Jeesal Akman Care Corporation Limited

Jeesal Cawston Park

Inspection report

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Date of inspection visit: 24 and 25 March 2021
Date of publication: 28/05/2021

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

Ratings

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

Summary of findings

Overall summary

We expect Health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, 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 or autistic people.

The paragraph below was added as a revised section of the report following the completion of enforcement action so it clear to the public what action had been taken following this inspection.

We took enforcement action against the registered provider to remove the services registration - this meant they would not be allowed to continue to provide a service after a specified date. This decision was made due to continued serious concerns about the quality of service provision. In response to this action the provider decided not to appeal the notice and agreed to close the hospital. Irrespective of the hospitals decision, we served the Notice of Decision to close the hospital using our civil powers to ensure that the closure took place without delay.

The enforcement action undertaken limited our overall rating of this location to inadequate.

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

- The service could not show how they met the principles of Right support, right care, right culture. People were not being kept safe from avoidable harm because there was not enough suitably trained staff to keep people safe and incidents continued to recur.
- People continued to receive care that did not meet their needs and was not always compassionate or kind. The service did not have a clear model of care, and did not have the required specialists and therapies suitable to meet the needs of people with learning disabilities and/or autistic people to ensure they did not spend longer than necessary in hospital. However, the provider told us that activities had been limited by the COVID-19 pandemic.
- Leaders had failed to ensure the service improved and governance systems and processes were ineffective in identifying, managing and mitigating risks and improving the quality of the care provided. There was insufficient oversight of restrictive practice.
- We also identified issues with the monitoring of the effect of medicines on people's physical health, issues with long term segregation and policies that were not in line with national guidance.

However:

- The care environments were clean and well maintained, people's views were recorded in their care plans and information was available in accessible formats.

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 	Our rating of this service went down. We rated it as inadequate because: • We took enforcement action against the registered provider in relation to the concerns that we identified during this inspection. This limits our rating of the service and all the five key questions to inadequate. • The provider failed to submit data in relation to several of our requests. The lack of assurance increased concerns about the providers ability to provide safe care and treatment and it was necessary to liaise with other stakeholders to gain the necessary assurances. • We served a Notice of Proposal to close the service. The hospital decided not to appeal the notice and this then became a Notice of Decision to close the hospital. Following our inspection and enforcement action, the provider agreed to close the hospital. All people in this service were discharged or transferred to an alternative hospital and closed on 12 May 2021. • People were not being kept safe from avoidable harm, abuse and poor care. The service did not have sufficient, appropriately skilled staff to meet people's needs and keep them safe. There were also issues with ligature risk assessments containing inaccurate information. • Staff did not always monitor the effect of medicines on people's physical health, medicines records were incomplete, and staff did not always follow prescribing instructions. People were not always supported to lead healthy lifestyles. • Staff did not support people through recognised models of care and treatment for people with a learning disability or autistic people. People's length of stay was high. • People did not receive care, support and treatment that met their needs and aspirations. Care lacked a focus on people's quality of life and did not follow best practice.

Summary of findings

- The service did not have all the specialists required to be able to provide effective care and treatment and meet people's needs.
- People only had access to a limited range of activities that were mostly self-directed and were not part of planned therapy or care to support them to achieve their goals or discharge.
- People did not always receive kind and compassionate care from staff. Staff did not always protect and respect people's privacy and dignity or understand each person's individual needs. People's human rights were not always upheld.
- Although people's care, treatment and support plans reflected their needs, these were not always followed by staff in practice.
- Although people's risks were assessed regularly, staff were not proactive in preventing further incidents and people were not involved in managing their own risks.
- The provider did not have a restrictive practice reduction programme or sufficient oversight of restrictive practice and the use of physical restraint was increasing.
- Clinical and quality audits were not effective in identifying risks or evaluating the quality of care and did not lead to improvements in the service.
- Carers were not always actively involved in planning people's care and did not always receive communication.
- Independent external reviews of long term segregation did not take place every three months and one person's long term segregation was not in line with the Mental Heath Act code of practice. There were also delays in requesting second opinion appointed doctors.
- People were not receiving active, goal oriented treatment. Although people had clear care plans in place, there were issues with the effectiveness of discharge planning to support people to return home or move to a community setting.
- Leadership and governance processes were not effective and did not ensure the service kept people safe, protect their human rights or provide good care, support and treatment. The service was not effectively working to develop and

Summary of findings

improve the service. The provider had not ensured its policies followed national guidance in relation to infection prevention and control, observation and visiting.

However:

- People's care and support was provided in a well equipped, furnished and well maintained environment which met people's sensory and physical needs.
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- People's views were recorded in their care plans and information was shared in a way that could be understood through easy read formats.
- Apart from the issues identified around long term segregation, 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.

Summary of findings

Contents

Summary of this inspection

Background to Jeesal Cawston Park

Jeesal Cawston Park was provided by the Jeesal Akman Care Corporation Limited. It was an independent mental health hospital for adults with learning disabilities and/or autistic people.

Jeesal Cawston Park was registered to provide the regulated activities assessment or medical treatment of persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury. The hospital had a registered manager.

Although the location had 54 beds, this location had a registration condition which the provider agreed via the tribunal process in 2020, to provide regulated activities to a maximum of 12 people.

At the time of our inspection, there were eleven people receiving care and treatment at Jeesal Cawston Park. Although, one person was not staying at the hospital because they were in the process of transitioning to another service as part of their discharge.

At the time of our inspection, people were being cared for in:

A main ward called the Lodge that had 14 beds and accepted both males and females.

Two smaller bungalows called Manor Lodge and Yew Lodge. Both bungalows had three self-contained flats.

There were five patients staying on the Lodge, three patients were staying at Yew Lodge and two patients were staying at Manor Lodge.

The location had other properties which had been de-commissioned, therefore we did not visit these at part of this inspection.

We have inspected this location 15 times since it became registered with the CQC in 2011.

The location has a history of non-compliance to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have inspected this location seven times previously in the last three years. At all those inspections the provider was in breach of the regulations.

Jeesal Cawston Park has been in special measures since 2019. In our previous inspections, we used our civil enforcement powers to take enforcement action against the provider due to failures to meet the regulations.

At this inspection, we found the provider was unable to demonstrate improvements despite caring for a significant reduction in the number of people being cared for by the service.

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed conditions on the provider's registration. We also issued a Notice of Proposal to close the hospital which was not appealed and became a Notice of Decision requiring the hospital to close.

Summary of this inspection

Following our inspection and civil enforcement action, the provider agreed to the closure of the hospital. All people were discharged from the service by 12 May 2021.

What people who use the service say

As part of our inspection we spoke with four people who were staying at the service and eight carers. They gave mostly negative feedback about the service.

All the four people using the service told us that they did not like being around the other people that were also staying at the service. On the Lodge, they said this was because they preferred having their own space. On Manor and Yew Lodges, this was because they felt the people staying there all had different needs. They told us they found it difficult to get along with the other people staying in the same place. One person told us this made them feel very isolated, particularly during the pandemic restrictions where the mixing of people had reduced and opportunities to go out had decreased.

All four people that we spoke to told us that they had been at this hospital for a long time. Two people told us that they were bored at the hospital because there was not much to do.

Two people told us that they were experiencing pain. One of these people had toothache for over three months. We report on this in further detail later in our report.

However, one person told us that staff had provided them with bereavement support and two people told us that they had a positive relationship with some staff.

All carers told us that during the COVID-19 pandemic lockdown restrictions they had to maintain contact with people by telephone, video calls and/or letters. They had not been able to visit people in person due to a blanket restriction on visiting. However, in between the different lockdowns there had been some visits permitted in person.

Four carers told us that activities were limited to things such as: music, colouring, jigsaws and walking.

Four carers raised concerns about staff not providing kind and compassionate care. Two carers of one person raised concerns about incidents that resulted in a person being injured. This was subject to a safeguarding investigation. They felt that staff had provoked the person prior to the incident. One carer told us that their relative felt threatened by larger build male staff that worked at the service and another carer reported an incident where staff were brusque with a person they cared for.

Two carers told us that they had concerns about people gaining weight since their admission to Jeesal Cawston Park. One of these people had developed type two diabetes during their stay.

Two carers told us that people's belongings had gone missing from the service.

Two carers told us that people had to ask staff for toilet paper. This restriction was not due to their individual risks.

Two carers told us that there was a lack of communication and involvement from staff. One carer told us their views were not listened to.

Summary of this inspection

However, one carer told us that communication was good and they were involved in people's care plans and two carers told us that on the whole staff were respectful.

How we carried out this inspection

Our inspection team comprised one lead CQC inspector, one team CQC inspector, one medicines inspector, one specialist advisor who was a registered nurse and one expert by experience.

All members of the inspection team had specialist experience in learning disabilities and autism.

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.

During our inspection, we:

- Toured the care environments and observed how staff were caring for people.
- Received feedback from eight carers and/or relatives of people who were staying at the service.
- Spoke with four people who were using the service.
- Received feedback from the independent advocate working with people in the service.
- Interviewed three leaders of the service including the chief operating officer who was the registered manager, the deputy hospital director and the clinical general manager.
- Interviewed 13 other staff including: the consultant psychiatrist, clinical psychologist, social worker, a physical health nurse, a registered nurse, a nurse practitioner, a senior support worker, support workers, the quality improvement and audit manager and the head of training and staff development.
- Observed two meetings including one multi-disciplinary team meeting and one Covid 19 meeting.
- Reviewed five care records.
- Completed a review of two episodes of long term segregation and one episode of seclusion.
- Reviewed three staff files.
- Completed a specific check of medicines management.
- Reviewed a range of documents and policies in relation to the running of the service.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider 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 three legal requirements.

- The service must ensure that care environments are assessed, and prompt action is taken to manage and mitigate safety risks (Regulation 12).
- The service must ensure that there are enough suitably qualified and trained staff to provide safe care and treatment and meet people's needs. This must include an effective system to assess and monitor the number of staff to keep people safe (Regulation 12).

Summary of this inspection

- The service must ensure that all policies and procedures are in line with national guidance and relevant guidance from the National Institute of Health and Care Excellence (Regulation 17).
- The service must ensure that there are effective systems and processes to assess, monitor and mitigate risks and improve the quality of the service. (Regulation 17).
- The provider must ensure that the care of people is appropriate, meet their needs and reflects their preferences (Regulation 9).
- The service must ensure that physical health monitoring after the use of rapid tranquilisation is completed in line with national guidance (Regulation 12).
- The service must ensure that all physical health checks for people on High Dose Antipsychotic treatments are completed in line with national guidance (Regulation 12).
- The service must ensure staff follow the prescribing instructions when administering medicines (Regulation 12).
- The service must ensure that care and treatment complies with the Mental Health Act and the Mental Health Act code of practice 2015 (Regulation 17).

Action the service SHOULD take to improve:

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

- The service should ensure that staff receive the mandatory training.
- The service should ensure that requesting a second opinion appointed doctor is not delayed.
- The service should ensure that the administration and outcomes of when required (PRN) medicines are recorded consistently and accurately in care records.
- The service should review the design and layout of the service.

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 stayed the same. We rated it as inadequate because:

- People were not being kept safe from avoidable harm in this service. We have taken enforcement action against the registered provider in relation to concerns about safety in this service. This limits our rating of this key question to inadequate.
- People's care and support was not always provided in a safe environment. The risk assessment of ligature anchor points incorrectly stated that the risks of ligature anchor points were mitigated because staff were always observing people. A ligature point is anything which could be used for the purpose of hanging or strangulation. Some people did not have staff with them all the time. In addition, on eight out of 32 night shifts, people's observations were reduced due to staff shortages which meant they did not always have staff with them. This meant that the risk assessment was not accurate. The actions that the provider had determined were necessary to mitigate ligature risks were not being implemented and people were at risk of harm.
- Staff had not identified a safety risk that we identified in the seclusion room on the Lodge. There was a Perspex covering over the toilet flush which was sharp and could have been used by someone to harm themselves and/or as a ligature anchor point. We raised this during our inspection and the maintenance team completed work to reduce this risk.
- The provider had not implemented a bare below the elbows policy in clinical areas which was not in line with the Public Health England Covid 19: infection prevention and control for mental health and learning disabilities settings guidance. This meant that they had not taken all practicable steps to minimise the potential risk of transmission of COVID-19 and/or other infections.
- The service did not have enough staff, who knew the people and had received the relevant training to keep them safe. It was not clear how the provider had determined the number of staff to keep people safe and to meet their needs. There was no set minimum number of registered nurses required for each shift and ward. The Resuscitation Council UK, National Patient Safety Agency and National Institute for Health and Care Excellence recommend that all clinically trained staff (nurses and doctors) who deliver or are involved in rapid tranquilisation, physical restraint and seclusion are trained in immediate life support and rotas should ensure 24/7 immediate access to immediate life support trained staff.
- When we visited the service on 24 March 2021 at night, the service had one registered nurse on duty for Lodge and Manor and Yew Lodges and they would not be able to attend the Manor and Yew Lodges quickly in a medical emergency. Twenty five out of 88 shift logs reviewed showed the hospital did not have the number of staff the provider

told us was needed to keep people safe. Five of these shifts did not have a registered nurse on duty at the Lodge and another at Manor and Yew Lodges for the whole shift. In addition, on eight out of 32 night shifts, people on the Lodge had their observation levels reduced because of staff shortages. Between 01 October 2020 and 24 March 2021, 16% of shifts were covered by agency staff and 11% of shift were covered by bank staff in this period.

- The provider did not ensure that there was immediate access to staff trained in immediate life support 24 hours per day. Training data did not include immediate life support. The provider told us that all staff had completed Emergency First Aid at Work and 25% of staff had completed extended Emergency First Aid at Work. After our inspection, the provider told us that 60% of registered nurses and support workers were trained in intermediate life support but there was no evidence of this provided. It was unclear whether this met the training standard developed by the Resuscitation Council UK. From November 2018 to the time of our inspection, there had been three medical emergencies that had resulted in the deaths of three people.
- The provider failed to respond to our requests for data on staffing. We were unable to review data in relation to staffing in the following areas: the number of shifts not filled by bank or agency staff, staff sickness rates, staff turnover rates and the number of times that Section 17 leave was cancelled due to staff shortages as the provider did not submit data in response to the request.
- There were two out of 21 training elements deemed mandatory by the provider that were not up to date. These were widget at 49% and effective communication at 72%. Widgets are easy to read and understand symbols that present written words.
- People were not involved in managing their own risks. There was no evidence that people were involved in any of the risk assessments in the four risk assessments reviewed.
- The service did not always keep people and staff safe. The service did not have a good track record on safety and had not managed patient safety incidents well previously. Although risk assessments were comprehensive and updated in response to incidents, staff did not anticipate and manage risks well. Incident reports showed evidence that similar incidents recurred which meant that lessons were not being learnt and people were at risk of avoidable harm because effective action was not being taken. Examples of this included people damaging the environment and using this to try and harm themselves.
- The service's policy and practice in relation to observation did not follow best practice guidance. The duration of continuous observations without regular breaks was in excess of the two hours recommended by the National Institute for Health and Care Excellence NG:10 Violence and aggression: short-term management in mental health, health and community settings guidance. This meant that the quality of the care provided was at risk because staff were not taking regular breaks.
- The use of physical restraint on people had increased. From 01 January to 23 March 2021, there were 638 incidents of physical restraint. This was a 30% increase in the use of restraint on a patient cohort of 10 people compared with the 489 physical restraints on a patient cohort of 14 people over a three-month period at our last inspection. Incidents reports showed that restraint was used in situations where people were a risk to themselves or others and for the shortest time possible. There were no incidents of prone restraint.
- The provider did not have a restrictive intervention's reduction programme. There was a reducing restrictive practices policy and procedure in place. However, there was no strategy to support reducing the use of restrictive interventions.
- The service did not have a system or process to assess and identify blanket restrictions on people's freedoms including those that would be appropriate for a hospital ward. This meant that there was a risk that blanket restrictions could be implemented without detection, appropriate authorisation or review. However, apart from two people being restricted access to toilet paper, we did not identify any other inappropriate blanket restrictions in operation.
- People were not always safe from abuse and neglect. At the time of our inspection, there were two incidents of unapproved restraint under investigation that occurred between February and March 2021. It had also only come to light in early 2021, that a person was assaulted by a member of staff shortly before a serious incident in July 2020. This was under police investigation at the time of our inspection. In addition, we also identified poor care and treatment during our inspection that had not been reported to, recognised or addressed by the provider. This meant that the safeguarding systems and processes were not effective in ensuring people were safe from abuse and neglect.

Inadequate

Wards for people with learning disabilities or autism

- People were not always being kept safe from the potential side effects of medicines on their health and well-being. One person had not had their physical health monitored in line with their care plan or the provider's policy to monitor the effects of high dose anti-psychotics. In September 2020, there were concerns from the result of a blood test. A further blood test was completed in November 2020 however, there was an issue with the sample so the results could not be obtained. There had been no further blood tests completed. There had been not been an electrocardiogram completed since August 2020. In two out of three uses of rapid tranquilisation, there were gaps in the post administration physical health monitoring.
- Staff did not always record the reason for administering or the effect of as and when required medicines and rapid tranquilisation in people's records.
- Staff did not always follow the prescribing instructions for as and when required medication. There were six occasions where staff had administered a medication that should have been a second line medication before the first line medication. There was no record as to the rationale for staff not following the prescribing instructions.

However:

- People's care and support was provided in a clean, well equipped, furnished and well-maintained environment. The environment was low arousal to meet people's sensory and physical needs. The service complied with guidance on eliminating mixed sex accommodation.
- People's care records were accessible to staff, and the system ensured it was easy to maintain high quality clinical and care records. These were mostly electronic records.
- Apart from the medicines issues identified above, staff mostly followed systems and processes to safely prescribe, administer record and stored medicines. People received the correct medicines at the right time. Staff were aware of the STOMP (stopping the over-medication of people with a learning disability, autism or both) principles and followed these. Medicines to manage behaviour were used infrequently. As and required medicines (PRN) and rapid tranquilisation use was low and variable doses tended to be given at the lowest available dose. This was in line with the STOMP principles.

Are Wards for people with learning disabilities or autism effective?

Inadequate

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

- People in this service were not receiving effective care and treatment. We have taken enforcement action against the registered provider in relation to concerns about the effectiveness of this service. This limits our rating of this key question to inadequate.
- Although care and support plans were personalised, holistic and reflected people's needs and aspirations, these did not reflect the care that staff delivered to people in practice. Our observations showed that staff did not always follow people's care plans and provided care that was not always kind and compassionate and that disregarded people's needs.
- Care and treatment did not focus on people's quality of life outcomes and did not meet best practice. Daily activity plans showed that people were not accessing any recognised and/or structured therapies and activities were limited. The daily routine for all people was the same which was not person centred. Activities included: walking, going out on a bus ride, watching TV, woodwork, art, drama, cycling, sensory room, listening to music and feeding the peacocks and ponies. Most of these activities were self-directed by people and were not an organised activity as part of a plan to achieve a goal and/or develop a skill, or as part of a discharge plan. However, the inspection took place during the COVID-19 pandemic lockdown restrictions and this may have impacted on the activities available in the community.

Inadequate

Wards for people with learning disabilities or autism

- Care and support was not always provided in line with people's positive behaviour support plans. We observed care to one patient where staff did not follow the strategies in the person's positive behavioural support plan. This care was not compassionate and did not meet the person's needs.
- Although support with self-care and everyday living skills was available to people who needed it activity plans contained punitive language including some people having to "pass a mood assessment" in order to do things such as having a bath rather than a shower, to be able to prepare food, to take part in cleaning and going out on the bus. The requirement for a mood assessment was not clearly based on individual risks and there was no formal mood assessment. This meant that there was a risk that this could be used inconsistently by staff, open for punitive use and people would not be clear about what the expectations were for them.
- People did not always have access to good physical healthcare and were not always supported to live healthier lives. We identified issued with physical health monitoring in relation to the effects of medication on people's health and well being. Staff had not taken proactive action to ensure a person received timely dental treatment and they were in pain for over three months. Records reviewed showed that two people had a diet plan in place because they were overweight. One of these people had gained 18kg since their admission in 2018 and one person had developed type two diabetes since their admission. Two carers told us that they were concerns about people gaining weight since their admission to the service.
- People's outcomes were not consistently monitored using a recognised outcome rating scale. Although initially completed, staff did not repeat the outcome rating scale which meant that it was not possible to assess people's progress and outcomes over time.
- There was no evidence of functional assessments for people who needed them. Although meetings took place daily to discuss incidents, there was limited evidence that staff took the time to understand people's behaviours.
- Staff did not participate in any benchmarking and quality improvement work to understand and improve the quality and effectiveness of care.
- Although there was a clinical audit programme in place, this was not effective because it did not identify issues in the safety, effectiveness or quality of care and did not lead to improvements.
- People were not supported by a team of staff from a range of disciplines. The previous occupational therapist and speech and language therapist had left. There was sessional speech and language therapist support however, no one was receiving speech and language therapy. Although a psychologist was in position, they were working remotely and were not providing any direct therapy with people. The social worker was due to leave shortly after our inspection. This meant that people were not able to access the range of therapies to support their care and treatment to ensure they received effective care and their length of stay in hospital for the shortest time possible.
- We were unable to determine whether staff received regular supervision and appraisal because the provider did not submit any data in response to our request.
- Staff did not receive training in Autism and this meant that they may not have the knowledge and skills required to support autistic people well. However, people received care from some staff that had received training in Makaton, signalong and mental health first aid.
- Staff did not always follow the Mental Health Act code of practice 2015 in relation to long term segregation. Two people were being cared for in long term segregation and the provider had not ensured that there had been independent external reviews of their segregation since September 2020. The Mental Health Act code of practice 2015 states that this should be completed every three months. This meant that opportunities to ensure that the long term segregation remained appropriate were missed. The service was continuing with the segregation of one person because there had not been additional funding agreed to enable more staff to reduce these restrictions. There was a lack of clarity from the provider about what hours of staffing were required and what this would be used for which was delaying this decision. This person's long term segregation care plan was not in line with the Mental Health Act code of practice 2015.
- There was sometimes a delay in requesting a second opinion appointed doctor (SOAD) when a person's treatment needs had changed.

Inadequate

Wards for people with learning disabilities or autism

However:

- There had not been any admissions to the service since 2018, so we did not assess the admission assessment process.
- People had an annual health check completed by their GP and there was evidence people were accessing routine health checks including, cervical screening.
- Managers provided an induction programme for any new or temporary staff.
- Apart from the concerns relating to long term segregation identified, staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. People were informed of their rights at regular intervals and staff recorded their understanding, people had section 17 forms in place for leave authorised by their responsible clinician. Staff completed capacity assessments and consent to treatment documents in line with the Mental Health Act.
- Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Standards. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions. Care records contained evidence of mental capacity assessments and best interest decisions made in line with legislation and guidance where this was appropriate.

Are Wards for people with learning disabilities or autism caring?

Inadequate

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

- People received care that was not always kind or compassionate and disregarded people's needs. We have taken enforcement action against the registered provider in relation to concerns about how people were being cared for in this service. This limits our rating of this key question to inadequate.
- One person spent over three months with tooth pain because staff did not follow the care plan in place, and they were not proactive in ensuring timely care treatment. Although, an initial dental examination in December 2020 had identified a tooth extraction was required and regular pain relief had been prescribed, pain relief was insufficient and there was no date for this procedure. The person's care plan stated that staff should seek medical advice if pain continued or if there was any swelling. Records also showed discussions with relevant external professionals. However, staff failed to raise issues about ongoing pain and did not take proactive action to ensure timely treatment.
- Another person was not supported in line with their care plans and was left by staff in distress and pain to self soothe. The person's positive behavioural support plan provided specific person-centred techniques for staff to use to support the person when they reported pain and asked for PRN medication. We saw that staff did not attempt to use any of these techniques and instead staff made no attempts to alleviate the persons anxiety or physical discomfort. There was no evidence of any physical examination or observations completed by staff and the registered nurse told the person they could not have any medication but did not explain why.
- People were disrespected by staff, including senior staff. Some staff walked straight into people's bedrooms and flats without knocking. We saw people were not always greeted or acknowledged by staff, staff spoke directly to each other and did not involve people even when it was relevant and appropriate.
- Four out of the eight carers we spoke with raised concerns about staff not providing kind and compassionate care. These included concerns about incidents that resulted in injuries to a person, staff provoking a person, a person feeling threatened by larger build male staff and an incident where staff were brusque with a person. These concerns had been reported to and investigated by the commissioners, safeguarding and/or the police.
- Staff did not always protect people's privacy and dignity. Two carers told us that people had to ask staff for toilet paper. This restriction was not required to mitigate people's risks.

Inadequate

Wards for people with learning disabilities or autism

- Staff did not always maintain contact and share information with those involved in supporting people, as appropriate. Two carers told us that there was a lack of communication and involvement from staff and one carer told us their views were not listened to. However: one carer provided positive feedback about communication and was involved in developing a person's care plan.
- The service did not follow the national guidance on visiting to support people to maintain links with those that were important to them. During the COVID-19 pandemic lockdown restrictions, carers maintained contact virtually and were not able to visit the service. This was not in line with guidance that permitted visits to continue for people with learning disabilities and autistic people during the pandemic restrictions. However, in between the lockdowns some visits took place in person.
- People were not always enabled to make choices for themselves and supported to fully understand and control their treatment and support. People had limited choice about activities and therapies available to support them to progress in their care and treatment. Daily activity plans showed routines that were the same for all people. These were not person centred and some were written in a punitive way. This included some people having to "pass a mood assessment" in order to do things like have a bath or clean their sleeping area. This was not positive or proactive care.

However:

- People had easy access to independent, good quality advocacy. People took part in planning their care. Staff recorded people's views in their care plans.
- Although we observed poor care being provided, we also observed some positive interactions between people and staff. These interactions showed that some staff were friendly and clearly knew people and their needs well. Two people also told us that they had a positive relationship with some staff and two carers told us that on the whole staff were respectful.
- In a survey completed in March 2021, people reported that they had been able to speak to their relatives and friends if they had wanted to.

Are Wards for people with learning disabilities or autism responsive?

Inadequate

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

- People were not receiving care that was responsive and that met their needs in this service. We have taken enforcement action against the registered provider in relation to concerns about the responsiveness of this service. This limits our rating of this key question to inadequate.
- This service did not work to a recognised model of care and the care and treatment provided fell far below the minimum standards expected of a specialist hospital for people with learning disabilities and/or autistic people. Senior leaders told us that the hospital needed to develop an effective model of care. At the time of our inspection, the registered manager told us the service was operating as a locked rehabilitation type of service (which are also known as high dependency rehabilitation services). However, there was no clear standard operating procedure or service specification that outlined this. The delivery of the service was not in line with high dependency rehabilitation services because the service did not have a team that included or provided access to the full range of specialists required to meet people's needs. There were also no recognised therapies being delivered and the activities available were limited and fell below the standards expected in a specialist hospital. This meant that people were not receiving care that was responsive to their needs to ensure their stay in hospital was for the shortest time required.
- People stayed in this hospital for a long time. There had been no new admissions to the service since 2018. Following our last inspection, we took civil enforcement action against the provider and the registered provider agreed to reduce

the number of people being cared for at the hospital from 57 down to a maximum of 12 people. At the time of our inspection, the hospital had eleven people admitted to the service. The longest length of stay was nine years and seven months and the average length of stay of current people was 6.76 years. This is a significantly higher length of stay than what would be expected for this type of hospital.

- Not all people had discharge plans with clear timescales in place to support them to return home or to move to a community setting. The provider reported that there was one delayed discharge due to delays in building works at a community placement. None of the four care records reviewed contained adequate discharge plans. One person had a discharge plan to stay in Yew Lodge until the hospital had de-registered from being a hospital into an adult social care location. This meant that the patient was staying inappropriately in hospital for longer than needed. There was no timescale for the provider to make any changes to the service they were providing and it was not clear if this would meet the Right Care, right support, right culture guidance. Another person was being cared for in continuing long term segregation because funding to support the end of their segregation had been delayed. Staff had also informed external professionals at the last care programme approach meeting that this person would not be ready for discharge for a year however, there was no clear rationale or indication of the care and treatment required during these 12 months. Two people had discharge plans that did not contain any timescale for discharge. For one of these people, it was not clear what the goals were, and the therapies would support this.
- The service's design and layout did not always support people's care and support well. Manor and Yew Lodges consisted of self-contained flats, a corridor and a nurses' office. This meant that there was no communal space for people to interact with each other. People staying in Manor and Yew Lodges had also a range of different needs and abilities.
- People's communication needs were not always met because staff did not always follow people's care plans when supporting people.
- We did not see any evidence of how the provider learned from complaints. However, between 1 September 2020 and 24 March 2021 there had been two complaints received. One of these complaints was ongoing and one was not upheld. For the same period, the provider reported they received 16 compliments.

However:

- However, one person was on extended section 17 leave to a community placement.
- Each person had their own bedroom with an en-suite bathroom. People could personalise their room and keep their personal belongings safe.
- Although people were not always supported to maintain a healthy weight, the service provided people with a choice of good quality food. People could access drinks and snacks at any time unless staff had completed assessments and care plans imposing restrictions due to individual people's needs.
- Staff helped people with advocacy, cultural and spiritual support.
- People had access to information about their rights in appropriate formats including easy to read format.

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

Inadequate

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

- We have taken enforcement action against the registered provider in relation to concerns about leadership and governance in this service. This limits our rating of this key question to inadequate.

Inadequate

Wards for people with learning disabilities or autism

- The provider has a long history of non-compliance with the regulations and this location has been in special measures since 2019. Following previous civil enforcement action, we agreed to a consent order at tribunal to reduce the number of people being cared for in this service from 57 to a maximum of 12 people. Despite the significant reduction in the number of people being cared for in this service, the provider had not been able to demonstrate improvements. We also identified serious quality and safety concerns at this inspection.
- Our findings from the other key questions showed that governance processes were not effective and did not keep people safe, protect their human rights and ensure people received good quality care and support.
- Despite long standing risks, issues and concerns in this service, leaders did not have a good understanding of the current performance of the service or the quality and safety risks including those that we identified during our inspection.
- The provider failed to respond to several of our requests for data to support the inspection process which meant we could not assess the provider's performance in several areas.
- The service did not have an effective model of care based on best practice guidance. At the time of our inspection the provider intended to continue to operate, however they did not have a clear vision for the service or an improvement plan with any timescale.
- Staff did not always demonstrate the provider's values in practice. We observed poor care and feedback that raised concerns about how people were treated by staff in this service.
- Although staff reported that they were able to raise concerns without fear of retribution, there were several concerns about the care and treatment provided to people that staff had not identified as a concern and had not reported.
- There were limited opportunities for career progression for staff.
- The service did not engage in any local or national quality improvement activities or accreditation schemes.

However:

- Staff reported they felt respected, supported and valued and that leaders were visible.
- Staff had the information they needed to provide care and treatment.

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 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 Governance systems and processes were ineffective in ensuring the service was safe and the quality of the service improved. Long term segregation did not comply with the Mental Health Act and the Mental Health Act code of practice 2015. The providers policies did not always follow national guidance and relevant guidance from the National Institute of Health and Care Excellence.

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 service did not have enough staff that have received the relevant training to keep people safe. There was no effective system in place to assess and monitor the number of staff required to keep people safe. Ligature risk assessments were inaccurate and we identified a safety risk that had not been identified. People were not always been kept safe from potential side effects of medication on their physical health. Staff did not always follow prescribing instructions when administering medicines.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People were not always receiving care that was appropriate, met their needs and reflected their preferences.** **Staff did not always provide people with kind and compassionate care.**

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	S17 Notice of Decision to cancel registration A Notice of Decision was served to close the service as a result of ongoing failures by leaders to provide a service to people with a learning disability and/or autism across all CQC domains of safe, effective, caring, responsive and well led which is evidenced in this and previous inspection reports.