Jeesal Cawston Park

Quality Report

Jeesal Cawston Park
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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 safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	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.

Summary of findings

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

This service was placed in special measures in September 2019. Insufficient improvements have been made following this inspection and the service will remain in special measures because there remains a rating of inadequate for the safe domain. The service will be kept under review and, if needed, further urgent enforcement action could be taken.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

Jeesal Cawston Park provides a range of assessment, treatment and rehabilitation services for adults with learning disabilities and autistic spectrum disorder.

We rated Jeesal Cawston Park as requires improvement because:

- At this inspection, the inspection team found further incidents where patients were placed at risk of harm due to observations not being completed correctly. Despite the senior management team putting extra measures in place to address concerns raised at the last inspection, the issue had not been resolved and patients were still being put at risk. At the last three inspection concerns were raised that staff did not correctly carry out supportive observations.
- Staff who witnessed colleagues sleeping on duty did not challenge this poor practice and accepted this behaviour. We reviewed seven pieces of randomly selected CCTV footage and found that on five of the occasions a member of staff was asleep when they were meant to be carrying out their duties. When some staff commenced their enhanced observation duties, we saw that they had brought with them a cushion or pillow and made themselves comfortable on the chairs before falling asleep. We saw evidence of staff moving chairs, or sitting in unusual places such as a kitchen worktop, which positioned them out of sight of the CCTV cameras. This demonstrated there was intent behind their actions and evidence of a culture which covered up these practices amongst night staff. This could be seen as indicative of a closed culture. When staff were sleeping, they would not be alert and able to respond quickly if immediate action was needed to keep a patient or a colleague safe. Therefore, this posed a significant risk to the safety of patients.
- The leadership team had not effectively addressed the issues outlined above despite being aware of these for over ten months. Managers had initially attributed the issue of staff sleeping to the use of agency staff; indicating it was agency staff who engaged in this practice. However, seven out of the eight staff members noted on the CCTV footage were permanent employees at the hospital.
- Staff did not sufficiently encourage patients to maintain a healthy lifestyle, for example to manage their weight by eating a healthy diet and do sufficient exercise. The 2018 Learning Disabilities Mortality Review found that poor quality healthcare causes health inequalities and avoidable deaths and people with a learning disability have worse physical and mental health than people without a learning disability. Therefore, if patients are not supported to maintain a healthy lifestyle this could have a disproportionate impact on their physical health. We were not assured that staff were working closely with the patients to agree and implement healthy living plans or that it was identified as a need in a timely manner, for example, before the patient had gained a significant amount of weight. This had seriously impacted on patients with co-morbid physical health conditions. Both the GP and patients' relatives had voiced concerns about this.
- Staff had not taken all actions necessary to reduce the spread of infection. At the time of the inspection, there was a heightened risk of infection due to the Covid-19 pandemic. During the inspection, we found that

Summary of findings

systems and processes were not effective in identifying and reducing all infection control risks, for example, broken equipment and a lack of cleaning in some areas

However:

- The service now had enough nursing and support staff to ensure that it could meet patients care and treatment needs.
- All patients had a care plan which was accessible and in an easy-read format. This was an improvement since the last inspection.
- During the inspection, we observed many kind and positive interactions between staff and patients.

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** 	We rated this service as Requires Improvement

Summary of findings

Contents

Requires improvement

Jeesal Cawston Park

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

Summary of this inspection

Background to Jeesal Cawston Park

At the time of the inspection, Jeesal Cawston Park provided a range of assessment, treatment and rehabilitation services for adults with learning disabilities and autistic spectrum disorder. The patients receiving care and treatment in this service have complex needs associated with mental health problems and present with behaviours that may challenge.

The service is registered with CQC for the assessment or medical treatment for persons detained under the Mental Health Act 1983, and the treatment of disease, disorder and injury.

There were 57 registered beds:

• The Grange – a 15 bedded locked ward accepting male patients only – currently closed

• The Lodge – a 14 bedded locked ward accepting both male and female patients

• The Manor – a 16 bedded ward which accepts both male and female patients – currently closed

• The Manor Flats – has six individual living flats, where patients are supported to live independently

• The Yew Lodge - has three self-contained flats, where patients are supported to live independently

• The Manor Lodge – has three self-contained flats, where patients are supported to live independently.

There were 14 patients in the hospital at the time of inspection. Following this inspection, and previous enforcement action, new conditions have been agreed with the provider via the tribunal process. The provider is now open for admissions and can provide regulated activities for a maximum of 12 patients. This has reduced the capacity of the hospital from 57 to 12 beds.

The Care Quality Commission inspected Jeesal Cawston Park Hospital on six occasions within the last 18 months, between June 2019 and August 2020, due to ongoing concerns about patient safety and leadership at the hospital. The Care Quality Commission has taken a range of supportive and enforcement action during this period. Whilst our enforcement action is ongoing, we are maintaining enhanced engagement with the provider and monitoring of the service. Various other stakeholders are also monitoring the provider such as Clinical Commissioning Groups, local safeguarding authorities and NHS E.

The Care Quality Commission has a duty under Section 3 of the Health and Social Care Act 2014 (HSCA) to consider the safety and welfare of all patients at the hospital. We looked at this throughout all our inspections of this provider.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, two CQC inspectors, a specialist professional advisor who had current experience of working with people with learning disabilities and autism and an expert by experience.

Why we carried out this inspection

This inspection was a full, comprehensive inspection to assess the quality of care and to monitor whether the provider had made the required improvements following the previous inspections.

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?

Before the inspection visit, we reviewed information that we held about the service and asked a range of other stakeholders and organisations for information.

During the inspection, the inspection team:

- Visited all open wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with five carers of patients who were using the service
- spoke with the Chief Operating Officer/Registered Manager, the Deputy Hospital Director, the operations manager and the service manager
- spoke with 13 other staff members; including the medical director, nurses, support workers, occupational therapist, speech and language therapist, social worker and activities co-ordinator
- received feedback about the service from 5 care co-ordinators or commissioners, the service general practitioner and feedback from the local safeguarding authority
- spoke with the independent advocate for the hospital
- looked at six care and treatment records of patients
- carried out a specific check of the clinic rooms and medicine management on all wards
- Viewed CCTV footage of staff carrying out observations
- and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Patients we spoke with told us that staff were kind and we observed many caring, positive interactions between staff and patients.
- One patient told us how staff had supported her to maintain her relationship with her boyfriend who lived in another part of the country.
- Four carers told us they were happy with the care that was given to their family members and that staff were friendly, polite and helpful.
- One carer told us that communication could be difficult with staff who did not have English as their first language.

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

We rated safe as inadequate because:

- The issues about the lack of safe observation practice had been raised at the last three inspections. At this inspection, the inspection team found further incidents where patients were placed at risk of harm due to observations not being completed correctly. Despite the senior management team having put measures in place in an attempt to address concerns the issues had still not been addressed and patients were still being put at significant risk.
- Staff who witnessed colleagues sleeping on duty did not challenge this poor practice and accepted this behaviour. We reviewed seven pieces of randomly selected CCTV footage and found that on five of the occasions a member of staff was asleep when they were meant to be carrying out their duties. We saw evidence of staff moving chairs, or sitting in unusual places such a kitchen worktop, which positioned them out of sight of the CCTV cameras. This demonstrated there was intent behind their actions and evidence of a culture which covered up these practices amongst night staff.
- Staff lacked an understanding of the risks posed to patients and staff by them sleeping whist on duty. When staff were sleeping, they would not be alert and able to respond quickly if immediate action was needed to keep a patient or a colleague safe.
- Staff had not taken all actions necessary to reduce the spread of infection. At the time of the inspection, there was a heightened risk of infection due to the Covid-19 pandemic. During the inspection, we found that systems and processes were not effective in identifying and reducing all infection control risks.
- Environmental and operational risk assessments did not cover all risks evident on the ward, staff had difficulty finding risk information and it was unclear how risks were communicated to new staff.

However:

- The service had enough nursing and support staff to keep patients safe. This is an improvement since the last comprehensive inspection.

Summary of this inspection

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. This is an improvement since the last comprehensive inspection.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not sufficiently encourage patients to follow a healthy lifestyle. The 2018 Learning Disabilities Mortality Review found that poor quality healthcare causes health inequalities and avoidable deaths and people with a learning disability have worse physical and mental health than people without a learning disability. Therefore, if patients are not supported to maintain a healthy lifestyle this could have a disproportionate impact on their physical health. We were not assured that staff were working closely with the patients to agree and implement healthy living plans or that it was identified as a need in a timely manner, for example, before the patient had gained a significant amount of weight. This had seriously impacted on patients with co-morbid physical health conditions.

However

- All patients had a care plan which was accessible and in an easy-read format. This is an improvement since the last comprehensive inspection.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- An advocacy service was available for patients. The independent advocate for the hospital had been invited to attend clinical governance meetings which enabled a regular, formal opportunity to raise patient issues with senior managers.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Staff did not raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff were still sleeping during the night instead of observing patients. Staff failed to recognise the importance of not sleeping at night and we saw staff planning to sleep during the night. Other staff members who witnessed this did not report it.

However:

Summary of this inspection

- During the inspection, we observed many kind and positive interactions between staff and patients.
- Patients told us staff treated them well and behaved kindly and they felt safe and happy at the hospital.
- Staff used appropriate communication methods to support patients. This is an improvement since the last comprehensive inspection
- Staff involved families and carers appropriately. Staff facilitated video and phone calls to help families stay in touch with their loved ones during the Covid-19 pandemic.

Are services responsive?

Good

We rated responsive as good because:

- Staff had improved the planning and recording of activities for patients, including those in long term segregation. During the inspection, we saw evidence of staff offering an increased number of activities and therapies to patients. This is an improvement since the last comprehensive inspection.
- Staff had sustained improvements in discharge planning for patients since the last comprehensive inspection
- The service had assessed, and made improvements to, the long-term segregation environments. Further improvements were planned following delays caused by the Covid-19 pandemic.
- There was a full range of rooms available at the hospital, including clinic rooms, an activity centre, sensory rooms, gymnasium, art therapy and woodwork rooms. Staff had carried out risk assessments to enable patients to continue using the sensory rooms and gym during the Covid-19 pandemic.

However:

- Staff offered limited activities at weekends and evenings.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The provider had not ensured they had effective systems in place to assess and monitor the quality of care for patients. Managers had not identified a high number of incidents where night staff were sleeping on duty, despite internal assurance processes. Despite the leadership team having been aware of these issues for ten months, they had still not taken effective action to eradicate this practice. The management team had stated the issue was attributed to the use of agency staff.

Summary of this inspection

However, seven out of eight staff noted on the CCTV footage were permanent employees and it should not matter which group of staff continued this practice, managers had not recognised the seriousness and significant risk it posed.

- Managers had not addressed, or acted upon, the risks of a closed culture developing at the hospital. We saw evidence of a closed culture at night as there was a lack of challenge to poor practice and staff who witnessed colleagues asleep accepted this behaviour. Staff we spoke with told us they felt able to raise concerns without fear of retribution and were aware of the whistleblowing process. However, it was evident that staff knew, but did not raise concerns, about the conduct of their colleagues at night. We saw evidence of staff moving chairs, or sitting in unusual places such a kitchen worktop, so they were not in view of CCTV cameras.

However:

- The Registered Manager had made changes to the governance processes which were starting to become embedded and had led to some improvements in patient care.
- Managers had improved oversight of recruitment processes and procedures.
- Staff we spoke with felt personally respected and valued. Staff told us that colleagues supported each other, and managers were visible and approachable.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff provided patients with written information and a verbal explanation of their legal position and rights at the time of their detention/admission and every three months. Staff provided a fresh explanation at key times as recommended in the Code of Practice (4.29).

The Mental Health Act administrator and the speech and language therapist developed easy read Mental Health Act leaflets in two formats, one of which they called 'super easy read'. There was extra information in the Mental Health Act leaflets for patients who were in long-term segregation.

The Mental Health Act (MHA) administrator completed an audit of Mental Health Act processes on each ward every three months including audits of Mental Health Act section papers, section 132 information, consent to treatment and section 17 leave. During the Covid 19 pandemic this was devolved to the wards, however at the time of the inspection the MHA administrator had resumed oversight of the regular audit.

Staff completed a recording form for section 17 leave, including a risk assessment prior to the patient leaving the ward and the outcome of the leave. At the previous comprehensive inspection in February 2020, we reported that staff were not recording the patient's ongoing risks on the risk assessment form. During this inspection, we looked at four section 17 risk assessments. Staff had carried out the risk assessment based on the patient's current presentation prior to the leave, however there was nowhere on the form where staff could write in any risks specific to the patient, for example that they were at risk of swallowing objects. It is important that staff are aware of all patients' historic and current risks, whilst they are on section 17 leave so they can ensure patient safety.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of the time of inspection, 94% of staff in this service had received training in the Mental Health Act. More staff had completed training than at the last comprehensive inspection.

An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints. We spoke with the independent advocate who was positive about their work at the hospital. They had been invited to attend clinical governance meetings and they told us this gave them a regular, formal opportunity to raise patient issues with senior managers.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had sustained improvements in the recording of mental capacity, which had been a concern at previous inspections. During this inspection, we saw evidence that staff were using the capacity assessment tab, which had been added to the provider electronic recording system, in all the care records that we looked at.

During the inspection, we saw evidence of staff holding best interest meetings, with advocates supporting patients, to make decisions about particular aspects of patients care.

The responsible clinicians assessed patients' capacity to consent when there were changes in the treatment plan.

At the time of inspection, figures provided by managers showed that an average of 91% of staff had received training in the Mental Capacity Act and deprivation of liberty safeguards.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

Environmental and operational risk assessments did not cover all risks evident on the ward, staff had difficulty finding risk information and it was unclear how risks were communicated to new staff. The external health and safety consultant had completed environmental and operational risk assessments which were due for review at the end of August 2020. However, during the inspection, staff we spoke with had difficulty finding the information when we requested it. One long-standing member of staff was able to demonstrate knowledge of environmental risks; however, they were unclear how this was covered in induction for new staff. This meant that new staff may not have been aware of all the environmental risks on the wards and how to mitigate them. During the inspection, we identified some environmental risks such as a broken plastic truck and a torn chair, with exposed foam, which could have posed a choking or infection control risk. The risk of injury from these items was mitigated by the fact they were in areas where patients were always supervised, however these had not been picked up by the Nurse in Charge checks and the infection control risk remained a concern.

There were numerous blind spots and points that could be used to self-ligature throughout the hospital. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff used their knowledge of patients, individual risk assessments and zonal observations to mitigate risks, including ligature risks. In The Lodge convex mirrors were used throughout communal areas to enhance patient safety. Staff were not able to find the ligature risk assessments for the flats and bungalows during the inspection. Managers provided us with these following the inspection. If staff cannot easily access this information, they may not be aware of all the ligature risks in the area they are working in. Staff told us that patients currently in these areas were not at risk of self-ligature. However, if there were new admissions in the future, the risk profile of patients could change so it is important that staff are aware of all the risks in the environment. Staff had completed a ligature point assessment sheet for The Lodge which had been updated in May 2020. The assessment detailed the ligature points on the ward and what additional controls were in place to mitigate risks.

The provider had addressed the risk of fire. We saw evidence of a report the health and safety consultant provided to the Clinical Governance Committee confirming that the fire risk assessments completed in April and May 2019 had been actioned and completed. The external health and safety consultant had become a member of the Clinical Governance Committee and reported to the committee if future actions were required.

At the last comprehensive inspection, we reported concerns about the safety of the window in the seclusion room at The Grange. Since this inspection, staff had decommissioned this seclusion room and it was no longer in use.

Staff were completing a Quality & Safety checklist once daily and nightly, which incorporated an environmental

checklist. The Nurse in Charge on each of the wards had overall responsibility for completing the checklists. The Quality Improvement and Audit Manager carried out an audit of the checklists in June 2020. The audit showed that nurses maintained checklists to a level of 81% in April and 96% in May 2020. The baseline standard was set at 100%. During this audit period the hospital was experiencing the impact of Covid-19 and this was given as a mitigation as to why the baseline standard of 100% had not been met. The standard of the content within the checklists, comments, actions and tick boxes, rated as 'good' or 'excellent' was just above average at 53% for April and 67% for May. Following this audit, a number of actions were generated to improve the quality of the audits and increase compliance to 100%. Managers had allocated a person responsible for these actions and a timescale by which they should be completed.

All of the wards complied with the Department of Health's guidelines on mixed sex accommodation, including provision of a female only lounge on The Lodge.

On the Lodge, staff had easy access to alarms and patients had easy access to nurse call systems. There were no patient alarms in the Yew or Manor flats, however staff carried radios and staff remained with patients all the time due to their needs.

Maintenance, cleanliness and infection control

Staff had not taken all actions necessary to reduce the spread of infection. At the time of the inspection, there was a heightened risk of infection due to the Covid-19 pandemic. During the inspection, we found that systems and processes were not effective in identifying and reducing all infection control risks. We found several items in the staff fridge and the patient activity fridge that were open but undated and one fridge was not clean. We also found two white coats in a food preparation area in a kitchen that had not been regularly washed and were designed to be used by staff to serve food. There was a chair in a patient-accessible activity room which had exposed foam which was both an infection risk and a risk for patients who may self-harm by swallowing the foam. On day one of the inspection there were no disinfectant wipes available in the office in The Lodge to routinely wipe office equipment including computer keyboards and phones. There was also no guidance for staff regarding how many staff should be in the office at one time. This could be an infection control risk. During the inspection, staff had difficulty finding cleaning records when these were requested. When they were found, we saw that they were completed to say an area had been cleaned, however staff were unclear how these were audited or who had oversight that cleaning was completed to the correct standard. However, increased cleaning schedules had been in place since late March 2020.

Managers had put in additional infection control measures to mitigate the risks of Covid-19 including, routine temperature checks for staff and patients, ensuring that staff wore face-masks in clinical areas and ensuring the supply of handwashing materials was readily available around the hospital. During the inspection, we observed that staff were using personal protective equipment, including face masks, appropriately.

The practise nurse carried out an infection prevention and control audit in August 2020 which did not identify the gaps noted above. This audit rated all areas as green, i.e. there was evidence of good practice, apart from a need to review the infection control policy and to re-instate the meetings of the infection control group. Managers had generated actions from this audit, and these had been assigned to a named member of staff with a target date for completion.

An infection control assessment had been carried out for the two sensory rooms, including easy read infection control actions, which ensured that patients could still safely use these spaces during the Covid-19 outbreak.

Four patients had been tested positive for Covid-19, all of the patients had mild symptoms and the service acted to test and isolate the patients to limit the spread of the infection.

Seclusion rooms

There was one seclusion room at the hospital on The Lodge. The seclusion room on The Grange had been decommissioned since the last comprehensive inspection in February 2020.

The seclusion room was clean and allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

The clinic room fridge was not clean at the bottom and the emergency medicines kit was full of dust which suggested

that the tops of cupboards were not regularly cleaned, although the cleaning schedule was ticked to say it had been done. This was brought to the attention of staff at the time of the inspection.

The clinic room on The Lodge was fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked regularly.

Staff had made regular checks of emergency equipment and all appropriate equipment was present and in date.

Safe staffing

The service had enough nursing and support staff to keep patients safe. The service had significantly fewer patients since the last inspection which had allowed managers to reduce the number of bank and agency staff required. The service reported a vacancy rate of 25% for registered nurses and 0% for support workers. The 25% vacancy for registered staff meant a quarter of registered nurse shifts still had to be filled via the use of long-term agency or bank.

Levels of sickness had reduced since the time of the last comprehensive inspection. The average sickness from May to August 2020 was 3.25% including long term sickness and Covid-19 self-isolation requirements. This was an improvement on the 25% reported previously. Managers told us this significant reduction in sickness absence was attributed to improved recording, daily absence monitoring and implementation of informal and formal improvement plans.

Between June and August 2020, 1,128 shifts were filled by bank or agency staff to cover sickness, absence or vacancy for qualified nurses or support workers. This was a reduction from the 3,563 shifts filled by bank or agency staff in a comparable time period in 2019.

Where possible, managers requested staff familiar with the service and made sure all bank and agency staff had an induction and understood the service before starting their shift. However, during the inspection senior staff told us that it was unclear how environmental and infection control risks were covered during induction for new staff.

Managers kept human resources (HR) files complete and in good order. This is an improvement since the last inspection. We looked at three HR files and all were complete with the required documentation in place. Since the last inspection, paper HR records had been moved to the provider's electronic recording system and HR staff told us this made HR systems and processes more effective and accessible.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

Staff had mostly completed and kept up-to-date with their mandatory training. The Covid-19 outbreak had affected the ability of some staff to complete training.

The service set a target that 75% of its staff should have completed mandatory and statutory training. Of the training courses listed two had failed to meet the provider target. The average rate of compliance for Positive Behaviour Support day 2 was 73% and for Effective Communication was 70%. At the time of the inspection, 77% of staff had completed face to face training in autism awareness. The provider had been unable to provide the full 'Managing Violence and Aggression (MVA)' training since the beginning of the Covid-19 pandemic. At the time of inspection, 91% of staff were up to date with MVA training. Staff who had not completed MVA training had completed de-escalation and breakaway training to ensure they could respond to distressed patients and keep themselves safe.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always manage risks to patients and themselves well. At the last three inspections, we had reported on the high number of incidents that had occurred where patients had caused harm to themselves, or were exposed to harm, due to observations not being completed correctly. We carried out a responsive inspection in May 2020 following further concerns about patient safety and we found that staff did not complete patient observations safely and in line with the provider's observation policy.

Prior to the May inspection, managers informed us of an incident in which staff had intermittently fallen asleep whilst completing 1:1 patient observations. In the month prior to this inspection, the service reported a further

incident where managers had identified a member of staff as being asleep on duty during a routine check of CCTV. We also received an allegation from a whistleblower that staff were sleeping on night duty.

During the inspection, we viewed a sample of CCTV footage, over seven nights, and found further evidence of night staff sleeping on duty. Four out of five pieces of footage showed a member of staff asleep when they should have been carrying out 2:1 observations. Staff members did not rouse their sleeping colleagues and did not report this to the nurse in charge or to managers. This could be indicative of a closed culture within the organisation where it is seen as usual, or acceptable, for support staff to sleep when they are on observations.

During our review of CCTV footage, we also saw that some staff were moving chairs so they were under the CCTV cameras or sitting/lying in other unexpected places. This could indicate that staff were trying to avoid being viewed on CCTV. We raised these concerns at the time of inspection and managers took immediate action. The Registered Manager also assured us they would fully investigate, including viewing further CCTV footage, and provide a report of actions taken.

Managers had previously taken a number of actions to address staff not completing observations correctly and sleeping on duty, including requiring staff to complete an observations competency workbook, issuing guidance to staff about how to combat sleepiness whilst on a night shift and conducting walk rounds and spot checks at night. However, these actions had not been effective as staff sleeping incidents continued to occur.

During the previous comprehensive inspection in February 2020, it was reported that staff were using their tablet computers (which should be used to complete observations records) to carry out personal internet searches or play games. Managers confirmed they had now permanently restricted access to the internet for nursing and support staff. This was an improvement since the last inspection.

Assessment of patient risk

Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident. Staff updated risk assessments on a regular basis, including after incidents. This is an improvement since the focused inspection in May 2020.

Use of restrictive interventions

The use of restraint had decreased. Between June and August 2020, there were a total of 489 episodes of the use of restraint across the hospital. The number of episodes of restraint reported during this inspection was lower than the 725 reported at the time of the last comprehensive inspection. However, there were significantly fewer patients at the hospital since this time. At the time of the comprehensive inspection in February 2020 there were 34 patients at the hospital whilst at the time of this inspection there were 14 patients so a reduction in the number of incidents and restrictive interventions would be expected.

There were no incidents of prone restraint. Prone restraint was no longer taught as a technique for managing violence and aggression at the service.

Staff had sustained the improvements in the recording of restraint since the last comprehensive inspection. We looked at three restraint records and saw that staff had recorded episodes of restraint in good detail and recorded physical observations after each episode of restraint. Staff had completed body maps, or provided a rationale if one was not completed, for example if the patient was too distressed.

There were 15 incidents of rapid tranquilisation over the reporting period. Staff completed an incident form and physical observations after each episode of rapid tranquilisation. This is an improvement since the last inspection.

Between January and August 2020 there had been five instances of seclusion. The number of seclusion incidents reported during this inspection was lower than the 24 reported at the time of the last comprehensive inspection. However, there were significantly fewer patients at the hospital since this time so a reduction in the number of seclusions would be expected. Staff confirmed they only used seclusion as a last resort. The registered manager had made a recommendation to the clinical governance committee that the one remaining seclusion room was decommissioned at the hospital. Managers agreed at the July clinical governance committee that the service will stop using seclusion at the end of August 2020, if they could put alternative arrangements in place. Staff discussed

alternative ways to manage patients who were highly distressed, but we could not see evidence of any concrete plans or guidance for staff of what these alternatives could be.

We looked at two seclusion records for one patient. In both instances there was a rationale for the seclusion and reviews were carried out in line with the Mental Health Act Code of Practice. The speciality doctor was consulted, and attended, on both occasions.

Two patients were in long term segregation (LTS) at the hospital at the time of our inspection. Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multidisciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis.

We reviewed the hospital audit of LTS reviews. The Quality Improvement & Audit Manager had completed an audit of LTS reviews in July 2020. The audit showed that between April and June 2020 daily reviews were recorded in the patients records on 98% of the days possible. Doctors completed 100% of the weekly reviews for each of the months included. This is an improvement since the last inspection. During the audit period, the external 'approved doctor' was unable to attend the hospital site to carry out the quarterly reviews due to the Covid-19 pandemic, however these took place at the end of June once lockdown restrictions had eased.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. At the time of inspection, 96% of staff had completed safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

The service employed two social workers whose role involved overseeing safeguarding referrals, completing safeguarding audits, liaising with the local authority and acting as a point of support for safeguarding advice for other staff in the service

Between June and August 2020, the service reported 14 safeguarding incidents. At the recent focussed inspection in May 2020, we reported that staff were not notifying CQC of all reportable safeguarding incidents in a timely manner. At that inspection, staff informed us they would wait to report incidents to CQC, until the local safeguarding authority told them they were opening a section 42 enquiry. This meant that CQC was not receiving certain safeguarding notifications and that others were not reported in a timely manner. Since the May 2020 inspection, the Registered Manager had updated the Quality Improvement - Action Plan to ensure that all incidents would be reported to CQC at the same time as the local safeguarding team. We viewed the latest version of the service safeguarding policy, which was updated in August 2020, and saw evidence the wording had been changed to reflect this. However, we viewed the service safeguarding log and saw that out of the 14 incidents, there was still one incident from the beginning of August that had not been reported to CQC. Managers assured that that staff would report all incidents going forward.

We sought feedback from the safeguarding authority prior to the inspection. The safeguarding authority had identified some recurring themes in July 2020, including observations not being carried out properly, the management of patient physical health needs, the management of patients at risk of swallowing objects and environmental risks.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff had access to the equipment and information technology needed to do their work. Staff had access to portable tablet computers. They could input observations and effectively access patient care and treatment plans.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. This is an improvement since the last inspection.

Managers told us that the service was working towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP). The use of high dose psychotics had reduced across the site and was not linked to the reduction in patient numbers. This is an improvement since the last inspection. The service had conducted a STOMP audit in May 2020. At the time of the audit, 34% of the prescribed medications had been either discontinued or there had been a reduction in use of that specific psychotropic drug.

At the last comprehensive inspection, we reported that staff had not clearly documented the rationale for giving as required (PRN), sedative medicine for a patient in long term segregation. Since this inspection, doctors had discontinued the use of this medication and prescribed an alternative medication which had fewer side-effects, including less risk of dependency. This is an improvement since the last inspection.

Medicines, including controlled drugs and emergency medicines, were stored securely.

Staff monitored the temperatures of medicine storage fridges.

Medicines were mostly disposed of appropriately. During the inspection, we found one cream which was out of date from the beginning of August and one bottle not dated. We also found a sharps bin on The Lodge that had not been signed when opened. Sharps bins should be disposed of every three months for infection control purposes and if a bin is not signed to say when it was opened, staff would not know when it should be disposed of.

The external pharmacist provided clinical and medicine management audits to comply with best practice and regulatory requirements. Feedback was given to managers on the day of the audit and reports provided to staff via confidential access to their website. We viewed the audit and found it to be up to date and complete.

Track record on safety

Between January and August 2020, six serious incidents were reported via the Strategic Executive Information System. A serious incident is an incident that has resulted in serious physical or emotional injury or damage to property essential to the security and effective running of the unit. Of the total number of incidents reported, the most common type of incident was self-inflicted harm.

The number of serious incidents reported during this inspection was lower than the 32 reported at the last comprehensive inspection. However, there were significantly fewer patients at the hospital since this time so a reduction in the number of serious incidents would be expected.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff recorded incidents onto the electronic patient information system. All staff, including agency staff, were provided with portable tablet computers connected directly to this system so they could complete incident reporting immediately after an incident.

Each recorded incident was reviewed by the senior management team in their daily morning meeting as well as by the psychology department. Incident data was used to inform various forums including patients' individual multi-disciplinary team meetings, Positive Behaviour Support plans, functional assessments and case conferences with the staff team. Data regarding incidents for each patient was available for all staff members to review via a desktop or tablet computer.

At the last inspection, we reported that managers were inconsistent at reviewing and learning from incidents. We reported that lessons learnt bulletins were poorly worded and lacked useful detail of what happened, and managers were not assured that staff could find, or were reading, information about lessons learnt. During this inspection, we noted some improvements, however we were still not fully assured that managers were identifying, and effectively sharing, lessons learnt immediately following incidents or that processes were yet sufficiently embedded.

Since the last inspection, the Quality and Patient safety forum had got underway and members of the forum had met four times and staff discussed outcomes of serious incidents, root cause analysis reports and lessons learnt. During the May meeting, the group discussed how lessons learnt could be made more accessible to staff. Specific information on lessons learned were shared on information screens across the hospital, via incident de-briefing of staff,

at morning meetings and through supervision. We saw evidence of lessons learnt displayed on screens in The Lodge and patient safety bulletins were available in key areas. The bulletin informed staff where you can find out about other lessons learned, for example on posters, ward meetings and via the provider electronic recording system. This is an improvement as at previous inspections we were not assured that staff knew where to look for this type of information. However, managers did not provide evidence of any immediate lessons learnt following three incidents that were subject to a root cause analysis report. Following an incident, it can take several weeks for a root cause analysis to be completed and so if immediate lessons are not identified and shared, there can be an increased risk of further, repeat incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour training was mandatory for managers in the service. Staff are introduced to the duty of candour regulations during the company induction and are reminded during their work practice.

Managers debriefed and supported staff after any serious incident. The service had added a screen to the provider electronic recording system which enabled managers to refer staff for a debrief and for managers to have a record which staff had received a debrief and on what date.

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 developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans and positive behaviour support plans when patients' needs changed.

Positive behaviour support plans were present and supported by a comprehensive assessment

Staff ensured that all patients had a care plan which was accessible and in an easy-read format. This is an improvement since the last inspection.

We reviewed six care and treatment records for patients and saw that these had all been updated and there was evidence of staff recording of patient views where appropriate.

Best practice in treatment and care

Staff did not sufficiently encourage patients to maintain a healthy lifestyle, for example to manage their weight and do sufficient exercise. The 2018 Learning Disabilities Mortality Review found that poor quality healthcare causes health inequalities and avoidable deaths and people with a learning disability have worse physical and mental health than people without a learning disability. Therefore, if patients are not supported to maintain a healthy lifestyle this could have a disproportionate impact on their physical health. We spoke with the GP surgery for the service who told us they were concerned about the lack of a holistic approach to healthy living for patients at the hospital. The GP surgery told us that patients were not consistently supported to limit their intake of high calorie snacks and 'junk food' and they saw evidence of patients gaining weight. One carer we spoke with told us that they were concerned about their family member's weight gain during the Covid-19 lockdown and that staff did not encourage them to do enough exercise. We received feedback from another carer, via the patient's commissioner, that their family member was not encouraged to walk during their admission to Jeesal but was driven everywhere. At the previous comprehensive inspection, a care and treatment review had highlighted concerns about the weight gain of a patient who was in long term segregation. The service had access to a dietician who gave advice to staff regarding patient nutrition and produced diet plans for individual patients, and a fitness instructor, however we were not assured that staff were robustly implementing healthy living plans or that they were provided in a timely manner, i.e. before the patient had gained a significant amount of weight.

Staff carried out physical healthcare checks on a monthly basis with patients and these had been completed in all of the records that we looked at. However, staff did not always act on the findings in a timely manner, for instance when a patient was identified as being an unhealthy weight. There

was little evidence of supporting the patient to understand the risks associated with weight where patients had co-morbid conditions and referrals to other services, e.g. the dietician, did not occur in a timely manner.

Psychological therapies were offered, as recommended by the National Institute for Health and Care Excellence. The range of interventions included, anger and anxiety, bereavement and emotional and distressed behaviour. Psychologists were involved in writing positive behaviour support plans.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward.

Managers gave each new member of staff a full induction to the service before they started work. However, senior staff told us they were not aware of how new staff were made aware of environmental and infection control risks.

The provider had ensured that most staff were trained in Makaton or Signalong to communicate with patients whose main form of communication was Makaton. At the time of the inspection, 90% of staff had received this training. This was an improvement since the last inspection.

At the time of inspection, 77% of staff had completed face to face training in autism awareness. This is slightly lower that the 86.2% of staff who had this training reported at the last inspection. However, the Covid-19 outbreak had affected the ability of some staff to complete training and the figure was above the provider baseline of 75%.

Between March and July 2020, the provider reported that 91% of staff were up to date with supervision. Staff we spoke with during the inspection told us they had regular supervision, and this was supportive.

Managers had introduced coaching for staff. Grow coaching sessions continued to be available to staff.

Multi-disciplinary and interagency team work

Staff worked as part of a multi-disciplinary team, which included doctors, nurses, support workers, occupational therapists, speech and language therapists, social workers, assistant psychologists and members of the educational skills development team.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff provided patients with written information and a verbal explanation of their legal position and rights at the time of their detention/admission and every three months. Staff provided a fresh explanation at key times as recommended in the Code of Practice (4.29).

The Mental Health Act administrator and the speech and language therapist developed easy read Mental Health Act leaflets in two formats, one of which they called 'super easy read'. There was extra information in the Mental Health Act leaflets for patients who were in long-term segregation.

The Mental Health Act (MHA) administrator completed an audit of Mental Health Act processes on each ward every three months including audits of Mental Health Act section papers, section 132 information, consent to treatment and section 17 leave. During the Covid 19 outbreak this was devolved to the wards, however at the time of the inspection the MHA administrator had resumed oversight of the regular audit.

Staff completed a recording form for section 17 leave, including a risk assessment prior to the patient leaving the ward and the outcome of the leave. At the previous comprehensive inspection in February 2020, we reported that staff were not recording the patient's ongoing risks on the risk assessment form. Staff had developed a form in order to carry out a risk assessment based on the patient's current presentation prior to taking leave. However, there was nowhere on the form where staff could read what the specific risks were in order to make a correct judgement. It is important that staff are aware of all patients' historic and current risks, whilst they are on section 17 leave so they can ensure patient safety.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Requires improvement

Wards for people with learning disabilities or autism

As of the time of inspection, 94% of staff in this service had received training in the Mental Health Act. More staff had completed training that at the last inspection.

An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints. We spoke to the independent advocate who was positive about their work at the hospital. They had been invited to attend clinical governance meetings and they told us this gave them a regular, formal opportunity to raise patient issues with senior managers.

Good practice in applying the Mental Capacity Act

Staff had sustained improvements in the recording of mental capacity, which had been a concern at previous inspections. During this inspection, we saw evidence that staff were using the capacity assessment tab, which had been added to the provider electronic recording system, in all the care records that we looked at.

During the inspection, we saw evidence of staff holding best interest meetings, with advocates supporting patients, to make decisions about particular aspects of patients care.

The responsible clinicians assessed patients' capacity to consent when there were changes in the treatment plan.

At the time of inspection, figures provided by managers showed that an average of 91% of staff had received training the Mental Capacity Act and deprivation of liberty safeguards.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff did not raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. During the inspection, we viewed seven pieces of CCTV footage which showed night staff carrying out 2:1 observation, i.e. two members of staff were observing one patient. In five instances, at least one of the staff members was asleep. The other staff member did not try to rouse their colleague, or report this, as would be expected.

Staff used appropriate communication methods to support patients. This is an improvement since the last comprehensive inspection. At previous inspections, we reported that eight members of staff were trained in Makaton or Signalong. At the time of this inspection, 90% of staff had received training and all staff carried a key fob with easy read signs they could use with patients. No patients used Makaton or Signalong as their primary method of communication.

Patients said staff treated them well and behaved kindly. We met with four patients; three patients told us that staff were kind to them and they felt safe and happy at the hospital. One patient was unable to speak with us due to communication difficulties; however, we observed a very caring interaction between this patient and a member of staff.

Staff gave patients help, emotional support and advice when they needed it.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient.

Staff followed policy to keep patient information confidential.

Staff respected patients' privacy and dignity. Staff had addressed the concern, reported at the last comprehensive inspection, regarding a patient continually wearing anti-rip clothing. At this inspection, we saw evidence in the patient's care plan that they were only wearing anti-rip clothing when at heightened risk of self-ligature, and for the minimum time possible. Staff had recorded this clearly in the notes. During the inspection, we observed the patient and they were wearing normal clothing appropriate for the season.

During the inspection, we observed many examples of kind and positive interactions between staff and patients on the wards.

Involvement in care

Involvement of patients

Requires improvement

Wards for people with learning disabilities or autism

Staff introduced patients to the ward and the services as part of their admission.

We reviewed six care and treatment records for patients and saw evidence of staff recording of patient views in each domain. All patients had access to easy read care plans. This is an improvement since the last inspection.

Patients knew how to access an advocate; they said that staff would help make a referral. We saw information displayed on the wards about the advocacy service, their staff, and other services.

Staff enabled patients to give feedback on the service they received via patient snapshot surveys. Patient snapshot surveys were carried out each month with patients being asked about a different topic each month, for example about their feelings of being safe and understanding their care plans . All the snapshot surveys were produced in 'easy read' versions which had been supported by the Speech & Language Therapy team and patients were assisted to complete them by a member of staff if necessary.

Involvement of families and carers

Staff involved families and carers appropriately. We spoke with five patients' family members or carers. Four of the carers we spoke with felt they were involved appropriately with the care of their family member and were invited to meetings and care reviews as appropriate. One carer felt that communication with staff could sometimes be difficult if English was not their first language.

Staff wrote to families and carers at the start of the Covid-19 pandemic to inform them of the steps that they were taking to keep patients safe during the outbreak.

Staff helped families to stay in touch with their loved ones during the Covid-19 pandemic by installing extra benches for families to meet patients outside and facilitated video and phone calls.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Between January and August 2020, the average bed occupancy was 24 patients. The Care Quality Commission had issued the provider with a Notice of Decision in November 2019 to prevent further admissions, without the agreement of the Care Quality Commission, and no new patients had been admitted since that time.

Staff had sustained improvements in discharge planning for patients since the last comprehensive inspection. A significant number of patients had been discharged since the last inspection and most of the remaining patients had clear discharge plans. A small number of remaining patients had particularly complex needs, which meant it was difficult for commissioners to find appropriate alternative placements. However, staff at the service were working closely with clinical commissioners on discharge planning to meet the best interests of the patients.

Facilities that promote comfort, dignity and privacy

At the last comprehensive inspection, it was reported that the design, layout, and furnishings of long-term segregation (LTS) environments did not create a therapeutic environment. We saw some improvements at this inspection. Further improvements had been delayed by the Covid-19 pandemic.

In May 2020, Staff had completed Patient-Led Assessments of the Care Environment (PLACE) assessments in all areas of the hospital including the LTS environments. PLACE assessments are undertaken from a patient's perspective and focus on what matters to the patient based on a visual assessment. Following the PLACE assessments, a task list was created on the provider electronic recording system to address the areas of improvement. We saw evidence that staff discussed the outcome of these assessments in the clinical governance meetings held in June and actions that were still outstanding were discussed, for example the re-decoration of one patient's flat. Staff recorded that some of the tasks had been delayed by the Covid-19 pandemic, as external contractors were unable to visit the hospital site.

Staff had completed a dignity checklist for patients in LTS in May 2020. The dignity checklist consisted of 22 items which corresponded with the Dignity in Care campaign (2006). Following completion of the checklist, staff created tasks on the provider electronic recording system to address

Requires improvement

Wards for people with learning disabilities or autism

identified areas of improvement. At the time of the inspection all of the actions had been completed apart from one where the provider was awaiting the delivery of an item from an external supplier.

At the last comprehensive inspection, we reported that one patient did not have a suitable table to eat from. Since that inspection, staff had trialled various different options without success and carried out an occupational therapy assessment. Following this assessment, a specialist table had been ordered.

Staff had improved the planning and recording of activities for patients, including those in long term segregation. During the inspection, we saw evidence of staff offering an increased number of daytime activities and therapies to patients. However, there was still limited activities offered during the evenings and at weekends. The Covid-19 pandemic had affected the ability of staff to provide some activities, such as groups and trips, however staff had completed risk assessments to allow patients to continue using the gym and sensory rooms and groups were getting underway again with control measures in place. The provider had employed an activities co-ordinator who offered a modular group programme to patients focusing on life-skills. We saw evidence that a number of patients were engaged with this programme and one patient had received a certificate having completed the whole programme.

There was a full range of rooms available at the hospital, including clinic rooms, an activity centre, classrooms, gymnasium, art therapy and woodwork rooms.

Each patient had their own bedroom, which they could personalise. We saw evidence that patients had personalised their rooms during the inspection. Patients had a secure place to store personal possessions.

The service had quiet areas and a room where patients could meet with visitors in private and patients could make phone calls in private.

The service had an outside space that patients could access easily. The hospital is set in spacious, pleasant grounds, so patients were able to access outside areas including a small farm and take part in gardening and horticultural activities.

Patients could make their own cold drinks and snacks and were not dependent on staff.

Meeting the needs of all people who use the service

There were adapted bedrooms in the hospital for patients needing disability support. These rooms had suitable en-suite facilities.

Wards had information leaflets available including in easy read formats and the service had improved the information available on the wards to make it more accessible, e.g. provided easy read activity and calendar boards.

The hospital provided a menu for patients to choose a variety of meals, which met their individual religious and cultural needs.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Independent advocates were available to assist patients with making complaints if required.

The hospital had received two formal complaints since May 2020 and nine compliments.

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

Requires improvement

Leadership

The leadership team had remained the same since the last comprehensive inspection in February 2020. The Chief Operating Officer/Registered Manager had been in post since January 2020 and demonstrated a good understanding of the service. The Registered Manager had made changes to the governance processes which were starting to become embedded and had led to some improvements in patient care. Since the focussed inspection in May 2020, the Registered Manager had taken on oversight for quality for the hospital as it had been

unclear who undertook this role. Staff we spoke with during the inspection told us that managers were approachable. Staff told us that the Registered manager had an open and transparent management style.

Vision and Strategy

The provider vision statement is: 'Our vision is for people with a learning disability to live a happy, meaningful and fulfilling life'. The provider states its values as: 1. Patients Voice 2. Coaching and Support 3. Employee Engagement 4. Family Involvement 5. Employee Development. The provider took a number of actions to embed the vision and values within the organisation, for example assigning two members of staff as employee engagement representatives and facilitating patient meetings and advocacy. Staff we spoke with told us that the senior managers had an 'open door' policy to encourage staff to raise concerns and contribute to service development.

Culture

We were concerned that there was a closed culture amongst night staff at the hospital, where it was seen as acceptable for staff to sleep whilst on duty. The Care Quality Commission has identified that a closed culture is a poor culture in a health or care service that increases the risk of harm.There were a number of factors which put the provider at a higher risk of a closed culture developing. The service was geographically isolated, and many patients were a long way from their families, and some had been at the hospital for an extended period of time. Prior to February 2020, there had been a significant change in management over a short period of time. There had been long-term high use of agency and bank staff and although at the time of the inspection all support staff were permanent, there was still a 25% vacancy rate for registered nurses. We saw evidence of a closed culture at night as there was a lack of challenge to poor practice and staff who witnessed colleagues asleep accepted this behaviour as how things were done. Staff we spoke with told us they felt able to raise concerns without fear of retribution and were aware of the whistleblowing process. However, it was evident that staff knew, but did not raise concerns, about the conduct of their colleagues at night. We saw evidence of staff moving chairs, or sitting in unusual places such a kitchen worktop, so they were not in view of CCTV cameras.

Staff morale had been affected by the possible closure of the hospital, but all the staff we spoke with told us that the staff team had supported each other, and they felt supported by managers.

Governance

The provider had not ensured they had effective systems in place to assess and monitor the quality of care for patients. Managers had not identified a high number of incidents where night staff were sleeping on duty, despite internal assurance processes. We were concerned that despite the leadership team having been aware of these issues for ten months, change had not been effectively implemented. The management team had stated the issue was attributed to the use of agency staff, however this was a concern whether it was agency or permanent staff and all the staff noted on the CCTV footage were permanent employees.

We saw improved governance meetings which identified areas for improvement and sufficient priority was set for those meetings to take place regularly. Since the last comprehensive inspection in February 2020, the Registered Manager had widened the membership of the clinical governance committee to include key staff such as ward managers, the health and safety consultant and the independent advocate. This enabled a broader range of staff to contribute to clinical governance and to feel clearer about their roles and responsibilities. Clinical governance meetings were a priority for the service, and we saw evidence that meetings took place on a regular basis. The Registered Manager had plans to further develop the clinical governance agenda with the support of the Quality Assurance and Audit Manager and a consultant psychiatrist.

The provider ensured actions set in governance meetings were easily identifiable, had a responsible person allocated to complete the action, and a timeframe allocated to each action. We viewed four sets of minutes for clinical governance meetings between May and July 2020. Actions resulting from the meeting were assigned to a specific member of staff with a deadline for completion via the tasks generated on the provider electronic recording system. We could see how other systems and processes fed into the clinical governance meetings, for instance the results of audits and PLACE assessments.

The provider had improved systems for ensuring appropriate oversight of the management of serious

incidents including completing reviews of serious incidents and sharing learning with the wider staff team. However, we could not see a discussion of how lessons learnt were identified and shared with staff immediately after incidents. As there can be a lengthy delay in receiving recommendations from Root Cause Analysis reports, it is essential that immediate learning is identified and addressed.

Managers had identified concerns such as the variability in quality of the Nurse in Charge quality and safety checklists and had identified actions to improve these and scheduled a further audit to check if improvements had been made. Since the last focussed inspection in May 2020, the Patient Safety and Quality Review Committee had got underway. The purpose of this committee was to improve patient safety, discuss root cause analysis, serious incidents and lessons learned from incidents. Outcomes and actions from this committee were reported into the clinical governance meetings. We viewed three sets of minutes from these meetings and could see evidence that staff had discussed how to effectively share lessons learnt with staff and identified actions needed.

The provider had mostly ensured audits were effective, comprehensive, robust, and contained the necessary detail to appropriately oversee the service to be able to make changes where required. We saw evidence of a range of audits that had taken place, including section 17 leave forms, medicines management, safeguarding, capacity assessments and physical health. Staff used a standard template to undertake audits which used a RAG rating system and the Quality Improvement and Audit Manager had oversight of completed and forthcoming audits and any outstanding actions. At this inspection, we saw evidence that audits had been completed as planned and the outcomes of audits were fed into the quality and safety committee and clinical governance. Actions from audits were assigned to individuals with dates for completion then reviewed and monitored on an electronic task system. Staff had a more co-ordinated approach to audit. The Quality Improvement and Audit Manager reported to the Registered Manager who had taken on oversight of quality for the hospital. However, we saw that the cleaning audit for the clinic room confirmed the environment was clean when there was enough dust on the emergency medicines bag to indicate it had not been cleaned for a significant period of time. This cast doubt on the validity and quality of the audit. We also saw that the infection prevention and control audit did not identify the need for extra cleaning supplies in the nurse office in the Lodge nor guidance for staff to clean the keyboards and phones or the maximum number of staff members who should be in the office. There were no wipes available in the office during inspection.

Management of risk, issues and performance

The provider had not ensured they had effective systems in place to assess and monitor the quality of care for patients. This was a concern reported at the last three inspections. Managers had failed to identity a high number of incidents where night staff were sleeping on duty. Managers had been aware of these concerns for some time, had identified one recent incident and taken disciplinary action with the staff concerned. Managers had carried out spot checks of CCTV and had conducted visits at night. However, they had failed to identify several incidents identified during our inspection. We were concerned that there may have been other incidences that had been missed and the systems and spot-check processes were not sufficiently robust to identify these.

Managers did not always identify poor conduct even where it was a known concern. However, when it was identified, managers addressed poor performance effectively. Managers had implemented improved recording, daily absence monitoring, and informal and formal improvement plans which had led to a significant reduction in sickness rates and staff absence. Managers took decisive action when the inspection team advised them of our findings of staff sleeping on duty.

Managers worked with registered nurses to encourage accountability by confirming their responsibilities and encouraging them to lead as the Nurse in Charge whilst on shift.

Managers had improved the oversight of recruitment processes and procedures. We looked at three personnel (HR) files and all were complete.

Managers ensured the provider's corporate risk register was reflective of current risks.

Engagement

Senior leaders engaged with other stakeholders, including commissioners, through visits and telephone calls.

Requires improvement

Wards for people with learning disabilities or autism

Managers also attended weekly sit rep calls with clinical commissioners and other key stakeholders to discuss patient discharge planning and provide quality and safety updates.

Before the inspection, we sought feedback from 23 clinical commissioners to gather their views on patient care at the hospital. We received a response from four clinical commissioners who told us they had seen improvements in care at the hospital over the previous six months. However, there were concerns about consistency of care, i.e. over-reliance on certain experienced and skilled staff members, and delays in receiving information from the hospital.

Information Management

Staff had access to the equipment and information technology needed to do their work. Staff had access to portable tablet computers where they could input observations and access patient care and treatment plans. Managers had restricted access to the internet on the tablets to prevent staff from being distracted from patient care, but this had not always been effective in preventing staff from misusing the internet access.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff correctly carry out supportive observations correctly in accordance with the supportive observation policy and patient care plans. [Regulation 12(1) (2) (b) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment].
- The provider must ensure they encourage patients to maintain a healthy lifestyle. [Regulation 12(1) (2) (a) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment].
- The provider must ensure that staff take all actions necessary to reduce the spread of infection. [Regulation 12(2)(h) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment].
- The Provider must address the risks posed by a closed culture at the hospital at night. [Regulation 13 (1) (2) (3) HSCA (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.]
- The provider must ensure they have effective systems in place to assess, monitor and improve the quality and safety of patients at the hospital. [Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance].

Action the provider SHOULD take to improve

- The provider should ensure that staff are aware of, and know how to find, written environmental risk assessments and ligature risk assessments.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The conditions below are to be imposed on the provider's registration certificate as new conditions: 1. The Registered provider must only provide regulated activities to a maximum of 12 patients at Jeesal Cawston Park Hospital. 2. The Registered Provider must devise, review and assess the effectiveness of the systems and processes for auditing night staff to ensure observations are done in line with service users individualised care plans. 3. The Registered Provider must send a report to the Care Quality Commission on a monthly basis for nine months.