The Breighmet Centre for Autism

Quality Report

The Breightmet Centre for Autism
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Date of inspection visit: 06/06/2019, 14/06/2019, 20/06/2019
Date of publication: 02/12/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Inadequate
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

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

Professor Sir Ted Baker
Chief Inspector of Hospitals

Overall summary

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 urgent and immediate action against the provider.

We have imposed the following conditions on the provider's registration:

1. For six months commencing 1 November 2019, the registered provider must not admit more than one new patient every three weeks, subject to a maximum number of twelve patients being placed at the Breightmet Centre at any one time.

2. The registered provider shall, until the CQC considers it no longer necessary, submit a monthly report to the CQC on governance systems and processes that it has put in place, and/or any changes in such systems or processes that it has implemented, to ensure that care and treatment for each patient is safe, effective and responsive to their needs.

3. By the end of April 2020, the registered provider shall report to the CQC, using an appropriate quality audit toolkit, on the views of families, staff and other stakeholders on the quality of the service being provided.

4. The registered provider shall, until the CQC considers it no longer necessary, submit a monthly report to the CQC providing details of the risk assessments and care plans for all newly admitted patients.

We rated Breightmet Centre for Autism as **inadequate** because:

- Safety was not a sufficient priority with monitoring of safety not adequate. The care premises, equipment and facilities were unsafe. There were significant environmental concerns in this service, with broken furniture and fixings that placed patients at risk of harm. The foam padding in some furniture was exposed. This presented an infection control risk. Walls and flooring were damaged with holes and cracks present in a number of patient bedrooms. There were urine splash marks in one bathroom and staining on the toilet and walls. In one ward, half eaten food including hot dogs and pizza had been left out in the dining area.
- Substantial or frequent staff shortages or poor management of agency or locum staff increased risks to people who use services. Staff did not assess, monitor or manage risks to people who use the services. Opportunities to prevent or minimise harm were missed. This had led to incidents in which preventable harm to individuals had occurred.
- Effective governance systems were not in place to ensure that all policies and procedures were adhered

Summary of findings

to by all staff working at the hospital. Systems and measures put in place to improve some areas of practice were ineffective and not being maintained and kept up to date to ensure effectiveness.

- Patients did not have their rights protected. Patients received care from staff who did not have the skills or experience that was needed to deliver effective care. Staff could not develop the knowledge, skills and experience to enable them to deliver good quality care.
- People's privacy and dignity was not respected. Their basic needs were not met with the hygiene and cleanliness needs of patients not consistently being met. At the time of our visits, two patients were dressed in soiled clothing and one patient had very unclean feet. People did not know or did not understand what was going to happen to them during their care. People did not know who to ask for help. They were not involved in decisions about their own care or treatment.
- Patients did not feel cared for and the feedback about staff interactions was negative.
- Patients did not find it easy to, or were worried about, raising concerns or complaints. When they did, they received a slow or unsatisfactory response. Complaints were not used as an opportunity to learn.
- The facilities and premises used were inappropriate with very little furnishings present in most rooms. The limited activities present did not meet people's needs.

However:

- Positive behavioural support plans were individualised. Staff developed individual care plans, which contained positive behavioural support plans. Care plans were personalised and included the voice of the patient.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Inadequate

The Breightmet Centre for Autism

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Background to The Breighmet Centre for Autism

The Breightmet Centre for Autism was an independent hospital run by ASC Healthcare Limited. It was situated in the Breightmet district of Bolton, Greater Manchester, at the time of inspection the provider was registered to provide the following regulated activities from this location:

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

The centre provided enhanced services and support to adult patients with a learning disability or autism, who were either detained under the Mental Health Act or admitted informally. The hospital took admissions from across the country.

The registered manager had left the service in April 2019, and the service was being managed by the provider's Chief Executive on an interim basis.

The accommodation was divided into five separate wards which were referred to as apartments. These included four multi occupancy apartments and a single occupancy standalone apartment. They were located over two floors. The four multi occupancy wards consisted of four or five single bedroom suites with full ensuite facilities and a shared communal lounge, a dining room, a quiet room and access to an outdoor area. The wards linked to the main annex which contained staff offices, a library, a kitchen and a family visiting room.

At the time of our inspection, there were sixteen patients living at the hospital. The four female patients were residing on two of the wards with male patients on the other three.

- The Breightmet Centre for Autism registered with the CQC in August 2013. There have been five previous inspections carried out at the centre. These include four routine inspections in September 2013, January 2014, July 2015 and May 2018, and an inspection in response to concerns on 14 August 2014. During the responsive inspection in 2014 we identified that the service was not meeting the essential standards. In July 2015 and May 2018, we rated the service as good for each key question (safe, effective, caring, responsive and well led) and good overall.

This current inspection was triggered by intelligence we had received about the hospital. A whistleblower had contacted CQC to report concerns about the welfare of two patients and the fact that a visitor's room was being used as a patient bedroom.

Our inspection team

The service was visited a number of times during the inspection period. The inspection team comprised a CQC Inspector, a Mental Health Act Reviewer, two inspection managers, a head of hospital inspection, a best interest assessor specialist advisor, a clinical psychologist specialist advisor and an expert by experience who was familiar with learning disability services.

Why we carried out this inspection

This was an unannounced inspection. We inspected because people had contacted us to raise concerns about patient safety.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection visit, the inspection team:

- visited all five inpatient wards at the hospital, looked at the quality of the environment and observed how staff interacted with and cared for patients
- spoke with all 16 patients and four patient relatives
- interviewed the provider Chief Executive Officer who was currently acting manager for the service
- interviewed staff including the deputy manager, five qualified nurses, eight support workers, the clinical psychologist, the occupational therapists, two assistant occupational therapists and the consultant psychiatrist
- spoke with the human resources advisor, and data assistant
- spoke with the local safeguarding authority
- attended a shift handover
- reviewed Mental Health Act procedures and processes for the service and looked at detention records for five patients
- interviewed the Mental Health Act Administrator for the service
- looked at medication records for 12 patients and care records for seven patients
- completed a review of capacity assessment documentation
- looked at training records including seven staff records
- looked at incident records
- carried out a specific check of the medication management across the centre
- observed 26 different patient interactions or activities during three different periods
- looked at a range of policies, procedures, audits and other documents relating to the running of the service.

What people who use the service say

During our visits, we met with all patients present at the hospital and interviewed three. We also spoke to relatives of some of the patients.

Patients told us that there were not enough activities to keep them engaged and that there was not enough equipment in the kitchen to make food. Patients told us that when furniture was damaged this was not replaced and that sometimes patient bedrooms were not cleaned up promptly and that dirty dishes and rubbish were often left for some time. A patient told us about damage to doors and sinks not being fixed when raised. One patient told us about not feeling safe at the hospital and not liking the environment. Patients also spoke about the poor internet connection at the hospital.

Some families and carers told us that most of the nursing and support staff who worked regularly on the wards were friendly and approachable. All carers told us they would like better communication from the service including regular updates about care and treatment. Carers were not offered opportunities to engage in conversations about the care of their loved ones. Carers told us that there were no facilities for visitors including not always having a room to use for visits despite visits being pre-planned and families calling the hospital before each visit. Carers told us that the hospital would not allow family members onto the wards. Staff only permitted family visitors to see patients in the visitor's room or other room in the main part of the hospital. This meant that family carers did not see the conditions on the ward itself.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

Our rating of this service went down. We rated safe as inadequate because we had taken enforcement action in relation to the care and treatment of patients within this service which limited our rating to inadequate. This was because:

- The areas of the wards that accommodated the patients were dirty and poorly maintained. Communal areas and bedrooms had stains on floors and walls. Staff had not cleared up leftover food and there was dirty clothing piled up in the corner of three of the bedrooms. The building showed signs of wear and tear throughout; with cracks in the walls, damaged flooring and large holes in the ceiling of one patient's room. Many items of furniture were damaged. These included chipped tables, chairs and sofas with casing torn and foam exposed, damaged toilet seats and blocked drains affecting sinks and toilets.
- The communal areas and most rooms, including bedrooms, were bare and sparsely furnished. Staff had not recorded the justification for this and some patients told us they would like to have more furniture and personal items present in their rooms.
- Staff did not dispose of clinical waste promptly. As a result, the clinical waste bins were overfilled.
- There was high use of agency and temporary staff on every shift.
- The arrangements for out of hours doctors were not sufficient and psychiatric cover relied on one psychiatrist working at and covering two hospitals.
- Not all staff were trained in basic life support and not all qualified nurses had been trained in immediate life support.
- Patients' monies, which the hospital was supposed to store securely, were not managed safely by staff as we found in an unlocked office which had monies left on the desk.
- Staff did not update risk assessments following individual incidents or take mitigating action to reduce risk to patients.
- Managers and staff did not investigate incidents or share lessons learned with all staff. This meant that other staff had not learned from these events and that the service missed opportunities to prevent or minimise future harm.
- Staff used physical restraint frequently and the number of times that restraint was used had increased considerably in recent months.

Summary of this inspection

Are services effective?

Inadequate 

Our rating of this service went down. We rated effective as inadequate because we had taken enforcement action in relation to the care and treatment of patients within this service which limited our rating to inadequate. This was because:

- Access to therapeutic interventions was limited and the staff team did not have the skills required to provide specialist care to people with complex needs. Ward teams had access to an occupational therapist and psychiatrist twice a week. At the time of our inspection there was no speech and language therapist in post and the specialty doctor had left the hospital a couple of months prior to our inspection. This meant, there were instances where patient assessments had been delayed.
- The majority of staff providing direct care were not qualified nurses, but support workers and a substantial proportion of shifts were filled by bank and agency staff. Managers provided staff with only a few opportunities to update and further develop their skills. They offered staff no specialist training to enable them to work with patients with complex learning disabilities and challenging behaviour.
- As a result of the staffing situation, the service did not provide a range of treatment and interventions suitable for the patient group in line with current best practice guidance.
- Staff did not always undertake physical health assessments on admission.
- Staff commenced working at the hospital before all pre-employment checks had been completed; including disclosure and barring service and reference checks.
- Staff did not fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff did not fully understand the provider's policy on the Mental Capacity Act 2005 and did not assess and record capacity clearly for patients who might have impaired capacity.
- The provider did not recognise situations which constituted long term segregation and did not have appropriate safeguards in place to ensure that patients' rights were protected by undertaking regularly monitoring and review.

However:

- Staff used recognised rating scales to assess and record severity and outcomes.
- Staff developed individual care plans, which contained positive behavioural support plans. Care plans were personalised and included the voice of the patient.

Summary of this inspection

Are services caring?

Inadequate

Our rating of this service went down. We rated it as inadequate because we had taken enforcement action in relation to the care and treatment of patients within this service which limited our rating to inadequate. This was because:

- When we observed how staff interacted with patients, we witnessed occasions when staff failed to engage actively with the patients they were caring for. On some of these occasions, staff ignored the patient or were engaged in conversations with colleagues to the exclusion of the patient.
- There were occasions when staff did not respect patients' dignity. Staff allowed a patient to use a toilet with the door facing onto a communal corridor left open. When a patient took off their clothes in a communal area, staff did not protect their dignity by moving them away from the communal area. Also, staff left two patients wearing soiled clothing after they had been incontinent.
- Care plans were not written in conjunction with carers

However:

- Staff treated patient information confidentially and sought consent to share patients' information with others.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- Care plans did not contain evidence of discharge planning or goals orientated for discharge.
- There was a lack of meaningful therapeutic activities for patients.
- The environment was not appropriate to the needs of patients present at the hospital and did not support privacy and dignity of patients. The ward environment was bland and not individualised to each patient's needs.
- Patients, staff and carers we spoke with knew how to raise concerns, however, did not always feel confident to do so.
- The provider had not been responsive to concerns raised by staff, patients and management about the premises, with repairs not actioned promptly.
- There was no evidence of lessons being learned and shared with staff by the provider.
- Concerns raised during the inspection about the privacy and dignity of two patients had not been immediately acted upon by the provider.

However:

Summary of this inspection

- We did find staff responding to patients with a range of different communication methods.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- Staff were not following the systems and processes in place that the hospital had in place to monitor and develop the service.
- Staff did not feel supported and morale was low amongst most the staff we spoke with.
- The service was not acting or acting in a timely manner in response to risk or concerns raised by staff and patients about environmental dangers and changing patient presentations.
- The service did not engage with national quality improvement activities.
- Staff did not feel confident to raise concerns to managers.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At the time of our visit, all of the patients were detained under the Mental Health Act.

Training records showed 86% of staff had completed Mental Health Act training in the last 12 months.

There had been no Mental Health Act monitoring visits to the service prior to our last inspection. The last two visits were on April 2016 and November 2017. However, during the inspection period a Mental Health Act monitoring visit was conducted.

During the inspection and at the time of this visit we found:

- One patient was living alone in a standalone apartment and did not have regular contact with other patients or other people except staff. Despite this, staff did not view this as long-term segregation and there was no documented rationale present within the patient's care records for this approach to care.
- No easy read information or contact details was displayed on the walls for patients to contact advocacy or support services.
- There was no process for making referrals to the independent Mental Health Act advocate.
- Patients were not all supported in understanding their rights and assessments were not always made to ensure these rights were understood.
- Risk assessments for section 17 leave forms, which should be completed prior to leave and updated upon return, were not consistently completed in the records we reviewed.

The provider offered staff training in the Mental Health Act but the staff we spoke with were not confident about the Mental Health Act, the Code of Practice and its guiding principles.

The provider had recently employed a new Mental Health Act administrator, who was awaiting the provision of training. Staff told us if they had any queries about the Mental Health Act, they would approach qualified nursing staff or the consultant psychiatrist for support.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our visit all the patients were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards applications made by the hospital in the 12 months before our inspection.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Not all staff we spoke with had an awareness of the policy.

Staff and managers we spoke with showed varied understanding of the principles of the Mental Capacity Act despite training information stating 85% of staff had completed training in the Mental Capacity Act. We found there was a limited understanding of the presumption of capacity and its decision-specific application and when best interest assessments were required. Staff told us they regularly acted in patients' best interests but this was not documented in the care records we reviewed. We only found one best interest assessment.

Staff would contact the consultant psychiatrist if they had any queries or needed further clarification in relation to the Mental Capacity Act.

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

Safe and clean environment

During our visits we had significant concerns about the safety and cleanliness of environments across the service.

Managers told us staff were required to update environmental risk assessments every three months and report any problems on a daily basis. However, staff had not captured all the concerns we identified during our inspection, including problems with doors and drainage.

The service was divided into separate distinct wards. There were no blind spots, which meant that line of sight was good, allowing staff to observe all parts of each ward where patients were present. The layout was spacious to meet the needs of the patients.

Much of the ward environment was not personalised, was bare and very bland. Communal areas and most rooms including bedrooms were sparse with limited furnishings. Most bedrooms were not personalised with the patents' own belongings. The provider advised us that this was because of the needs of individual patients, which meant they required low stimulus environments. However, we did not find this recorded in the care records we reviewed and some patients told us they would like to have more furniture and personal items present in their rooms.

Each of the four main wards had a communal bathroom. There were many potential ligature anchor points present within the communal bathrooms, bedrooms and communal areas of the ward. Some of these had not been captured in the providers own ligature assessment including non-standard curtain rails in communal bathrooms. Risk to individual patients was reduced with most patients being observed by a number of staff.

Access onto each patient area was restricted to those who needed it and any visitors were accompanied by members of staff. Staff carried personal alarms and patients had access to call buttons for prompting staff for assistance. We saw evidence of staff responding promptly to patient and staff requests for support. However, staff did tell us there were instances when they didn't carry alarms, because one was not available or due to the additional risks associated with an individual patient and carrying alarms. Managers we spoke with were not aware of this and advised there should be no instance when a staff member does not carry an alarm.

We found, on one ward, patient money had been left on a desk in an unlocked office. The provider advised that patient money would normally be locked away except when staff completed the ward daily checks.

Domestic staff worked at the hospital during the day. Despite this, the environment on each of our visits was not consistently clean and some areas required a deep clean. We found food and dirty plates which had been left on dining tables and on the floor in the quiet room. In one apartment, food items had been left half eaten in the open, including hot dogs and pizzas.

In one communal bathroom urine splash marks were present within the bathroom with staining on the toilet and walls visible.

In four bedrooms, two communal bathrooms and a dining room, there were signs of spillages on the floor and wall

and three bedrooms had dirty clothing piled up in the corner. The building showed signs of wear and tear throughout. This included cracks in the walls, damaged flooring and large holes in the ceiling of one patient's room.

A number of items of furniture on each ward were damaged, including chipped tables, chairs and sofas with casing torn and foam exposed. In apartment one, six sofas and chairs had the torn casing with exposed foam. In apartment two, two tables were chipped and with exposed rough edges. in apartment three, three sofas were torn and dining tables were damaged. This broken furniture presented a safety hazard to patients and the exposed foam a potential infection control risk. This had not been identified or acted on by the service.

A number of rooms had damaged toilet seats and blocked drainage pipes that meant that waste water was slow to drain from sinks. Staff said this damage had been reported, but it was not included on the list of maintenance jobs the service held and managers were not aware of it.

Staff and patients told us that repairs and maintenance were not undertaken promptly. We heard about drainage problems affecting ensuites in two of the bedrooms in the past and in a communal bathroom which been out of service for a number of months before it was repaired. These had experienced difficulty with how waste water was emptied, which we were told had led to accumulation of water. As a result, the bathrooms had been out of service for a number of months. One patient spoke about damage to the patients bedroom door which had prevented it from locking. Managers confirmed they had experienced delays in fixing maintenance problems in the past which had been escalated to the provider's board.

There was a laundry room which patients could use under staff supervision. However, we found dirty and soiled clothing piled up outside the laundry room waiting to be washed, which presented both a trip hazard and an infection risk.

On one of the wards, the staff office door had been damaged and could not be securely closed and locked.

The hospital complied with the Department of Health guidance on eliminating mixed sex accommodation. Male and female patients resided in separate wards.

Clinic rooms were safe and fully stocked. The hospital had four separate clinic rooms located in the multi occupancy wards. These were clean and fully stocked with equipment which staff regularly checked to ensure it was safe to use. There were first aid kits present in each and on each floor clinic rooms had access to a defibrillator and oxygen.

Safe staffing

As part of the inspection we looked at staffing arrangements at the service to ensure arrangements were appropriate to deliver safe care and treatment.

We found that there wasn't an adequate staffing establishment. The service had an established staff base of nine qualified nurses and 80 support workers, with three vacancies for qualified nurses at the time of the inspection. The number of wards on the unit, would have required a minimum of 12 established nursed to cover all shifts. As a minimum requirement there were four qualified nurses allocated to each apartment during the day and two at night. On one of the days of our visit, there were 40 support workers and four nurses on shift during the day and two nurses and 28 support workers on shift at night.

For the three-month period from 1 February 2019 to 30 April 2019, 1233 shifts were covered by temporary staff. This on average was 100 shifts per week being covered by temporary staff. This was a substantial increase from our last inspection when 233 shifts had been covered by temporary staff over a three-month period. The provider utilised its own staff bank and agency along with a number of recruitment agencies to provide temporary staff.

Charge nurses could adjust staffing levels according to needs of patients including requesting staff from the staff bank or the provider's staffing agency. If staffing needs could not be met by these two options, other recruitment agencies could be used, after senior manager approval had been given.

Mandatory training

Staff were expected to complete 10 mandatory training modules. This was reduced from 12 training courses at the time of our last inspection. Training covered a range of different areas which included fire safety, first aid awareness, health and safety and creative intervention training in response to untoward situation, which was the service's approach to managing violence and aggression. Compliance for all training courses was above the provider's target of 85% except for Information governance training, which was at 80% compliance. However, the

provider did not provide basic life support training to all staff. Some staff we spoke with advised us that they had received training which covered how to give cardiopulmonary resuscitation but the provider was not able to confirm how many had received this training. The provider advised it only had four staff trained in immediate life support training. Qualified clinical staff must be trained in immediate life support in services that use restrictive interventions.

The mandatory staff training courses and completion rates were:

- First Aid Awareness: 87%
- Fire Safety: 85%
- Health and Safety: 87%
- Infection Control: 87%
- Safeguarding: 84%
- Mental Health Act and Deprivation of Liberty Safeguards: 86%
- Mental Capacity: 85%
- Diversity and Equality:87%
- Information Governance: 80%
- CITRUS: 95%

There were no systems in place to monitor the skills, training and experience of temporary staff, with a reliance on agencies to complete checks and monitor temporary workers.

Medical staff

There was inadequate medical cover at the hospital. The full time speciality doctor had left two months earlier and the consultant psychiatrist worked across two hospitals, which included two days at this hospital. Psychiatric cover was provided by the consultant psychiatrist both during the week and out of hours. The provider was not able to confirm how long it would take for the consultant to attend in the event of an emergency, only that he would attend when needed. For all physical health concerns the hospital relied upon GP practices with whom individual patients were registered including for out of hours support.

Assessing and managing risk to patients and staff

During the visit we looked at how risk was managed at the service. We did this by looking at records the service held but also talking to staff and patients about their experiences and understanding.

Staff used recognised risk assessment tools and outcome measures including the Salford Tool for Assessing Risk and the Short-Term Assessment of Risk and Treatability tool. We reviewed seven patient records. All seven patient records had a risk assessment present, which was completed on admission.

Management of patient risk

Staff did not consistently assess and manage risks to patients and themselves well, with assessments not always updated following incidents and changes in presentation. We noted that following injury and harm, a patient's risk assessment had not been updated. This included an incident which resulted in a member of staff being assaulted. There was no management plan in place to reduce the likelihood of these incidents happening again. On two other records, we found that risk assessments had last been updated three months earlier. Staff told us that risk assessments were routinely reviewed every three months.

However, patient records did contain individualised plans to support patients in times of crisis, which included how to distract them and to avoid situations that might trigger distress. These all included detailed strategies from previous placements as well as the hospital's staff team.

Patient observation levels were dependent on the risk levels of each patient. Nursing staff could increase observation levels. Decreases had to be agreed by the multidisciplinary team in weekly meetings held to review the care of each patient. We found that the observation levels were changed following most incidents.

There were blanket restrictions on patients' freedom. Patients could not independently leave their ward to access other communal areas within the hospital. This included the enclosed outdoor spaces and gardens which were all locked during our visits which patients could access only if they asked staff. Patients were not allowed smartphones, which they could use to access the internet.

Use of restrictive interventions

The wards in this service participated in the provider's restrictive interventions reduction programme. Staff were trained in the creative intervention training in response to untoward situations which focused on using least

restrictive interventions when dealing with aggression. The service also operated a no seclusion policy across the service which meant they did not have a dedicated seclusion room on site.

The service provided data on the use of restrictive interventions in the previous six months to our inspection. The data showed there had been 467 episodes of restraint. This was an increase from 253 episodes of restraint between October 2017 and March 2018. A number of different types of physical restraint were used with the average duration of physical restraint just over 6 minutes. This included 52 incidents of positive handling. There were no incidents of prone (chest-down) restraint.

The service had not used rapid tranquilisation in the previous six months to our inspection. There was a policy in place to ensure staff followed best practice guidelines when administering rapid tranquilisation and staff we spoke with could describe the actions they would take to monitor a patient's physical health.

Staff had used 'as required' (PRN) medication to help manage patients' distress and behaviour 289 times over the same 6-month period.

Safeguarding

Records showed that 84% of staff had received safeguarding training. Staff we spoke with knew how to report a safeguarding concern and how to identify the signs of abuse. However, we were not assured that staff always knew how to safeguard patients. We observed patients to be living in an unclean and unsafe environment. The hospital deputy manager was the safeguarding lead for the service. Over the 12 month period prior to our inspection, the hospital had made eight referrals to the local safeguarding authority.

Over the month preceding the inspection five staff had worked a shift at the hospital without a disclosure and barring service (DBS) check being completed and 22 staff had worked without the provider having received references. A further 20 staff had commenced employment with the provider before DBS checks had been completed including 11 this year. Checks on temporary staff were held by their respective individual recruitment agencies, which shared details with the provider.

Staff access to essential information

The information required to deliver patient care was held in a number of different places, which made records management difficult for staff to follow and audit.

Patient records were kept in a mixture of separate paper and electronic files. This included records from the multi-disciplinary team meetings. This meant it was difficult to follow patients' care. We saw the impact of this during the inspection, because staff could not always locate records relating to a patient's detention or corresponding patient activities.

Medicines management

We reviewed the medication administration records for 12 patients. Three of the records did not have a patient photograph attached to them, which were intended to help unfamiliar staff identify patients.

Staff generally followed good practice in the prescription, storage and administration of medication. We noted that one patient had missed two dosages of the medication procyclidine in the weeks preceding our inspection because it had not been available. This meant the patient did not receive medication which would alleviate side effects. The provider told us that this was due to a breakdown in communication between the provider's contracted pharmacy, general practice and the hospital. There was no evidence that the provider had taken actions to reduce the chance of this happening again.

We found a medical/sharps waste bin was 4 weeks past its dispose-by date and was overfull of waste with used syringes at the top.

Track record on safety

During the inspection we asked staff about their experiences of safety and reviewed information about safety and incidents that the service held.

We reviewed records for the period August 2018 to June 2019 which showed that there had been 1281 incidents recorded resulting in physical harm. Most of these incidents were recorded as patient to staff harm incidents. There had been two incidents recorded as leading to moderate harm. These incidents resulted in moderately serious injury, damage or loss.

Reporting incidents and learning from when things go wrong

Inadequate

Wards for people with learning disabilities or autism

The hospital had systems in place for recording and analysing safety concerns. All staff could report an incident directly. Staff completed paper forms which were reviewed by charge nurses and later inputted into an electronic system. The provider told us that these were then reviewed by a senior manager and any learning was informally shared at staff handover meetings and team meetings.

Staff we spoke with knew how to raise concerns and report incidents. This was evident from the incident records we reviewed, which showed there had been 2191 incidents reported by staff at the hospital over the preceding 12 months. These varied from concerns expressed by staff and near misses to incidents of patient aggression and harm.

We did not find evidence of incidents being investigated and lessons shared with the staff team formally. Managers told us that investigations were informally completed. When we asked the provider for investigation reports for all investigations conducted in the last 12 months, only one report was made available. This was not detailed and did not assign responsibilities or timelines for actions arising from the investigation. In one serious incident a staff member had been stabbed after a knife went missing from the kitchen. A number of weeks later another knife went missing, showing lessons had not been learnt from the first incident. Limited learning and sharing of lessons had also been raised as a concern following our last inspection in 2018.

Staff were not formally debriefed following incidents, but incidents were discussed during group supervision. Staff said they did not feel supported by the management team following incidents or assaults.

Duty of candour

The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if mistakes have been made in their care that have led to significant harm. The purpose of duty of candour is to help patients receive accurate and truthful information from health providers. A duty of candour policy was in place and all staff we spoke with were aware of the policy. The staff we spoke with were aware of duty of candour requirements, which emphasise transparency and openness with patients and carers when things go wrong. The duty of candour regulation requires providers to notify the relevant person of a suspected or actual reportable patient incident. Records provided by the hospital stated there had been no reportable incidents at the Breightmet Centre for Autism.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We reviewed how patient care was assessed and planned to ensure it met the needs of individual patients. Our review of seven care records found both areas for improvement and areas of good practice.

The records we reviewed all had completed comprehensive mental health assessments present. These had been commenced promptly upon on admission and we found that admission assessments were generally very detailed. However, other assessments including occupational therapy, psychology and speech and language therapy assessments had not all been promptly commenced and completed.

Physical health assessments were not present in two of the records we reviewed. Monitoring of physical health where concerns were raised was completed by patients' registered GP practices. Staff told us that they sometimes experienced difficulty getting GP appointments for patients, which meant there were sometimes delays in getting patients medical care and treatment. Staff told us they completed physical health monitoring on patients following the use of certain anti-psychotic medication.

Staff developed individualised and detailed care plans which reflected patients' assessed needs and were personalised. However, these were not all regularly reviewed and updated through multidisciplinary discussions. One record had been reviewed once in the last 12 months and two other records were reviewed three months earlier. Staff we spoke with were not clear of the reasons for this or what the providers policy was for reviewing care plans.

Positive behavioural support plans that identified positive approaches staff could use for each patient were present in

each record and were specific to each patient. However, these varied in quality and detail, with some offering staff reactive approaches to use with patients and not proactive strategies.

None of the records we reviewed were recovery-oriented and we saw no evidence of discharge planning within the records.

Best practice in treatment and care

As part of our inspection of a service we look at if best practice and guidance are followed to ensure care and treatment are delivered in the most effective way.

The service did not provide a range of treatment and interventions suitable for the patient group in line with current national and best practice guidance. Therapeutic interventions including behavioural, psychological, speech and language support had been limited since a number of the multi-disciplinary team had left the service.

Policies and procedures used by staff referenced current guidance including the Mental Health Act Code of Practice and National Institute for Health and Care Excellence guidance on short term management of violence and aggression (2015).

Staff used recognised rating scales to assess and record severity and outcomes. Evidence based practice for assessing risk, care planning and measuring outcomes was evident. Staff used the Salford Tool for Assessing Risk and the Health of the Nation Outcome Scales.

We did not find any evidence that staff participated in clinical audit or quality improvement initiatives.

Staff identified patients' physical health needs and recorded them in their care plans. Records showed that staff offered patients access to physical health care, including specialists as required. However, when patients refused care or treatment, staff did not follow this up consistently. This included an instance when a patient had a wound that required medical attention. The patient had refused, and this had not been followed up for a number of days.

Staff did not consistently help patients live healthier lives by supporting them to take part in programmes or giving advice. In the care of two patients we found drinks and snacks had been used to entice positive behaviour.

Skilled staff to deliver care

Patients only had access to a limited number of specialists required to meet their needs. Ward teams had access to an occupational therapist and psychiatrist to help them meet some of the needs of patients. A newly appointed part time clinical psychologist was due to start working at the hospital two days a week. A speech and language therapist and a specialty doctor had left the hospital a couple of months prior to our inspection.

Managers provided a two-week induction programme for new staff. Staff were required to complete this programme before starting work.

Staff appraisal and supervision are a means of assessing staff performance to ensure an individual's practice is appropriate and effective and that they have appropriate support available. The provider supported staff with appraisals and supervision, with 85% of staff completing regular supervision. However senior staff and managers seemed unclear how often supervision should occur, with some saying it should occur every eight weeks and some saying it should occur every 6 weeks. The hospital policy which had been ratified during our inspection period stated supervision should occur every 3 months. Data provided by the provider showed that 81% of staff had received an appraisal within the last 12 months. The provider advised us that the target for both appraisals and supervision was 80%, which was a reduction in comparison to our last inspection, when the target was 90%.

Managers did not make sure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff told us they had limited opportunities to update and further develop their skills. We found no evidence of additional or specialist training being available for staff including specific training to enable them to work with patients with complex learning disabilities and challenging behaviour.

Staff told us debriefs did not always occur after incidents and support was only available if it was sought by staff.

Team meetings which were intended to be held once a month were found to be infrequent, with the last meeting held in April 2019. Managers did not keep records of who attended and who did not attend. The notes of the meetings did not record actions arising.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary team meetings. Key partners including advocates were invited to these and to care programme approach meetings and care and treatment reviews. However, carers told us that they were not always informed about meetings or invited in a timely manner. We were also told by carers and the advocate that meeting delegates did not always receive documentation associated with the meeting beforehand.

Handover meetings were held to update staff about each patient at the start of each shift. We observed two of these meetings. Staff shared relevant information about each patient including change in presentation and risk.

The service engaged in regular conversations between the hospital and local authority safeguarding team to discuss any areas of concern or individual incidents.

Patients at the service were registered with a number of local GP practices. We were told by nursing staff and managers that relationships with some practices had been difficult due to past poor communication between the hospital and individual practices.

Adherence to the MHA and the MHA Code of Practice

Staff received annual training in relation to the Mental Health Act, which 86% of staff had completed. This was lower than during our previous inspection when 94% of staff had completed the training. However, some staff did tell us they were not confident about the Mental Health Act and would prefer more training be made available, which they had requested from managers.

Staff told us in the past they could approach the Mental Health Act administrator if they had any queries regarding the Mental Health Act. However, since a new Mental Health Act administrator had been appointed, who was still awaiting appropriate training, they would refer any queries to the multi-disciplinary team when they were available.

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

Information for patients was displayed on walls. However, posters about advocacy services did not include the contact number for the advocacy service, and information about the service was not presented in an easy read format.

The records we reviewed showed the hospital did explain patients' rights under the Mental Health Act to patients. However, in three of the files we reviewed, we did not find evidence of staff supporting patients to understand their rights whilst detained and making an assessment on whether these rights had been understood.

Certificates for consent to treatment (T2) and certificates authorising treatment by a second opinion doctor (T3) were attached to each prescription chart. Each patient's capacity to consent had been assessed at appropriate points in the patient's prescribed treatments. However, one patient's treatment had continued beyond the three-month period allowed under section 63 of the Mental Health Act meaning they could not be treated without their consent or the approval of a second opinion approved doctor. A referral had been made to Care Quality Commission for a second opinion approved doctor to visit, which was pending. In the meantime, treatments were being authorised under section 62 of the Mental Health Act. This is normally intended for urgent treatments only, however, the provider had used this for routine treatments because the application had not been made in a timely manner.

The consultant psychiatrists authorised section 17 leave for patients as required, and patients knew about their leave entitlement. Leave forms had a section to record risk assessment prior to leave being taken and a section to record any concerns arising from the leave. However, these sections were not consistently completed in the records we reviewed.

Managers did not make sure the service applied the Mental Health Act correctly by completing regular audits and discussing the findings. We found no evidence of regular Mental Health Act audits being completed by the provider, despite these being on the list of six-monthly audits the service planned to undertake.

Patients had access to the independent mental health advocacy service who visited two wards each week. However, patients who lacked capacity were not automatically referred to the service.

One patient was living alone in a standalone apartment and regularly did not have contact with other patients or other people except staff. However, the service did not view this as long term segregation and there was no documented rationale present within the patient's care

records for this. The provider did have a policy in relation to long term segregation, which stipulated if it was required, alternative placements must be sought by the service. This patient had a three week period when first admitted to the hospital, where the patient had no leave because assessments had not been undertaken.

Good practice in applying the MCA

Staff received annual training about the Mental Capacity Act, with annual refresher training offered to all staff. The provider stated that at the time of our inspection 85% of staff had completed this training. However, staff and managers did not consistently display good understanding of the underlying principles of the Act.

At the time of our inspection all the patients were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards applications made at the hospital in the preceding 12 months before our inspection.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards.

We found there was a limited understanding of the presumption of capacity and its decision-specific application and when best interest assessments were required. Staff told us they regularly acted in patients' best interests but this was not documented in the care records we reviewed, with only one best interest assessment found in the care records we reviewed.

Patients lacking capacity did not have access to an independent mental capacity advocate.

We found there was limited use of mental capacity assessments and only found one completed mental capacity assessment which was decision specific.

There were no audits undertaken in relation to the Act despite these being listed on a schedule of monthly audits the hospital planned to carry out.

Are wards for people with learning disabilities or autism caring?

Inadequate

Kindness, dignity, respect and support

During our visit, we observed how staff interacted with patients by using the short observation framework for inspection observation tool and listening to interactions. We also asked patients and carers about their experiences.

Whilst we saw some examples of staff treating patients with compassion, kindness, dignity and respect, we observed a number of occasions when interactions were poor. We saw when staff accompanied patients on leave, staff would walk ahead of patients with interactions only occurring between staff members present and not with the patient. We also witnessed patients being observed by staff who did not interact and actively engage with the patients they were caring for.

We used the short observation framework for inspection tool during this inspection. CQC inspectors use this tool to capture the experiences of people who use services who may not be able to express this for themselves. We undertook two observations, one just under an hour and one thirty minutes of observations on apartments one and four. Of a total of 26 interactions, 12 were positive including staff acknowledging patients and attempting conversation, enabling patients and showing acceptance and warmth. Seven of the observations were noted to be negative interactions, with the patients being ignored and staff having conversations amongst themselves.

Privacy and dignity were not consistently respected. When we walked onto the unit, a patient was using the communal toilet in the corridor with the door open and a staff member standing in doorway. On one of the ward corridors we observed a patient with a known tendency to remove clothing, take off the clothes they were wearing. Staff did not protect the individual's dignity and privacy by moving the patient away from the communal area. Instead they went to the patient's bedroom to find alternative clothing. Earlier, we had asked staff on the same ward how they would respond during such occurrences and all had advised us they would protect the individual's dignity and privacy by moving the patient away from the communal area immediately. We also observed with two patients that their individual incontinence needs were not being met. Both incontinent patients had been wearing soiled clothing which had not been changed. We found one patient whose bedroom floor was not clean had dirty feet as a result.

Inadequate

Wards for people with learning disabilities or autism

Most the staff we met were able to talk to us about the care and treatment they were expected to deliver to patients and they were able to talk in detail about how to support patients and this detail corelated to care records that we examined.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition. This included staff who used Makaton, which they had received training in prior to working at the hospital, to communicate with a patient. However, care plans and letters to patients explaining their rights were not written in a way that could easily be understood by patients.

Patients said that most staff treated them well and behaved kindly. However, patients did state some staff did not always respond to them positively.

We found many staff crowding the corridor in two of the apartments, which could feel quite intimidating and unsettling to patients.

The involvement of people in the care they receive

The provider had an initiative in place to support patients to be involved in their care. Staff introduced patients to the ward and the hospital as part of their admission. This included in the care of one patient, staff visiting the patient and arranging a number of visits to the hospital to familiarise the patient to the setting.

Patient involvement in care planning was not evident in all the records we reviewed.

We did not find evidence that staff made sure patients understood their care and treatment. The language used to record recovery goals was clinical and not understandable for patients. However, we did find staff using a range of communication techniques including use of picture boards and gestures in their interactions with patients.

The records we reviewed did not contain advance decisions where patients could give input into their care and treatment in the future.

Patients had access to support from a mental health advocacy service. A named advocate from an independent mental health advocacy service was available to support patients when required. The advocate would hold weekly drop in sessions within the wards and was invited to care planning approach meetings. The advocate would also visit the service on request of the service or a patient. However, there was no process in place for new admissions who lacked capacity, to be referred to the advocacy service by the provider.

Involvement of families and carers

During the inspection we spoke with the carers or relatives of four patients. Three out of four carers commented on communication difficulties with the service. This included not being invited by the provider to meetings to discuss the care and treatment of their loved ones. One family said they were only invited after they enquired about taking part in reviews and care planning discussions. Another carer spoke of attending meetings when informed by their loved one's social worker.

In the records and care plans we reviewed we did not find any comments or feedback from carers or family members. Three of the families we spoke with told us some of them had not seen the care plans for their loved ones.

The hospital had recently moved the designated family visit room. The provider had told us families could visit their loved ones on the wards if visits were planned. However, all the families we spoke with told us that they had been told they were not allowed to visit the wards and could only meet their loved ones away from the clinical area. Families told us that since the family visiting room had been moved, they did not have access to refreshments. They also told us they were required to call the hospital before visiting and there was not always a room available to meet their loved ones. This meant they were often left waiting for staff to find a room they could use.

Two families commented about how staff and managers did not always promptly respond when queries were asked, or concerns were raised.

Two of the carers gave positive feedback about permanent ward staff working on the wards. However, two carers expressed concern about the lack of consistent staff on the wards. One carer commented, that some staff were not approachable and did not respond positively to questions about the care and treatment of their loved ones.

Are wards for people with learning disabilities or autism responsive to people's needs?

Inadequate

Wards for people with learning disabilities or autism

(for example, to feedback?)

Inadequate

Access and discharge

The service provided data relating to bed occupancy for each ward between 1 December 2018 and 30 May 2019. The average bed occupancy across all wards was 81%. The highest bed occupancy was on male ward 2 where it averaged 90%. The lowest bed occupancy was on the female ward, which averaged 75% over the period.

The hospital accepted patients from across the country and had capacity for 19 patients. All the patients at the service were from outside the local authority catchment area. Referrals were accepted from clinical commissioning groups who commissioned services on an individual patient by patient basis. At the time of our inspection the hospital had 16 patients.

Over the last 12 months there had been 10 patients discharged from the hospital. The provider informed us that five of the current patients were delayed discharges. This was due to lack of suitable placements being available in the community. However, we do not see evidence of proactive engagement with community teams and commissioners when this was the case.

The records we reviewed did not contain any discharge planning. Patients that we spoke with were unclear about their discharge plans with one patient telling us discharge planning had not been discussed with them.

The average length of stay for male patients discharged over the previous 12 months was 871 days. The average length of stay for discharged female patients was 525 days. For the current patients the average length of stay for male patients was 444 days, and for female patients it was 766 days. The two longest length of stays were 1045 and 2130 days. The provider told us that both these patients were delayed discharges due to lack of community placements being available.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom with an en-suite bathroom. One of the bedrooms also had a private lounge and kitchenette. All wards had access to a lounge, dining room, communal bathroom, communal toilet and a quiet room.

Most patient bedrooms were not personalised and mostly contained only a few items. The lounges did not have enough seating for all the patients in the apartment. Ceilings and walls across all wards had food and drink stains present. Furniture in communal areas was sparse and most were stained and ripped in all the wards. Staff told us that furniture had been damaged by patients.

The hospital did have an activity room, computer room and sensory room. However, these were not used during our visits.

Patients had access to an activities of daily living kitchen under staff supervision. However, patients told us that there was not enough equipment present to make food. There was no cooker in the kitchen and the oven had been broken by a patient.

Patients were allowed to have their own mobile phones as long as they did not have a camera or internet access. There was a public phone in the activity room that patients could use, if accompanied by a member of staff. Each apartment had a cordless phone that could be used by patients in private. However, one of these was broken and staff were unable to tell us how long this had been the case and when it would be replaced.

The hospital had quiet areas and a room where patients could meet with visitors in private.

The service had a number of outside spaces that patients could access from the ground floor wards. However, we did not see these being used and doors leading to the gardens were locked on all wards. Managers told us patients could access these on request. We did not see any of the outdoor spaces being used during our visits nor did we find evidence that records were kept when patients used these spaces.

The hospital had two vehicles for taking patients out into the community and on visits. We saw these being used on each of our visits.

Patients' engagement with the wider community

Inadequate

Wards for people with learning disabilities or autism

Staff supported patients to maintain contact with their families and carers. Contact details for families and carers were easily accessible for patients and staff, should they be required. Some patients were taken into the local supermarket. However, we did not see evidence of wider engagement with the local community and resources available in the locality.

Meeting the needs of all people who use the service

We looked at how the service met the needs of its patients, who at the time of the inspection included patients who had experienced mental health difficulties and had a learning disability, Asperger's syndrome or autism.

The service did not meet the needs of all patients.

The multi faith room had been used as a store for broken furniture. Patients did not have access to spiritual, religious and cultural support. However, the provider informed us this was available if requested.

There was a lack of varied and therapeutic activities available for patients across the hospital, with the activities of daily living kitchen being the main resource used.

Easy read information and information in other languages was not present at the hospital.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns and staff understood the policy on complaints and knew how to handle them.

The service had a process for looking into concerns and complaints. However, carers and staff told us, when concerns had been raised these were not always looked into promptly and findings feedback was not given.

We were advised by the provider that most complaints were reported to staff informally which were looked at by senior staff and discussed at handover. Over the previous 12 months there had been seven complaints made formally to the service. One of these had been upheld.

The service received compliments from carers, patients and visitors. This service received 15 compliments during the last 12 months from June 2018 to June 2019.

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

Inadequate

Leadership

The leadership team did not have the skills and experience to perform their roles.

The leadership team had been substantially depleted since our last visit and the lack of experience in some areas was evident. Since our last inspection the registered manager, the lead nurse, head of governance and specialty doctor had all left the service. These roles had not been recruited into. The current hospital senior team consisted of the provider Chief Executive Officer who was acting as interim service manager, the deputy manager, the nursing clinical lead and the head of contracts and compliance. The leadership team did not have full autonomy required to do their roles with decisions and a number of actions requiring approval from the provider's board. There was evidence that the board made changes to staffing structures, including the decrease in senior roles, without consulting staff and managers.

Some staff had access to leadership opportunities.

The board had meetings at the hospital once a month.

Vision and values

The service values were 'pride, respect, compassion, standards, patients first and always'. These were not known or understood by all the staff we spoke with and were not evident in what we saw during our visits.

We observed some care practices which were not in line with the provider's values and when these were raised with the leadership team decisive action was not taken.

Culture

Staff did not feel respected and valued. They spoke about the negative impact of senior staff leaving.

Some of the staff we spoke with felt the service did not promote equality and diversity, and did not provide opportunities for career development.

Inadequate

Wards for people with learning disabilities or autism

There was not a positive culture at the service. This impacted on staff's motivation to complete their job role and morale across the staff body was low.

Staff told us that managers did not act when concerns were raised. Some staff stated they did not feel supported by the management team and some felt anxious about concerns over safety and lack of support.

Governance

Based on the number of overall concerns that we found during our visit, we have concluded that appropriate governance systems were not in place to ensure that all policies, procedures and processes were effective in the hospital.

The effectiveness of systems and processes to monitor and improve some areas of the service was not clear and could not be explained by the provider.

The provider had a governance audit cycle in place, which listed a number of audits, which the provider stipulated should be carried out routinely. These included prescribing record checks, clinic room checks, review of medication records, checks of emergency grab bags and a review of ligature risks present on the ward environment. Audit findings and concerns were discussed in fortnightly and monthly meetings which were appropriately documented. However, audits had not taken place each month and when asked about learning arising from audits, staff were not able to explain any improvements which had been made. When the provider was asked what concerns had been identified and improvements made following the cycle of 41 audits including 19 monthly audits, the provider was only able to provide three examples from the last 12 months.

Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

Management of risk, issues and performance

The service had a risk register which fed into the corporate level risk register. Managers discussed areas of risk and escalated these via the corporate risk manager as required.

Not all concerns raised during our inspection were included on the hospital risk registers and not all had been added to the corporate risk register including risks around provision and cover of the multi-disciplinary team.

Information Management

The service used systems to collect data from wards. The systems were not over-burdensome for frontline staff. However, some of these required office staff to transfer information in paper records to electronic systems and produce reports, which meant there could be a delay in managers seeing information, for example, relating to incidents and concerns.

Information including patient records were stored safely on a number of systems including paper-based records. However, during our inspection there were a number of occasions staff and managers could not easily find information that we were looking for. There were also a number of different files for each patient, which made information less accessible.

We found that managers did not always send notifications to external bodies as needed. Managers did not seem clear what information should be reported to which external organisation. This included information providers are required to notify the Care Quality Commission about incidents, such as incidents involving the police and avoidable harm.

Engagement

Staff had access to information about the service and the provider via handover meetings and daily management meetings.

We did not see any evidence of patients being invited to meetings to discuss and develop the service.

Managers engaged with some external stakeholders including the local authority safeguarding team and commissioners. They did not engage in local learning and forums with agencies such as the police and the local authority.

Carers told us that the hospital would provide information if it was requested and that this was not proactively done.

Learning, continuous improvement and innovation

Managers had access to opportunities to develop their skills and experience. However, staff were not given opportunities to enhance learning and develop their understanding in addition to the mandatory training they were required to complete.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure care premises, equipment and facilities are safe, and that risks are identified, managed and mitigated.
- The provider must remove all damaged furniture and ensure there is sufficient furniture, including dining tables and chairs, to accommodate patients.
- The provider must ensure patient money is managed safely.
- The provider must ensure the environment including all wards and patient areas are clean and that all waste including clinical waste is managed safely and disposed of promptly.
- The provider must ensure that all staff are trained in basic life support and that all qualified nurses are trained in immediate life support.
- The provider must ensure there are sufficient qualified nursing staff employed to care for patients.
- The provider must ensure that all patients have an up to date risk assessment, which is completed on admission, updated following incidents and contains all presenting risk, with an associated risk management plan.
- The provider must ensure serious incidents are fully investigated with lessons learned identified and formally documented and shared with all staff.
- The provider must ensure that disclosure and barring service checks and references are in place for staff before they begin working with patients.
- The provider must ensure all staff receive training in learning disability and autism.
- The provider must ensure care plans reflect patients' current needs.
- The provider must ensure that staff meetings take place regularly and that a record is made of attendance and actions.
- The provider must ensure staff understand their responsibilities in relation to the Mental Health Act and Mental Capacity Act and carry out their functions appropriately.
- The provider must ensure that the care provided is dignified, respectful and kind.
- The provider must ensure appropriate safeguards are in place for any patient in long term segregation with clear documentation and rationale recorded.
- The provider must ensure staff protect the dignity and privacy of patients at all times.
- The provider must ensure the individual incontinence needs of patients are being met and that patients are not left in soiled clothing.
- The provider must ensure that carers are involved in the care their loved ones receive ensuring carers are given opportunities to attend meetings and be involved in care planning and reviews of treatment for their loved ones.
- The provider must ensure there are appropriate and robust systems in place to review, develop and improve the service.
- The provider must ensure that patients have access to suitable activities to support their recovery.
- The provider must ensure that all patients have a discharge plan and are involved in discharge planning.
- The provider must ensure that information is available in formats suitable for individual patients' communication needs.
- The provider must ensure that patients' physical health needs are continually assessed and met.
- The provider must ensure that any restrictions on patient freedoms, including use of the internet and access to outside space, are based on individual risk assessments and reviewed regularly.

Action the provider SHOULD take to improve

- The provider should ensure all staff have opportunities to participate in quality improvement programmes.
- The provider should ensure second opinion appointed doctor referrals are made in a timely manner and avoid using section 62 to authorise non-urgent medication prescribing.
- The provider should ensure leave form risk assessments and updates should be completed before and after each instance of leave being taken.
- The provider should ensure details about the admission of patients who lack capacity is made available to the independent mental health advocate.

Outstanding practice and areas for improvement

- The provider should develop advance decisions for patients where appropriate
- The provider should ensure there are appropriate facilities available for carers and family visitors who visit the hospital.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Discharge planning was not evident in the care records reviewed.** **Easy read information and that in other languages was not available at the service and easy read posters were not on display at the hospital.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Information about the advocacy service was not displayed in an easy read format and did not include contact details for the advocacy service.**

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 **Pre-employment checks including references were not completed for all staff prior to them commencing work at the service.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Staff meetings did not take place regularly and frequently. Staff did not receive specialist training to enable them to work with patients with learning disabilities and complex needs. Based on number of patients and staff present, the service did not have sufficient number of qualified nurses present.