaction and engagement with patients when completing prescribed observations and the allocated observations approach went against best practice guidance.

Although complaints were investigated, the service did not treat concerns and complaints seriously, learn lessons from the results, and share these with the whole team and wider service. Families described staff as being defensive when issues were raised and said they were made to feel unwelcome on the wards. Commissioners and visiting professionals also shared this opinion.

Inadequate

Wards for people with learning disabilities or autism

Ward teams did not always have effective working relationships with staff from services that would provide or arrange aftercare. Commissioners said that when patients transferred to a new team, there were delays in staff accessing their records and sharing information. Information requested by us during and after the inspection was also not provided in a timely manner.

Lessons learnt information was limited. Team meetings and multidisciplinary team meetings were ineffective and did not share all relevant information with staff or review all aspects of patient care. Staff did not participate in effective clinical audits, benchmarking and quality improvement initiatives.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care or use that information to good effect.

Managers had not identified that staff did not have easy access to clinical information, or that high quality, regularly updated, complete clinical records were not maintained. This was not identified in the care record audits.

Team meeting minutes were not shared with staff following team meetings and staff relied on handovers for updates.

Information management

Staff collected analysed data about outcomes and performance and implemented local quality improvement activities.

Managers monitored and reviewed organisational data and information that related to patient care such as staffing levels, incidents, restraints, complaints and discharge. The service had identified that there were gaps in service provision and were creating new posts including clinical leads who would be present on the wards on both day and night shifts, a deputy hospital manager and full time administrative support to help with the safe and well led reviews.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

The provider had close working relationships with the host commissioner and local safeguarding authorities.

Learning, continuous improvement and innovation

The service had an active local quality improvement plan which was regularly updated.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had not created a culture where autistic people, carers, families and professionals felt able to speak up, share concerns, raise complaints and feel listened to.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider placed vulnerable people at risk due to their failure to take the required actions to ensure that assessments and treatment included all patients' needs. Care and treatment plans did not justify restrictions placed on patients, capture all physical health needs or evidence clear and regularly updated formulations for patients. Care plans did not enable patients to maintain their independence, and activities and learning in daily routines did not build skills for longer term goals. Care plans were undated and people using the service and/or those lawfully acting on their behalf were not actively encouraged and supported to be involved in making decisions about care or treatment.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider placed vulnerable people at risk due to their failure to take the required actions to ensure that staff responsible for the management of medication were competent and followed proper procedures for the storage, dispensing, preparation, administration and recording of medicines. The provider repeatedly failed to ensure that all staff working in the service took the required actions to prevent and control the spread of infections in line with current guidance.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service placed vulnerable people at risk due to their failure to take the required actions to ensure that safeguarding processes were fully embedded in patient care and treatment. Staff did not receive all the relevant safeguarding training at the suitable level for their roles and restraint was not only used when necessary and in relation to the risk of harm. Staff did not identify or raise safeguarding's for patients in their care.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider placed vulnerable people at risk due to their failure to take the required actions to ensure that systems and processes were established and operated effectively. Audits did not identify areas of improvement in the service, records were inaccurate or missing relevant information and were not available at the point of care. The provider did not actively encourage feedback about the quality of care and overall involvement with them. Staffing issues were not resolved in a timely way to ensure patient care was not affected.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider placed vulnerable people at risk due to their failure to take the required actions to ensure that there was a full multidisciplinary team to provide care, enough registered nurses each shift to deliver care and enough permanent staff who knew the patients' needs recruited. The autism training program delivered to staff fell below the expected standard.