The Breighmet Centre for Autism

Quality Report

The Breightmet Centre for Autism
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Date of inspection visit: 14/07/2019
Date of publication: 10/10/2019

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

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.

Overall summary

- Following an initial inspection, which identified risks to patients in June 2019, we revisited the hospital because of further concerns around risk to patients and a failure by management to urgently address our original concerns.
- Clinical and environmental risks were not being managed effectively by the provider. This left patients at risk of avoidable harm.
- Staff did not assess and manage patient risks, risk assessments were not always updated following incidents and changes in presentation. Staff were not aware of patients known risks as risk assessments were incomplete and out of date.
- Staff did not learn from incidents. Incident information was not used to update risk assessments and care plans. We did not find evidence of incidents being reviewed and the lessons learned shared with staff.

Summary of findings

- Patients were left at risk following the potential for harm following episodes of restraint. Staff were not trained in the skills needed to support patents in a medial emergency through basic life support and there was no medical cover on site.
- The ward environment across most of the hospital was dirty with food and human waste evident in some of the bedrooms and social areas. These posed an immediate infection risk to patients.
- Two wards contained furniture and fittings that was damaged creating further infection risks. We found chairs, sofas with their protective covers missing or torn. We found mattress covers to be torn or missing with the mattress foam exposed allowing for contamination.
- The building showed signs of wear and tear throughout. This included cracks on the walls, damaged flooring, and the ceiling in one patient's room damaged with a number of large holes and insulation exposed.
- A number of items of wooden furniture including tables, bed bases and chairs were cracked or chipped. These posed an infection risk or a potential risk of harm and injury to patients.
- Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

Summary of findings

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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 is an independent hospital run by ASC Healthcare Limited. It is 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 are 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 on an interim basis the service was being managed by the provider's Chief Executive.

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 inspection was triggered by information we had received from the hospital following our inspection in June 2019.

Our inspection team

The service was visited by two CQC inspectors, an inspection manager and an assistant inspector.

Why we carried out this inspection

This was an unannounced inspection. We inspected following concerns that urgent actions arising from our last inspection, had not been addressed.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the environment and observed how staff interacted and cared for patients;
- spoke with 2 patients

Summary of this inspection

- spoke with one patient's relatives;
- spoke with the deputy manager;
- spoke with three qualified nurses and seven support workers;
- looked at care records for four patients;
- looked at incident records;

Information about The Breighmet Centre for Autism

The patients we met did not raise any concerns with us.

The family of a patient we spoke with told us about their experiences at the hospital.

We were told about concerns about cleanliness of the hospital, lack of communication and involvement in their relative's care.

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.

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.

Wards for people with learning disabilities or autism

Safe

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

Prior to our inspection, the provider told us that a number of concerns raised about the environment had been addressed, including the removal of damaged furniture. The provider had said there were systems and processes in place to maintain cleanliness across the hospital. However, during the inspection we found that the service had not improved, damaged furniture and items were still present within areas intended for patient use.

Prior to our visit the provider had advised that the required maintenance work identified at our last inspection could not be carried out, due to it being in clinical areas and until further discussions between clinical staff and contractors had taken place. However, the provider had not addressed how concerns raised about the risk posed from damage to the building would be mitigated in the meantime, as patients were still residing in these areas.

During this visit we found the concerns identified previously had not been addressed and concerns regarding the environment had significantly increased since our last inspection.

The hospital was divided into separate distinct wards referred to as apartments, each with access to an outdoor space. There were also a number of rooms which were intended for use by all apartments including a multi faith room, an activities room, and an activities of daily living kitchen. The hospital also had a central reception area, which contained communal toilets for visitors. We visited all areas during the inspection.

We found significant concerns about the safety and cleanliness of the environment across the hospital. We found damaged furniture present in communal areas and patient bedrooms. Rooms including the multi faith room and the activity room, intended for use by patients and visitors were being used for storage. Hazards were present in outdoor spaces intended for use by patients. Surfaces and walls were not clean, with staff confirming the presence of human excrement present on some walls and door frames and urine stains present on many walls and surfaces.

Across the hospital, including communal areas, and most rooms and bedrooms were sparse with limited content and most were not personalised. The provider had 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 during our previous visits some patients had told us they would like to have more furniture and personal items present in their rooms.

We found, damage to the environment on the wards and outdoor areas. In one of the apartments the door to the office did not securely close. Staff said this could be a problem with patients attempting to gain access.

Domestic staff worked at the hospital during the day. However, the environment on some of the wards was not clean and, in some areas, required a deep clean. A staff member told us domestic staff did not clean patient apartments and support staff were expected to do so. We found human excrement, urine and food stains on different walls, floors, ceilings and door frame surfaces.

In apartment one, the bed base in two of the patient bedrooms was damaged, with one which had the outdoor covering of the base coming off and in another wood from the base was chipped. On another ward, a patient had used material from a damaged bed base to self-harm. We found a patient bed which had a tear in the mattress covering. This meant the exposed material presented an infection risk and a choking risk from the foam filling.

We found dried human excrement stains on the door frame of the communal bathroom where there were a number of unsealed bags filled with clothing stacked up in a corner. An open aerosol can and clothing were present on the windowsill in the communal bathroom. In bedroom 5, we found faeces stains on a wall. In the communal dining room there were old and recent food and drink stains present on the wall and floor surfaces with damage to a TV cabinet noted with the wood broken and projections exposed. In another bedroom, damage was noted to the

bed base and a sofa in the bedroom was torn across one arm, with the exposed foam posing an infection risk and potential choking hazard for patients. Electrical plug sockets in this room had been partly covered using a sticky tape like material. Staff told us this was to prevent the patient from inserting objects into the socket. We found a patients ensuite with damaged flooring and a wall showing signs of potential damp. In bedroom three, the ensuite had excrement stains on the floor surface. Bedroom two, had masking tape covering two large areas on the wall which had been damaged. In bedroom four, the ceiling had three large holes present with the insulation foam exposed. The apartment also had one ensuite where tiles were missing from the wall. In the communal corridor where staff were seated observing patients and where patients often also sat, seven sofas and chairs were present which were both in a dirty condition but also showed signs of damage with coverings either torn or missing and seats damaged. This posed an infection risk. On one sofa the cover was torn and the underlaying foam had been damaged posing a potential risk to patients on the apartment who all lacked capacity.

In apartment two, there was a mattress in the communal bathroom along with clothing in bags and on top of bags. Staff told us this was because the patient preferred to empty their room during the day. However, the floor surface was unclean and stained. In one patient bedroom, the ensuite had a number of toiletries and liquid containing containers which had been left near the sink. A patients toilet was unclean with dried faeces on the seat.

In apartment three, the communal toilet had a used disposable clinical glove near the sink. The toilet seat was stained with faeces. The flooring in two of the patient bedrooms was damaged with areas where the laminate type floor covering was missing and the surface exposed with rigid edges. A table was damaged and wood chippings exposed in the communal lounge.

In apartment four, a communal bathroom had urine splash marks present in the bathroom with staining on the toilet and walls. There was also a strong odour present in the bathroom. The lighting above the bath, had a laminated piece of paper wedged underneath it. This posed a possible fire risk and staff were advised to remove it immediately. Skirting boards were damaged in one of the bedrooms with wood peeling evident.

Doors in a number of apartments were damaged, with cracks present on door frames and walls. In two patient bedrooms damage to the walls had left plaster crumbling and exposed.

The hospital had a number of outdoor spaces available for patients which were secured by the presence of a fence and a number of gates. In one of these, accessed by apartment two, the wooden bench was damaged with wood chipped and a metal screw exposed. In the outdoor garden used by patients from apartment one, three and the standalone apartment, we found two broken sofa's, blankets, bed linen and old clothing, some of which had shown signs of mould. On the lawn of one of the outdoor spaces which contained the football and basketball nets, we found disposable clinical gloves, polystyrene balls used for fillers and medicine cups. Some of these items posed a choking risk and we instructed the provider to dispose of these immediately, whilst other items posed both a fire and infection risk. We instructed the provider not to use that space until the items had been cleared. A member of the management team advised us these spaces were not being used. However, staff had told us these were regularly being used and we saw one patient using the outdoor space earlier during our visit.

A gate leading into the hospital grounds and from where the outdoor spaces intended for patient use could be accessed was not secure. We found bungy ropes being used to secure the gate. The provider told us this was because the lock for the gate was broken. This meant entry into and out of the hospital was not secure. This posed a risk of patients being able to abscond but also of people being able to trespass onto the site.

The hospital had several rooms intended for patient use. An activity room and a multi faith room were being used to store furniture. The multi faith room was full of various items which were no longer being used including broken chairs, sofas, boxes containing books, black bin bags filled with toys, a damaged table and three mattresses. Two communal toilets were also being used to store damaged furniture and rubbish. We were told by staff the hospital often used these rooms as stores. The deputy manager told us this happened because furniture was being damaged frequently. The activity room was filled with new furniture, paints and glues for use in activities and was not locked

during our visit. The management team advised us that this was temporary, however, staff told us the activity room had not been used for a while because it was being used for storage.

In the activities of daily living kitchen, the damaged appliance we found on our previous visits had now been removed. However, the kitchen was unlocked when we entered and sharps and knives were stored in a locked drawer but the key for the drawer was kept in a container nearby. Staff told us some patients were aware of where the knives and sharps were kept and where the key was stored. One staff member told us that there had been occasions when, staff who accompanied patients into the kitchen felt fearful that sharps and knives could be used by a patient to attack them.

Staff and patients told us repairs and maintenance were not carried out promptly. We heard about and witnessed drainage issues affecting ensuites, communal toilets and bathrooms, which affected how waste water emptied. Staff told us how in the past a communal bathroom had been out of service for several months before it was repaired. Managers confirmed they had experienced delays in fixing maintenance issues in the past which had been escalated to the provider's board.

Safe staffing

We found that there was not an adequate staffing establishment. On the day of our inspection there were 32 staff on shift of whom three were registered nurses, which meant one ward was not supervised by a registered nurse. The registered provider did not employ a specialist doctor since the previous doctor had left the hospital some months ago.

Prior to our inspection the provider had advised us that hospital staff were not trained in basic life support and that the provider was currently looking for a training provider to support staff. Basic life support is a training requirement for all healthcare staff who work with patients in a mental health inpatient hospital. The training enables healthcare workers and professionals to identify signs of a deteriorating patient and trains them how to react appropriately when a patient becomes unresponsive. The guidance issued by the National Institute for Clinical Excellence and the National Patient Safety Agency requires mental health hospital providers to offer this training to all staff. The provider was unable to confirm what the first aid awareness training offered to staff covered, in terms of the basic standards required by current best practice guidance. We were advised the training provided was an online course.

During our inspection, we found some staff had an awareness of how to identify signs of a deteriorating patients. However, when asked about how they would respond to an unresponsive or unconscious patient, support workers told us they would seek the assistance of a registered nurse, with only one support worker stating the consideration of basic first aid to help.

Information provided to us before the inspection, by the provider, stated it only had four staff who were trained in immediate life support training. Qualified clinical staff must be trained in immediate life support in services that use restrictive interventions. Guidelines from the National Institute for Clinical Excellence

recommends there should be one doctor and an immediate life support trained member of staff available immediately in any service that might use restrictive interventions. When asked, who on shift was trained, staff were not clear about this.

Staff told us that half those on shift were temporary staff. Managers were asked to provide confirmation of how many staff on shift were permanent. This information was not known by senior staff present.

Assessing and managing risk to patients and staff

Following our inspection in June 2019, we had told the provider to undertake a review of all risk assessments to ensure these were reflected in nursing and care assessments. We had also asked the provider to ensure these were understood by staff working with patients and that all were appropriately updated and reviewed following incidents and change in presentation. The provider was instructed to ensure these reviews were done by professionals with experience of learning disabilities.

Before our visit the provider had said this was being reviewed and had been communicated with nursing staff. During the visit the staff we spoke with were not aware of the reviews or these discussions having taken place.

All but one of the patients were being observed, by at least one member of staff at all times. Observations should have been based on individual risk assessments and carried out in accordance with care plans.

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

Staff told us any incident relating to a patient should have been attached to the risk assessment documentation, once this had been typed and printed. However, we found that updates to risk assessments were not done regularly or following incidents. We found in the care and assessment records of one patient that not all incidents were attached to a risk assessment and management plan documentation. This meant staff unfamiliar with the patient were not aware of all the patients presenting risks.

In the care and treatment records for one patient, the provider had not mitigated the patients known risks which were posed to self and others. This included incidents where sharp items had been taken, hidden and used to cause harm, despite the patient telling staff of the intent to cause harm with the item staff were aware was missing. We noted a risk assessment stated observation levels should be increased to have two staff supporting the patient. However, the patients care records showed observation had not been changed. Despite the patient being observed at all times, the patient was able to cause harm to a staff member. There were four further incidents which had occurred, whereby the patient had obtained items and intended to cause harm to self or others. In one of these incidents the patient was able to take and ingest tablets in their bedroom in the presence of staff. The risk assessment had not been updated following this incident. In another incident a patient had called the police and requested assistance of the ambulance service, with the details not captured in the patient's assessment records. A patient who had told staff of the patient's intention not to eat, to lose weight, did not have this recorded as a known risk, despite a number of occasions where the patient refused meals.

We found that staff were not aware of the risks posed by the environmental damage to individual patients. Our review of patient records found incidents involving one patient in which damaged items of furniture had been used to cause harm to self.

Staff we spoke with told us patient risk and presentation were discussed during handover meetings before each shift. However, on one apartment, the nurse in charge and a support worker could not demonstrate an awareness of the risks associated with patients under their care. Both these staff members were temporary agency staff.

Reporting incidents and learning from when things go wrong

We asked staff about the reporting of incidents, what should be reported, what should be investigated and what lessons learned had been shared with them when things went wrong. We found staff knowledge about this to be limited and none of the staff we spoke with were able to give us examples of incidents being investigated or what lessons learned had been shared with them.