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 caring?	Inadequate

Summary of findings

Overall summary

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

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

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

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

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

- People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs.
- People were not protected from abuse and poor care. The service had sufficient staff to meet people's needs but staff were not appropriately skilled or effectively deployed and so people were not always kept safe.
- People were not being well supported to be independent and have control over their own lives. Their human rights were not consistently upheld.
- People did not receive kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs.
- People did not have their communication needs met and information was not shared in a way that could be understood.
- People's risks were not assessed regularly and managed safely. People were not given the freedom to manage their own risks whenever possible.
- We observed disproportionate use of restrictive practices including physical intervention. The provider was not taking sufficient action to review the use of restrictive practices at the service to try to reduce these.
- People and those important to them, including advocates, were not actively involved in planning their care. People were not supported to use their preferred methods of communication to express their views about their care. When people did raise concerns about their care these were not always listened to and addressed in a timely manner.

This service was placed in special measures following its inadequate rating in March 2022. Following the second inadequate rating, in December 2022, we commenced action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration within six months of the notice.

This urgent inspection was carried out to check the safety of people using the service and, as a result, we took action in line with our enforcement procedures to impose urgent conditions on the provider's registration to ensure people's safety including ensuring all people using the service were transferred to alternative placements by 14 April 2023 and to not make any further admissions. The provider complied with these conditions and the hospital has now closed.

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 	See above.

Summary of findings

Contents

Summary of this inspection

Background to The Breightmet Centre for Autism

The Breightmet Centre for Autism was registered with the Care Quality Commission on 15 August 2013. It is registered for the following regulated activities:

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

At the time of the inspection there was a nominated individual in post who was also the executive director as well as consultant psychiatrist. They had been in post since November 2022. There was no registered manager in post. The hospital manager had been in post since the second week of October 2022 and they had started the process of applying to be the registered manager.

This was the thirteenth inspection of this location. At the eleventh inspection, in March 2022, the service was rated inadequate overall with every key question rated inadequate. The service was placed in special measures. The service was served five warning notices for Regulations 9, 12, 13, 17 and 18.

In December 2022 we re-inspected. The service was still rated inadequate overall, with ratings of inadequate for every key question except responsive, which was rated requires improvement. We found breaches of Regulations 12, 13, 15, 17 and 18 at this inspection and following this inspection we issued a Notice of Proposal to cancel the provider's registration. The provider made representations in relation to this which were being considered by CQC at the time of this inspection.

This inspection was carried out due to concerning information we received in March 2023 about the immediate safety of people using the service. The inspection was focused on the safe and caring key questions.

What people who use the service say

There were 10 people using the service when we inspected. We spent some time with all 10 people, spoke with 4 people directly about their experience and spoke with 4 relatives/carers.

Some people told us that they did not feel safe at the hospital. They said that they did not trust the staff and they feared raising concerns about their care because they believed it would result in punishment. Others told us that they did feel safe and that they believed the staff were there to support them.

Some people described experiences of being physically restrained by staff in a way which they felt was punitive and excessive. They also described having possessions taken away from them, such as their mobile phone, which restricted their access to their friends and family outside the hospital.

Carers told us that they did not feel involved by staff in their relative's care and it was difficult to get information from the hospital. Some carers described the hospital preventing them from accessing their relative's bedroom and said that they did not think staff did enough to facilitate contact between them and their relative.

Summary of this inspection

How we carried out this inspection

The inspection team comprised two inspectors on site on the evening of 22 March 2023 and two inspectors on site all day and early evening on 23 March 2023. Prior to and following the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including commissioners and NHS England.

During the inspection visit, the inspection team;

• visited all 4 wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for people

• spent time with all 10 people at the service, this included talking with people and observing their care, including speaking directly with 4 people who could give us verbal feedback about their experience.

• spoke with 4 relatives and carers of people using the service.

• conducted 8 Short Observations for Inspection 2 (SOFI2 is a structured observation which captures people's experience of care) – these observations were on different wards and at different times of the day and evening.

• spoke with the manager and nominated individual/consultant psychiatrist.

• reviewed 6 care and treatment records of patients including care plans, risk assessments, observation records and daily notes.

• reviewed incident records and records of physical interventions.

• looked at a range of policies, procedures and other documents relating to the running of the service.

This inspection was unannounced and focused on the safe and caring key questions.

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

Areas for improvement

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

We told the service that it must take action to bring services into line with 5 legal requirements.

Summary of this inspection

- The provider must ensure that staff are aware of people's individual communication needs and act in accordance with people's care plans to communicate with them in their preferred ways (Regulation 9)
- The provider must ensure that staff are familiar with people's care plans and provide support to them which is in line with their planned care (Regulation 9)
- The provider must ensure that people have their care regularly reviewed by the multi-disciplinary team and changes are made to their care as required by their changing needs (Regulation 9)
- The provider must ensure that people have access to meaningful activities (Regulation 9)
- The provider must ensure that people using the service (and, where appropriate, their relatives/carers) are involved in the planning and delivery of their care as much as possible and they receive as much support as they need to communicate their views and preferences (Regulation 9)
- The provider must ensure that people are treated with dignity, respect and compassion at all times (Regulation 10)
- The provider must ensure that the care environment is safe, clean and meets people's sensory needs (Regulation 12)
- The provider must ensure that staff have access to personal alarms to enable them to respond to incidents in a safe and timely manner (Regulation 12)
- The provider must ensure that staff carry out supportive observations in line with the provider's policy and people's individual risk assessments and observation prescriptions (Regulation 12)
- The provider must ensure that people have physical health observations completed as stated in their care plans (Regulation 12)
- The provider must ensure that people have their freedom restricted only where they are a risk to themselves or others, as a last resort and for the shortest time possible (Regulation 13)
- The service must ensure that any physical restraint is reasonable, proportionate and the least restrictive response to the risks presented by the person (Regulation 13)
- The service must ensure that staff implement all alternative strategies contained in patients' positive behaviour support plans prior to using physical interventions (Regulation 13)
- The provider must ensure that people are protected from deliberate harm and abuse (Regulation 13)
- The provider must ensure that people have the opportunity for debrief and emotional support following incidents, particularly when they have been physically restrained (Regulation 13)
- The provider must ensure that people are able to express concerns about their care without fear of reprisal from staff (Regulation 13)
- The provider must ensure that each person using the service has a comprehensive and up to date record relating to all aspects of their care and that these records are accessible to all staff who need to access them (Regulation 17)
- The provider must ensure that staff make accurate records of untoward incidents (Regulation 17)
- The provider must ensure they have effective systems in place to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service and others (Regulation 17)

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

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Caring	Inadequate

Is the service safe?

Inadequate

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

- People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs.
- People were not protected from abuse and poor care. The service had sufficient staff to meet people's needs but staff were not appropriately skilled or effectively deployed and so people were not always kept safe.
- People were not being well supported to be independent and have control over their own lives. Their human rights were not consistently upheld.
- People's risks were not assessed regularly and managed safely. People were not given the freedom to manage their own risks whenever possible.
- We observed disproportionate use of restrictive practices including physical intervention. The provider was not taking sufficient action to review the use of restrictive practices at the service to try to reduce the use of these.

Safe and clean care environments

People were not cared for in wards that were safe, clean, well equipped, well furnished, well maintained and fit for purpose. We observed areas of the wards which were not clean, such as staining on chairs. We asked the provider to send us all their records of cleaning for the 7 days prior to our inspection. The documents submitted (night task sheets for the 7 nights preceding the inspection) did not provide assurance that all areas of the hospital were being cleaned to a safe and hygienic standard. On Ward 2 a safety pod was being stored in the lounge which meant it was not fit for purpose as a communal area for patients. There were alarms sounding very frequently on Ward 2 – although incidents had occurred, the alarms were not cancelled by staff in a timely way, which may have exacerbated the distress of people due to sensory sensitivities.

Staff used personal protective equipment effectively and safely. We observed staff donning disposable gloves before making physical contact with people and taking steps to ensure they had access to gloves of the correct size.

People had easy access to nurse call systems, however, staff did not always have easy access to personal alarms. On one of the incident reports we reviewed, a member of staff was involved in an incident where a person receiving care tried to take some scissors they were carrying. They shouted for assistance rather than using a personal alarm, but no colleagues responded and as a result the person was able to acquire the scissors, which put them and potentially others at risk of harm. The registered manager told us that work was ongoing to ensure that all staff were allocated an alarm at the start of their shift, however this proposed system was not yet in place at the time we inspected.

Safe staffing

Inadequate

Wards for people with learning disabilities or autism

The service did not have enough nursing and medical staff, who knew the people and received basic training to keep people safe from avoidable harm. Although there were enough staff to meet people's needs, staff did not have the skills to keep people safe from avoidable harm. Since our last inspection a police investigation had commenced in relation to an alleged assault of a person using the service by a member of staff and other people had raised concerns about not being supported appropriately, including allegations of unnecessary physical restraint. There were two registered nurses at the hospital at the time we inspected on both the evening and day shifts working across four wards, so there was not a qualified member of staff on each ward at all times. Some of the incident reports we reviewed stated that incidents had happened due to insufficient staff being available to manage the risks relating to people's care.

The numbers and skills of staff did not match the needs of people using the service. All people using the service were subject to an enhanced level of supportive observations, with some people having as many as 4 members of staff assigned to work directly with them. Additionally, when we inspected on 23 March during the day, there were several staff members working a shadow shift, observing the staff providing 4:1 support to someone. These staff members were crowded round this person's bedroom door, which meant they were not being supported with due regard to their privacy, dignity and sensory needs (it was stated in the person's positive behavioural support plan that they preferred to be cared for in a low stimulus environment). Carers told us that there were a lot of agency staff working at the hospital who did not know their relative well.

Staff recruitment and induction training processes did not promote safety. We observed a registered nurse asking a support worker who was undertaking a 'shadow' shift to participate in the physical restraint on the floor of someone who was highly distressed. When this new member of staff first began restraining the person, we observed the registered nurse saying to them "don't put all your weight on", as this member of staff was leaning with excessive force on the person's shoulder.

Staff did not know how to consider people's individual needs, wishes and goals when delivering care. We observed staff not acting in accordance with people's individual care plans and positive behavioural support plans, including when people became distressed.

People's records did not always include a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them. We asked the support worker who was documenting the observations of a person who does not use words if they had anything to refer to in relation to their preferred communication methods. They said they did not other than the information in the person's care plans, which were stored in the office. We observed staff acting in ways which were not supported by the person's positive behavioural support plan when they became distressed.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health care assistants for each shift. However, staff members were allocated to carry out enhanced observations for lengthy periods of time which is not in accordance with National Institute for Health and Clinical Excellence (NICE) guidance and meant staff were not able to care for people safely. We carried out CCTV spot checks which showed members of staff during multiple randomly selected night shifts who appeared to be asleep. Following our previous inspection, the provider had stated they would commence CCTV spot checks. However, when we asked for the records of all CCTV spot checks carried out in the eight weeks preceding our inspection, we only received records of checks carried out on 27 and 29 March. This did not provide assurance that the provider was adequately monitoring the quality of the service they were providing, taking into account the concerns identified at our previous inspections.

The service did not have enough trained staff on each shift to carry out physical interventions safely. The response to an incident we observed when someone was physically restrained appeared chaotic and staff reported receiving minor

injuries during the restraint. The person being restrained appeared highly distressed and the incident was not managed in accordance with the person's care plans and positive behavioural support plan. The incident reports from March 2023 showed that this person had been physically restrained on 38 occasions between 1 and 18 March 2023. Some of the incident reports referred to staff sustaining injuries during episodes of physical intervention. Other incident reports we reviewed included statements by staff that incidents had occurred or escalated due to a lack of staff to respond safely.

Staff shared key information to keep people safe when handing over their care to others. We observed two handovers on the evening of 22 March 2023. Information was shared about each patient's activities during the previous shift, and this was documented on a handover record. However, the risks relating to people's care were not clearly highlighted during the handover, which would have enhanced staff's ability to care safely for people.

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. There was a consultant psychiatrist and speciality doctor at the hospital during our inspection.

Staff did not always keep up to date with their mandatory training. The provider's training figures showed that 82% of ward- based staff were up to date with their physical intervention training at the time we inspected. Some of the carers we spoke with said they did not feel that staff had sufficient training or experience in relation to supporting autistic people.

Assessing and managing risk to patients and staff

People, including those unable to make decisions for themselves, did not have as much freedom, choice and control over their lives as possible because staff did not manage risks to minimise restrictions. All the people residing at the hospital at the time we inspected were subject to at least a 1:1 level of observation by staff at a minimum of 15-minute intervals.

People's care records did not help them get the support they needed. Staff were not always able to access people's records. Risk assessments and care plans were kept in the office and only qualified staff had keys to access these. There was not a qualified member of staff on each ward at all times. Some staff did not know where records such as risk assessments were when we asked for these. Support staff did not always have information to refer to while working with people, for example in relation to their preferred methods of communication. Staff did not always keep accurate records. For example, we reviewed the record of an incident we observed and the documentation of this did not align with the observations of our inspector. Carers told us that there was a lack of information in their relative's records which caused delays to their care when other care providers were involved.

One person did not have a full sensory assessment in relation to their dislike of wearing clothing. We were told the hospital did not have any staff who were trained to complete sensory assessments. This person's risk assessment did not refer to the fact that they were regularly removing all of their clothing to ensure staff could respond appropriately. Another person had not had a psychology assessment since January 2023, their risk assessment had not been reviewed since 6 February 2023 and their positive behaviour support plan had not been reviewed since 20 February 2023, despite a noted increase in incidents where they were physically restrained by staff in February and March 2023. A third person had been involved in a significant incident in March which included an attempt to self-harm using a ligature and their risk assessment had not been reviewed since 24 February 2023. Records of physical observations and food, fluid and bowel movement charts were not always fully completed when these had been recommended by the multi-disciplinary team.

Inadequate

Wards for people with learning disabilities or autism

The service did not effectively keep people safe through formal and informal sharing of information about risks. Risk assessments were not being updated in a timely manner following incidents. During the handover meetings we observed, although information about each person's activities during the previous shift was shared, key information about the risks relating to people's care was not highlighted in any systematic way.

People's freedom was not restricted only where they were a risk to themselves or others, as a last resort or for the shortest time possible. People using the service were continually observed by staff, often with multiple members of staff working directly with them. We observed staff crowding round some people's bedroom doors when they were in their rooms, restricting their freedom of movement. Carers told us that they were unable to spend time at the hospital with their relative without a member of staff being present.

Staff did not recognise signs when people experienced emotional distress or know how to support them to minimise the need to restrict their freedom to keep them safe. We observed a person who was restrained due to throwing a plastic cereal bowl in the air. No attempt was made to verbally de-escalate the situation in accordance with the person's positive behaviour support plan before resorting to physical restraint. Following this incident the person was distressed for over an hour and was physically restrained multiple times, including floor restraint involving up to seven members of staff. We raised a safeguarding referral in relation to this incident following the inspection.

Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. However, we did not observe staff following these plans in practice.

If a person's freedom was restricted by staff, they did not receive emotional support when needed. We saw very few attempts made by the staff involved in the restraint we witnessed to provide emotional support or reassurance to the person being restrained, even though they were showing clear signs of being highly distressed. We asked the provider to send us records of post-incident debriefing sessions but these records were not received. Some of the relatives we spoke with told us that they had experienced their family member sounding very distressed when calling them from the hospital, which made them concerned that they were not being treated kindly or given the emotional support they needed.

People were not restrained only where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest. Restraint was not always used in a safe and proportionate way. The restraint we observed did not appear to last for the minimum amount of time required to keep the person and others safe. We reviewed incident records which showed the very frequent use of physical intervention in relation to one person using the service, particularly throughout February and March 2023. This person had not had a behavioural assessment by the hospital's psychologist since January 2023. We observed staff not acting in accordance with this person's positive behaviour support plan prior to physically restraining them. We observed the person coughing during the restraint on two occasions but they were not supported to sit up so they could clear their airway on either occasion. The provider's summary of incidents from March 2023 showed that physical restraint was used in 111 out of 155 incidents (71%) with some of these restraints lasting for over two hours.

Restrictions of people's freedom were documented and monitored, however these did not always trigger a review of the person's support plan.

Staff knew about any risks relating to each person's care, however sufficient action was not always taken to prevent or reduce risks. During the incident we observed, alarms were sounding continuously and there were multiple staff

members crowded round the person's bedroom in addition to several staff being in the room responding to the incident. The person's positive behaviour support plan stated that a trigger for them can be excessive noise and that they should be cared for in a low stimulus environment. The staff who were not directly involved in the restraint did not take action to cancel the alarms in a timely manner which may have exacerbated the person's distress.

We reviewed staffing allocation charts for the night of 22 March 2023 which showed that staff were allocated to support patients on a 1:1 or 3:1 basis, sometimes for periods of seven hours. This is not in line with NICE guidance and does not ensure that staff are able to support people appropriately and safely. We also carried out a number of CCTV spot checks which showed staff who appeared to be visibly asleep when they were allocated to observe patients during multiple night shifts on different wards. We asked the provider to send us this CCTV footage following the inspection and this was not received.

On 22 March 2023 we observed that one person remained in their room with the door shut for over an hour without a member of staff observing them. This person's observation prescription stated that they should be observed by direct eyesight every 15 minutes. A staff member was placed outside their room to undertake these observations. It was not possible to observe the person through the door as the observation panel had been completely covered with card and paper, because the person did not like the light or to see people walking past. This meant that this person was not receiving safe care and treatment in line with their care plan because they were not being observed as prescribed to prevent them from coming to harm. This was also not in accordance with the provider's observation policy which states that when people have been assessed as needing level 2 observations their "location and safety must be *visibly* checked at specified intervals". We asked the provider to send us training records for staff in relation to undertaking observations but this information was not provided.

We saw no evidence that, if staff restricted a person's freedom, they took part in post incident reviews or considered what could be done to avoid the need for its use in similar circumstances. We asked the provider to send us records of post-incident debriefing sessions for the eight weeks preceding our inspection and this information was not supplied.

People were not being kept safe from avoidable harm or abuse. We observed CCTV footage of a member of staff who appeared to be assaulting a patient. This was being investigated by the police. Another person raised significant concerns about their care with us and said they felt that the way staff treated them amounted to punishment.

Medicines management

The service did not take sufficient steps to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed incident reports which showed that one person had been involved in 38 incidents between 1 and 18 March 2023. They had been given medication as part of the management of 24 of these incidents. The dose and type of medication was not documented in 14 out of 24 incident reports and the notes of the last multi-disciplinary team review of this person's care did not show that this frequent use of 'as required' medication in response to incidents had been meaningfully reviewed.

Staff did not always review the effects of each people's medication on their physical health according to NICE guidance. One person's records showed that they were not receiving daily checks of their physical observations (such as blood pressure and temperature) in accordance with their care plan.

Track record on safety

Inadequate

Wards for people with learning disabilities or autism

People did not receive safe care because staff did not learn from safety alerts and incidents. The incident reports we reviewed (from 1 to 18 March 2023) showed repeated incidents involving the same person which usually resulted in the person being physically restrained, sometimes for lengthy periods of time. We asked the provider to send us records of post incident debriefs held in the eight weeks prior to our inspection and no records were submitted to us in response to this request.

Staff did not accurately record incidents and near misses to help keep people safe. We observed a bruise on one person's body. We reviewed the records of all the incidents this person had been involved in throughout March 2023 and none of the body maps included on the hospital's standard incident form template had been completed to show how this person had sustained an injury. Some carers also told us that their relative had unexplained injuries which staff could not account for. We observed an incident when someone became highly distressed and was physically restrained for a lengthy period. The retrospective record made by staff about the trigger for this restraint did not align with our inspector's observations or contemporaneous notes. The member of staff who was documenting the restraint on the person's care records had no means of telling the time (and so accurately documenting how long the person was being physically restrained for) other than continually asking our inspector. Another person had been involved in several incidents of aggressive behaviour towards staff in January 2023. Their risk assessment had been reviewed since then but did not accurately reflect the behaviours described in the incident reports.

The people we spoke with who had been involved in incidents, including when they had been physically restrained by staff, told us that they did not receive any support following the incidents. We asked the provider to send us records of post-incident debriefing sessions for the eight weeks preceding our inspection and no records were provided.

Is the service caring?

Inadequate

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

- People did not receive kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs.
- People did not have their communication needs met and information was not shared in a way that could be understood.
- We observed disproportionate use of restrictive practices including physical intervention. The provider was not taking sufficient action to review the use of restrictive practices at the service to try to reduce the use of these.
- People and those important to them, including advocates, were not actively involved in planning their care. People were not supported to use their preferred methods of communication to express their views about their care. When people did raise concerns about their care these were not always listened to and addressed in a timely manner.

Kindness, privacy, dignity, respect, compassion and support

Staff did not treat people with compassion and kindness. Prior to the inspection we received an audio recording of a person at the hospital in extreme distress. We reviewed the hospital's CCTV footage of this incident during the inspection, which showed multiple members of staff standing around the patient without any observable attempts to soothe or comfort them. Carers raised concerns about their relative's basic care needs not being met, for example not being supported to wear appropriate clothing or being provided with dietary options which met their needs.

Inadequate

Wards for people with learning disabilities or autism

During the inspection we observed a lengthy restraint of someone who was highly distressed. Most staff involved in physically restraining this person, including on the floor, were not observed to verbally communicate with the person in any way, touch them in a compassionate or soothing way or make any other observable attempt to comfort, soothe or distract the person. Multiple new members of staff came to participate in this restraint and only one of these individuals greeted the person by name. The others did not make any attempt to acknowledge or communicate kindly with them. We observed one member of staff laughing while the person was extremely distressed. Another person told us about a recent restraint when they had been in holds for a long period and staff had been laughing at them.

We observed CCTV footage of an incident where a member of staff appears to be deliberately assaulting someone using the service. Eight other members of staff can be seen on the CCTV footage observing the incident and not intervening to help the person. The CCTV footage of this incident also shows that, immediately prior to the incident, the person was seeking support from staff in predictable ways which were documented in their records, but staff did not respond in line with the person's care plan. This shows that staff did not understand people's individual needs or provide them with person-centred support. This incident was already being investigated by the police by the time we inspected.

Staff did not respect people's privacy and dignity. We observed multiple instances of people not being appropriately supported in relation to their privacy and dignity in accordance with their care plans during the inspection. This included entirely preventable incidents, for example due to male staff using a female ward as a short cut to access other areas of the hospital and male staff undertaking shadowing when this was an intrusion on the privacy and dignity of a female person using the service. We also observed staff talking between themselves about someone's personal care in front of them while making no attempt to include them in the conversation.

Staff did not use appropriate styles of interaction with people. We observed staff failing to use people's preferred communication methods, such as Makaton sign language and the Picture Exchange Communication System (PECS). We also observed staff failing to follow the guidance in people's positive behaviour support plans when they began exhibiting signs of distress or agitation. Staff were not attentive to people's emotional needs or sensory sensitivities. During an incident we observed there were alarms sounding. The person who was distressed was known to find high noise levels difficult and this was documented in their positive behaviour support plan. There were multiple staff who were not directly involved in the incident standing crowded round the person's bedroom door but none of these staff members silenced the alarm as part of the incident response.

Some of the people we spoke with said they did not feel valued by staff. Some people said they did not feel safe at the hospital and they did not trust the staff members. However, some other people said they felt the staff were ok and they did feel safe. Some carers told us they were concerned about their relative's safety at the hospital due to how they presented during phone calls, for example using words which the relatives knew were linked to serious distress for the person.

We observed some individual members of staff showing warmth and respect when interacting with people. However, we also observed some members of staff treating people with a lack of warmth and respect or even failing to interact with the person they were supporting at all. For example, one person was crying in their room while we were observing their care using the SOFI2 observation tool. Some of the staff who interacted with them did so in a positive and supportive way, but some staff did not interact with the person at all, including when the person attempted to communicate with them directly.

People did not have the opportunity to try new experiences, develop new skills or gain independence. We observed very little in the way of activities during the inspection. One person was supported to interact with some activities in their

bedroom, but this was only for a couple of minutes at a time and they spent most of the period we were observing their care in restraint holds. Some of the people we spoke with said they did not have anything to do at the hospital. Carers told us that their relatives were not supported to undertake activities they enjoyed and were not given enough support to attend pre-arranged visits with their families.

We did not observe staff supporting people to be independent and have control over their own lives to the greatest extent possible. Most of the people were in their bedrooms during our inspection, with at least one member of staff sitting at their door. When people came out of their rooms they were followed closely by staff due to the provider's policy of all people being on an enhanced level of supportive observations. Some people had multiple members of staff crowded round the doorway of their bedroom. Carers told us that their relatives were subject to unnecessary restrictions, such as not being allowed particular items in their rooms even though this was not a risk for them.

Involvement in care

People were not always listened to, given time or supported by staff to express their views using their preferred method of communication. We observed the care of people whose care plans included information on their preferred methods of communication, for example Makaton signing or PECS. We did not see staff consistently using these communication methods to communicate effectively with people and to give them time and support to understand their care and express their views and preferences. People who could communicate verbally told us that they felt staff did not listen to them when they did clearly express their views and preferences.

We observed some individual members of staff who appeared to have a positive rapport with people and who seemed to know people well. However, we also observed some staff who made no efforts to engage positively and meaningfully with the people they were supporting.

People did not always feel listened to and valued by staff due to a lack of meaningful engagement with them. Some of the people we spoke with said they had raised concerns about their care before but they had no confidence that anything would change for the better. Some people told us that they did not feel able to use their voices safely and they feared reprisal from staff if they raised any concerns about their care.

Staff did not inform or involve families and carers appropriately. The relatives and carers we spoke with told us that they did not get a lot of information from the hospital about their family member's care. Some people told us they were not permitted to go on the ward to visit their relative's bedroom.

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 **Regulation 9(1) Person centred care** We observed staff failing to use people's preferred communication methods, such as Makaton sign language and the Picture Exchange Communication System (PECS). We also observed staff failing to follow the guidance in people's positive behaviour support plans when they began exhibiting signs of distress or agitation. Staff were not attentive to people's emotional needs or sensory sensitivities. People who could communicate verbally told us that they felt staff did not listen to them when they did clearly communicate their views and preferences. We saw CCTV footage of a person who was seeking support from staff in predictable ways which were documented in their care plans but staff did not respond in line with the person's care plan, following which the person became distressed. We identified frequent use of 'as required' medication in response to incidents which had not been meaningfully reviewed at the last multi-disciplinary team review of the person's care. People did not have the opportunity to try new experiences, develop new skills or gain independence. We observed very little in the way of activities during the inspection. Some of the people we spoke with told us they did not have anything to do. People using the service and carers/relatives told us that they did not feel involved in their care and the records did not show evidence of meaningful involvement.

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 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulation 10(1) Dignity and respect

Prior to the inspection we received an audio recording of a person at the hospital in extreme distress. We reviewed the hospital's CCTV footage of this incident, which showed multiple members of staff standing around the patient without any observable attempts to soothe or comfort them.

We observed a lengthy restraint of someone who was highly distressed. The majority of staff involved in physically restraining this person, including on the floor, were not observed to verbally communicate with the person in any way, touch them in a compassionate or soothing way or make any other observable attempt to comfort, soothe or distract the person.

We observed one member of staff laughing while a person was extremely distressed and was being restrained. Another person told us about a recent restraint when they had been in holds for a long period and staff had been laughing at them.

We observed multiple instances of people not being appropriately supported in relation to their privacy and dignity in accordance with their care plans during the inspection. This included entirely preventable incidents, for example due to male staff using a female ward as a short cut to access other areas of the hospital and male staff undertaking shadowing when this was an intrusion on the privacy and dignity of a female person using the service.

We observed staff talking between themselves about someone's personal care in front of them while making no attempt to include them in the conversation.

Some of the people we spoke with said they did not feel valued by staff.

We observed some members of staff treating people with a lack of warmth and respect or failing to interact with the person they were supporting at all.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(a), (b) and (c) Safe care and treatment** We observed areas of the wards which were not clean, such as staining on chairs. On ward 2 a safety pod was being stored in the lounge which meant it was not fit for purpose as a communal area for patients. Staff had documented in incident reports that incidents had occurred due to a lack of sufficient staff to respond safely or staff failing to respond when help was called for. Staff did not have personal alarms. Staff members were allocated to carry out enhanced observations for lengthy periods of time which is not in accordance with NICE guidance and meant staff were not able to care for people safely. CCTV spot checks showed members of staff during multiple randomly selected night shifts who appeared to be asleep. We observed that one person remained in their room with the door shut for over an hour without a member of staff observing them. This person's observation prescription stated that they should be observed by direct eyesight every 15 minutes. People were not always receiving daily checks of their physical observations (such as blood pressure and temperature) in accordance with their care plan.

Regulated activity	Regulation
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 **Regulation 13(4)(b) Safeguarding service users from abuse and improper treatment** People's freedom was not restricted only where they were a risk to themselves or others, as a last resort or for the shortest time possible. People using the service were

This section is primarily information for the provider

Enforcement actions

continually observed by staff, often with multiple members of staff working directly with them. We observed staff crowding round people's bedroom doors when they were in their rooms, restricting their freedom of movement.

People were not restrained only where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest. Restraint was not always used in a safe and proportionate way. We saw no evidence that de-briefs took place following incidents, including those involving physical restraint.

We observed CCTV footage of a member of staff who appeared to be assaulting a patient. This was being investigated by the police. Another person raised significant concerns about their care with us and said they felt that the way staff treated them amounted to punishment.

Some people told us that they did not feel able to use their voices safely and they feared reprisal from staff if they raised any concerns about 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 **Regulation 17(2)(a), (b) and (c) Good governance** Staff were not always able to access people's records. Risk assessments and care plans were kept in the office and only qualified staff had keys to access these. Some staff did not know where records such as risk assessments were when we asked for these. Support staff did not always have information to refer to while working with people, for example in relation to their preferred methods of communication. Staff did not always keep accurate records, for example we reviewed the record of an incident we observed and the documentation of this did not align with the observations of our inspector.

This section is primarily information for the provider

Enforcement actions

Risk assessments and positive behaviour support plans were not being reviewed in a timely manner following incidents.