Cygnet Cedar Vale

Quality Report

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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	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement

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

We inspected this service following information of concern from commissioners of this service. Commissioners were concerned about not being involved in best interest decisions about the care of patients that they commissioned care for, lack of staff knowledge about the Mental Capacity Act and autism and a culture of coercion and control within the hospital. Another commissioner contacted us previously with concerns

Summary of findings

about assessments not informing care plans that could have delayed the discharge of their patient. Therefore, we focussed on these issues at this inspection and only looked at two key questions which were effective and caring.

We rated Cedar Vale for effective and caring as requires improvement which changed the overall rating to requires improvement because:

- Staff did not develop holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Staff did not provide a range of treatments suitable to the needs of patients cared for in a ward for people with a learning disability and/or autism and in line with national guidance about best practice.
- Some staff had limited knowledge and understanding of how they should meet the complex needs of the patients. The ward team did not include or have access to the full range of specialists required to meet the needs of patients on the wards.
- The multidisciplinary team did not always work well with those outside the hospital who would have a role in providing aftercare.
- Staff did not fully understand and discharge their roles and responsibilities under the Mental Capacity Act 2005.
- Staff did not always treat patients with compassion and respect their privacy and dignity or understand the individual needs of patients.
- Staff did not always actively involve patients and families and carers in care decisions.

However:

- Managers ensured that staff received training, supervision and appraisal.
- Staff supported patients to live healthier lives.
- We observed staff speaking with patients in a calm and respectful way.
- Staff ensured that patients had easy access to independent advocates.
- The provider had invested money to improve the environment. We saw a new alarm system had been fitted, acoustic boards had been fitted to the lounge ceiling to reduce the noise and echo and an ensuite was being refurbished.

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	Requires improvement 	

Summary of findings

Contents

Requires improvement

Cygnet Cedar Vale

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

Summary of this inspection

Background to Cygnet Cedar Vale

Cedar Vale is an independent hospital registered to provide treatment of disease, disorder or injury and assessment or medical treatment for up to 14 male patients with learning disabilities, autism, and behaviours that may challenge who may be informal or detained under the Mental Health Act 1983.

Each patient had their own bedroom with en-suite facilities. Bedrooms were on the ground and first floors. An apartment area had been developed to accommodate up to six patients. Bedrooms were all en-suite and there was a separate lounge area and fully equipped life skills kitchen.

Cygnet Healthcare Limited own Cedar Vale. Cedar Vale is registered with the Care Quality Commission to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury

There have been four previous inspections of Cedar Vale. The previous inspection was on 3 October 2018. At this inspection, we rated Cedar Vale as good overall and good in all five key questions.

The last Mental Health Act review was in May 2019. They found that:

- Information about advocacy services and how to make a complaint to the Care Quality Commission was not displayed. At this inspection the information was displayed, but it was not clear if patients knew how to complain. However, patients had used the advocacy service.
- Staff had not recorded they had asked patients consent to have a photograph of them on patients records or whether the patient lacked the mental capacity to consent to this.
- Mental capacity assessments relating to consent to treatment were not always sufficiently detailed. Functional tests lacked detail and did not provide a narrative, so it was difficult to understand how the assessor concluded that the patient lacked capacity or had capacity to make the decision.

Our inspection team

The team that inspected the service comprised one Care Quality Commission inspector, one specialist advisor who was a nurse with experience of working with people with autism and one expert by experience who was a carer of a person with autism.

Why we carried out this inspection

We inspected this service following information of concern from commissioners of this service. Commissioners were concerned about not being involved in best interest decisions about the care of patients that they commissioned care for, lack of staff knowledge about the Mental Capacity Act and autism and a culture of coercion and control within the hospital. Previous concerns from another commissioner was about assessments not informing care plans that could have delayed the discharge of their patient.

Summary of this inspection

How we carried out this inspection

For this inspection we only looked at two key questions:

- Is the service effective?
- Is the service caring?

Before the inspection visit, we reviewed information that we held about the location, spoke with commissioners for the service and the independent advocate for the service.

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the ward environment and observed how staff were caring for patients
- met with eight patients who were using the service
- spoke with the manager
- spoke with five other staff members; including nurses and support workers
- attended and observed one multidisciplinary team meeting
- looked at care and treatment records of three patients
- spoke with two patients' carers by telephone and met with another carer
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Cygnet Cedar Vale

Cedar Vale is an independent hospital registered to provide treatment of disease, disorder or injury and assessment or medical treatment for up to 14 male patients with learning disabilities, autism, and behaviours that may challenge who may be informal or detained under the Mental Health Act 1983.

Each patient had their own bedroom with en-suite facilities on the ground and first floors. An apartment area has been developed to accommodate up to six patients. Bedrooms are all en- suite and there is a separate lounge area and fully equipped life skills kitchen.

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What people who use the service say

Patients were unable to tell us their views due to their autism and communication needs. We spent time observing staff interactions with patients and spoke with three patients' relatives.

One relative told us they were happy with the service.

Another relative told us they were not involved in their relative's care plans and had to ask for minutes of meetings about their relative.

Another relative said that they had raised some issues about their relative's care with the manager, but these had not been responded to.

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 effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not develop holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Staff did not provide a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability and/or autism and in line with national guidance about best practice.
- Some staff had limited knowledge and understanding of how they should meet the complex needs of the patients. The ward team did not have access to the full range of specialists required to meet the needs of patients. The occupational therapist had left a few months before our inspection and a new occupational therapist had only started working at the service the week of our inspection. However, at the time of our inspection, they only worked two days a week at Cedar Vale.
- The multidisciplinary team did not always work well with those outside the hospital who would have a role in providing aftercare following the patients' discharge.
- Staff did not always understand and discharge their roles and responsibilities under the Mental Capacity Act 2005.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans. However, these were not reviewed regularly through multidisciplinary discussion and updated as needed. Care plans did not reflect all patients' assessed needs and were not holistic and recovery oriented.
- Whilst staff used recognised rating scales to assess and record severity and outcomes. it was not always clear how these informed patient care plans.
- Staff did not 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 mental capacity.

However:

- Managers ensured that staff received training, supervision and appraisal. Managers provided an induction programme for new staff.
- Staff supported patients to live healthier lives.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Staff did not always treat patients with compassion and respect their privacy and dignity. For example, staff sat outside patient's bedroom doors with doors propped open with little interaction or any therapeutic intervention.

Summary of this inspection

- Staff did not always actively involve patients and families and carers in care decisions.
- Staff did not always involve patients in care planning and risk assessment and did not use a range of ways to enable patients to feedback on the quality of care provided.
- However:
- We observed staff speaking with patients in a calm and respectful way.
- Staff we spoke with understood the needs of individual needs of patients and their likes and dislikes.
- Staff ensured patients had easy access to independent advocates.

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 inspection there were 13 patients at the hospital who were all detained under the Mental Health Act 1983.

Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Commissioners told us the multidisciplinary team made a best interest decision relating to personal care. However, this decision did not involve the patient's carer (nearest relative under the Mental Health Act 1983) or the commissioners of the service. Therefore, this decision was not made in line with the Mental Health Act Code of Practice.

The provider made Mental Health Act and Code of Practice training available to staff as part of mandatory training requirements.

Staff told us they had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Policies and procedures reflected the most recent guidance available. A copy of the Code of Practice was available at the hospital.

Staff did not always risk assess patients prior to them taking section 17 leave (permission for patients to leave hospital) when this had been granted. One patient's records we looked at included a form developed by the provider for staff to complete. However, staff did not always complete this form fully. The form described the period of leave granted, the area in which the patient could go, how many staff and gender of staff who should go with them. The form asked staff to state whether they had checked the section 17 leave form or had agreement from the doctor who authorised the leave. It also prompted the nurse in charge to assess the patient's mental state before they went on leave. Staff did not complete this part on eight of the leave forms for this patient in September 2019.

Patients had access to an independent advocate who visited the hospital weekly. This was not an Independent Mental Health Act Advocate as defined under the Mental Health Act 1983. Staff explained that the criteria for accessing this service in Nottinghamshire was needs led only, for example, to represent a patient at a tribunal. However, the independent advocate represented patients at multidisciplinary team meetings.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make decisions on their care for themselves. A best interest decision made about a patient's care by the multidisciplinary team did not involve the patient's carer or the commissioners of the service. There was not a clear record as to why these people had not been consulted in line with the Mental Capacity Act.

The provider made Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training available to staff as part of mandatory training requirements.

The provider had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff told us they were aware of the policy and knew how to access it.

Since our Mental Health Act Reviewer visited in May 2019, staff had assessed patients' capacity to consent to have a photograph on their records. However, in two capacity assessments we looked at it was not clear how the staff assessing had concluded that the patient lacked capacity to consent.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Good	Requires improvement	Requires improvement	Good	Good	Requires improvement
Overall	N/A	Requires improvement	Requires improvement	N/A	N/A	Requires improvement

Notes

Requires improvement

Wards for people with learning disabilities or autism

Safe	Good
Effective	Requires improvement
Caring	Requires improvement
Responsive	Good
Well-led	Good

Are wards for people with learning disabilities or autism safe?

Good

Not inspected at this inspection.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff assessed the physical and mental health of all patients on admission. We looked at three patients care and treatment records. These showed that staff observed patient's physical health observations on admission and then monthly and recorded these. However, one patient record stated that staff should weigh them weekly, but their records did not show this had been done.
- Before our inspection, commissioners told us that assessments completed did not inform patients' care plans. We saw this in the records we looked at. For example, one patient's record showed they had epilepsy, but their physical intervention protocol stated they had no physical health concerns. Staff would need to know how to safely use physical intervention for a person who has epilepsy. We observed some art and craft activities during our inspection. However, it was not clear how these activities were linked to patients' needs and care plans. Occupational therapy assessments we looked at did not relate to activities.
- Care plans we looked at did not reflect the patient's assessed needs and were not recovery oriented. For example, one patient's care plan for personal care did not state how staff should encourage the patient to do this. We observed in the patient's multidisciplinary team meeting that the patient had changed his routine to bathing and eating at night. This impacted on his activities during the day, since he spent most of the day in bed asleep. Staff confirmed this change of routine and we saw the patient was asleep in bed during our inspection. This did not prepare the patient for discharge into the community and promote his recovery. Another patient's nursing assessment completed in May 2019 stated that a behaviour he had previously displayed had now stopped. However, his daily records indicated that this behaviour was ongoing.
- Staff we spoke with told us they did not have much input into patient care plans. We observed one multidisciplinary meeting where the team did not refer to the patient's care plan to inform their discussion of the patient's needs. We saw that staff had not updated one patient's care plan following an injury, so it was not clear how staff would know how to support them.
- Nursing staff had evaluated the care plans we looked. However, this was basic and did not result in an update to the care plan if the patient's needs had changed. For example, one evaluation stated, "the use of physical intervention has been required", however there was no reason as to why or whether the outcome of this was positive or negative.

- Staff were in the process of transferring patients records onto the providers electronic record system. Staff were working between paper and electronic records but had access to both. Staff said this had not impacted on patient care. The provider had deployed staff to manage this process and reduce the risks to patient care.

Best practice in treatment and care

- Staff did not always provide a range of treatment and care for patients based on national guidance for people with a learning disability or autism and best practice. For example, many people on the autism spectrum have difficulty processing everyday sensory information. Any of the senses may be over or under sensitive, or both, at different times. These sensory differences can affect behaviour and can have a profound effect on a person's life. The hospital had a sensory room to support patients with their sensory needs. However, staff were not aware that the equipment was not working in the sensory room. It was not clear how long this had been out of use and how often staff supported patients to use this facility. The manager said that funding had just been approved to repair this and equipment had been sent to be repaired.
- At the time of our inspection, there was refurbishment work ongoing in the hospital. Some areas were untidy because of this. The clinic room had been refurbished and a treatment room provided. However, there were several boxes in the treatment room and files on the floor and the examination couch, which meant the room could not be used. Across the hospital we observed rooms which were untidy where refurbishment work was ongoing, or patients' belongings were stored. Staff told us that some patients could not tolerate many items in their bedrooms due to their autism which meant their rooms were bare. However, in some rooms of patients who staff said could not tolerate many items, we saw several items on the floor and around the room.
- The service was working on the stopping over medication of people with a learning disability(STOMP) project and the provider had trained registered nurses in this. We did not look at patient's medication records during this inspection.
- All patients were registered with the local GP. Record we looked at showed staff sought advice from the GP when needed. One record showed that the patient had been seen by the dentist. However, their record stated they had not been seen by an optician as this was not possible due to their learning disability. There are opticians who provide services for people with learning disabilities and can monitor the health of a person's eye. A relative told us their relative had not been seen by a dentist or optician although they had requested this.
- Staff supported patients with their physical health needs and encouraged them to live healthier lives. This included access to a gym, regular walking, healthier options on menus, smoothie group and annual health checks.
- Staff used recognised rating scales to assess and record the severity of patients with autism. Staff used Health of the Nation Outcome Scales and Spectrum Star, but it was not clear how these related to the review of patient's progress.
- A psychologist worked at the hospital and developed patient's positive behaviour support plans. Registered nurses told us they were not involved in these plans. The manager told us that nurses completed behaviour and incident forms and the psychologist used these to formulate the plans. One positive behaviour support plan we looked at was comprehensive and showed all the patient's needs. However, this did not inform the patient's nursing assessment. This stated the patient had stopped a behaviour, but the patient's daily records showed this behaviour was ongoing. Staff had not recorded in the patient's daily records how they had responded to the patient's behaviours, so it was not clear if they had followed the patient's behaviour support plan. Another patient's positive behaviour support plan only referred to signs of aggressive behaviours. It provided minimal guidance for staff and was not updated with the current plan as to how to encourage the patient to do his personal care.

Skilled staff to deliver care

- Some staff had limited knowledge and understanding of how they should meet the complex needs of the patients. Staff working with patients did not know what was in patients positive behaviour support plans and did not have input to these.
- The hospital did not have access to the full range of specialists required to meet the needs of patients. The previous occupational therapist had left. At the time of our inspection, a new occupational therapist had

started working there two days a week. Multidisciplinary records we looked at did not include occupational therapist input and one did not include speech and language therapy input.

- The hospital employed a speech and language therapist. They designed communication grab sheets for each patient and communication aids for staff to use with patients. We saw Makaton (a sign language used by some people who have a learning disability) signs around the hospital. The manager said they had organised Makaton training as one patient uses it and staff confirmed this. Some staff had signs and symbols on their key rings to aid their communication with patients, however we did not observe staff using these. We looked at two patient's communication grab sheets. These did not indicate the patient's level of understanding, which meant it was not clear how much the patient understood what staff were saying to them. One patient's communication grab sheet stated to include their interests when interacting with them and to use real objects, natural gestures and Makaton signs to communicate. However, it did not state what these were.
- The provider's human resources staff completed professional registration and disclosure and barring service checks on staff. There was a recruitment, selection, and appointment policy and procedure to support managers through the recruitment process. The hospital stored staff records securely and only authorised staff had access to them.
- The provider had a comprehensive induction programme which was tailored to the needs of patients. All staff, including agency staff, completed this and at least five shadow shifts before they worked at the hospital. Managers reviewed staff progress with their induction after one, three and six months as part of the probationary process.
- Staff told us they had regular supervision with one of the registered nurses or the manager and found this useful. They said their learning and development needs were discussed during supervision and training was booked to help develop their skills.
- The hospital had an annual training plan that identified mandatory and additional training to equip new staff members in skills essential to their roles. This included specialist training relevant to patient's needs, for example, autism, epilepsy and positive behaviour support.
- Managers initially addressed poor staff performance in probation reviews or supervision. The provider's human resources department supported managers to escalate and manage concerns. During our inspection, the manager informed us of an incident which had resulted in staff suspension. We had previously been informed of incidents where staff were suspended, these were investigated, and appropriate action was taken by the provider.
- During our inspection there were no roles filled by volunteers.

Multidisciplinary and interagency team work

- The multidisciplinary team met weekly to discuss individual patients. We observed this meeting for one patient during our inspection. The multidisciplinary team did not discuss the patient's recent care and treatment review, a recent best interest meeting relating to the patient's personal care or actions from the previous multidisciplinary team meeting. This meant that it was not clear how these contributed to the patient's current care plan. The multidisciplinary team did not refer to assessments that led to the decision to use physical intervention if the patient did not attend to his personal care.
- We looked at the records for another patient's multidisciplinary team meeting. This did not include any occupational therapy input, had brief speech and language therapy input and did not state who attended the multidisciplinary team meeting.
- The team did not have effective working relationships with staff from services that would provide patients' aftercare following discharge. Two commissioners told us that assessments did not inform care plans and prepare patients for discharge. We observed that the team did not have an effective plan that would prepare patients for discharge and meet their needs.
- **Adherence to the Mental Health Act and the Mental Health Act Code of Practice**
- At the time of our inspection, there were 13 patients at the hospital who were all detained under the Mental Health Act 1983. Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Commissioners told us the multidisciplinary team made a best interest decision related to a patient's personal care. However, this decision did not involve the patient's

carer (nearest relative under the Mental Health Act 1983) or the commissioners of the service. Therefore, this decision was not made in line with the Mental Health Act code of practice.

- The provider made Mental Health Act and Code of Practice training available to staff as part of mandatory training requirements. At the time of our inspection, 93% of eligible staff had received this training.
- Staff told us they had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Policies and procedures reflected the most recent guidance available. A copy of the Code of Practice was available at the hospital.
- Staff did not always risk assess patients prior to them taking section 17 leave (permission for patients to leave hospital) when this had been granted. One patient's records included a form developed by the provider for staff to complete. However, staff did not always complete this form fully. The form described the period of leave granted, the area in which the patient could go, how many staff and gender of staff who should go with them. The form also asked staff to state whether they had checked the section 17 leave form or had agreement from the doctor who authorised the leave. It prompted the nurse in charge to assess the patient's mental state before they went leave. Staff did not complete this part on eight of the leave forms for this patient in September 2019.
- Patients had access to an independent advocate who visited the hospital weekly. This was not an Independent Mental Health Act Advocate as defined under the Mental Health Act 1983. Staff explained that the criteria for accessing this service in Nottinghamshire was needs led only, for example, to represent a patient at a tribunal. However, the independent advocate did represent patients at multidisciplinary team meetings.

Good practice in applying the Mental Capacity Act

- Staff did not always support patients to make decisions on their care for themselves. One record showed that the patient lacked capacity to consent to a decision about having a bath. The multidisciplinary team made a best interest decision about this but did not involve the patient's carer or the commissioners of the service. There was no record as to why the carer or commissioners were not involved. Therefore, this decision was not made in line with the Mental Capacity Act code of practice. The patient did agree to have a bath. However, at the time of inspection, the patient was bathing at night which was impacting on their quality of life. The change to their current care plan had not been agreed in their best interests.
- The provider made Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training available to staff as part of mandatory training requirements. At the time of our inspection, 98% of eligible staff had received training.
- The provider had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff told us they were aware of the policy and knew how to access it.
- Since our Mental Health Act Reviewer visited in May 2019, staff had assessed patients' capacity to consent to having a photograph on their records. Records we looked at during this inspection showed that staff had completed the functional assessments of the patient's capacity. However, in two assessments we looked at it was not clear how the staff assessing had concluded that the patient lacked capacity to consent. One capacity assessment said that the patient was able to communicate the decision by any means but then stated that the patient was not able to understand the information about the decision and was not able to communicate any decision. Therefore, it was not clear how the capacity of the patient to make this decision had been assessed.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

- Patients were not able to tell us about their experiences of using the service due to their autism and communication needs. We spent time observing activities and observed that staff listened to patients and gave them time to respond. In all the interactions we observed staff treated patients with compassion and support. Staff spoke with patients in a calm and respectful way.
- The multidisciplinary team did not act with compassion towards the patient when they decided how they would

encourage them to do their personal care. Staff told us, and the patient's records showed that due to his change of routine from day to night he did not access the community. This meant that staff did not encourage the patient to be as independent as possible and prepare him for discharge.

- We observed staff sitting at patients' bedroom doors to observe them. The patient who had changed his routine to having a bath at night and now slept during the day was asleep in bed during our inspection. Staff had placed a chair in his doorway and propped the door open. This did not respect his privacy and dignity.
- Care plans we looked at did not show staff how to meet patient individual needs and respect their preferences. However, staff we spoke with knew individual patients' likes and dislikes.

Involvement in care

Involvement of patients

- The manager told us that staff asked patients for their views in different ways to meet their needs, such as talking with them during smoothie making sessions. We looked at minutes of three patient meetings. These were in a format that used pictures and easy to read statements. However, these did not show that staff had used a range of ways to engage patients to express their views. They followed a set structure to ask patients for their views about food, activities, staff and the environment. Patients answered yes or no to the questions asked and some patients left the meeting after a few minutes.
- In one patient's care plan about their personal care there was no easy read information or a way to explain to the patient in an accessible format how they could prepare for a bath. Staff spoken with during the inspection were unaware of ways to explain to patients about their care plans in a format that was accessible to the individual.
- We observed staff trying to engage patients in art and craft activities during our inspection. It was not clear how these activities were linked to individual patients' needs and their care plans. Occupational therapy assessments we saw during our inspection did not relate to these activities. Staff asked patients if they wanted to take part in a choice of three activities but did not show patients what these activities involved. None of the patients wanted to take part apart from a new patient who was in the process of being admitted to the hospital.
- Bedrooms respected individual likes and dislikes. They contained individual patients' personal possessions and had been decorated in different colours according to individual tastes.
- Staff referred patients to the independent advocacy service who visited the hospital weekly. The advocate told us that staff welcomed their involvement in meetings about patients on the patient's behalf. Information about how to contact the advocate was displayed around the hospital.

- **Involvement of carers**
- Staff did not inform and involve all families and carers appropriately. One patient's commissioners told us that they and the patient's relative had not been invited to a best interest meeting. Another patient's records of their multidisciplinary team meeting did not include any carer input, but their records showed that their relative wanted to be involved in their care.
- One relative told us they did not feel totally informed about their relative's care and had not seen their care plan. They said they had to ask for minutes of meetings about their relative and staff did not offer them these unless they asked.
- Another relative told us that they asked for action to be taken in some aspects of their relative's care. However, staff had not responded to their request or made the improvements needed.
- Another relative told us that they were very happy with the care given to their relative at Cedar Vale.

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

(for example, to feedback?)

Good

Not inspected at this inspection.

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

Requires improvement

Wards for people with learning disabilities or autism

Good

Not inspected at this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients' needs are fully assessed and inform their care plans so that staff know how to meet the patients' needs.
- The provider must ensure that staff record how they have responded to patients' needs and behaviours in line with their care plans, evaluate these fully and update them to meet patients' current needs.
- The provider must ensure that staff assess patients' capacity and make decisions in patients' best interests in line with the Mental Capacity Act 2005.
- The provider must ensure that all staff treat patients with compassion and respect their privacy and dignity.
- The provider must ensure that staff involve carers where appropriate in all aspects of the patient's care.

Action the provider SHOULD take to improve

- The provider should ensure that the environment meets the sensory needs of patients.
- The provider should ensure that staff complete all records before a patient goes on section 17 leave.
- The provider should ensure that all staff have the skills and knowledge to meet patients needs.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment had not been planned with a view to achieving service users' preferences and ensuring their needs are met; to enable and support relevant persons to understand the care or treatment choices available to the service user.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Staff did not always treat patients with compassion and respect their privacy and dignity. One patient's routine had changed which meant that he did not access the community.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff had not acted in accordance with the Mental Capacity Act 2005 and involved the relevant people to make decisions in a patient's best interests.