Coveberry Limited

Cedar House

Inspection report

Dover Road
Barham
Canterbury
CT4 6PW
Tel: 01227833700

Date of inspection visit: 16 and 17 May 2023
Date of publication: 24/07/2023

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

Ratings

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The Care Quality Commission (CQC) conducted an unannounced inspection of Cedar House on the 16 and 17 May 2023. The inspection was to check if the improvements required following the inspection in November 2022 and detailed in an action plan submitted by the provider in June 2023 had been made.

Our overall rating of this service stayed the same. However, our rating of well-led improved and the service has therefore exited from special measures.

We have identified breaches in relation to risk management and the quality and assurance systems in place at this inspection. We have issued the provider with a warning notice because processes to enable the systematic review and management of ligature risks were not robust. Audits used to oversee the safety of the service were completed but governance around how ligature risks were systematically reviewed and actions carried out were not evident or documented effectively. Furthermore, systems and processes in place were not robust enough to ensure oversight of the quality and safety of the service, experience of service users and accurate record keeping.

We rated it as requires improvement because:

- Local governance systems in place to effectively assess, monitor and improve the quality and safety of the service required further embedding. Ligature audits were not always reviewed thoroughly to help manage the risk to patients, staff did not always record clinic room temperatures routinely to ensure medicines were stored safely, care and treatment records following incidents were not always accurate or complete, and the review of people's restrictions for accessing kitchen areas were not always thorough. These had not been identified by the provider's internal governance processes.
- Staff did not always record or share key information to keep people safe when handing over their care to others.
- A systematic process for sharing lessons learned with staff at ward level was not embedded. Records of discussions about actions implemented because of lessons learnt were not well recorded in team meeting minutes and these were not regularly reviewed with all staff.
- Staff were not always assessing people's risk safely prior to section 17 leave. This meant that there was a risk of people being allowed to leave the hospital without the proper risk assessments conducted in a timely manner prior to leave.
- Staff were not consistently completing all their mandatory and statutory training. Only 40% of eligible staff had completed training in the safe administration of medicines. Managers did not ensure that all staff had completed the required competencies and mandatory training prior to administering medicines independently.
- Some areas of the environment remained tired and did not fully meet the needs of people using the service. Lighting had previously been identified as not suitable for autistic people. However, measures to reduce or remove the risks within a timescale that reflected the impact on people using the service were not effective.
- Staff were not always aware of the principles of 'right support, right care, right culture'. Most staff below ward manager level were unable to tell us about the new clinical model of care and how this underpinned their work with people using the service.

Summary of findings

However:

- People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs.
- People were protected from abuse and staff followed good practice with respect to safeguarding.
- People made choices and took part in activities which were part of their planned care and support. The staffing provision for psychological therapies had improved and this aligned with the new clinical model of care. A multidisciplinary team worked well together to provide the planned care.
- People received care, support and treatment that met their needs and aspirations. Care focused on people's quality of life and followed best practice. Staff ensured care plans were personalised, recovery focussed and holistic. People were involved in planning their care.
- People had clear plans in place to support them to return home or move to a community setting. Staff worked well with services that provide aftercare to ensure people received the right care and support they went home.
- The provider engaged with other organisations to improve the care offered at the hospital. Staff used national outcome measures to identify the effectiveness of their service.
- The provider offered professional development and training opportunities.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

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

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Summary of this inspection

Background to Cedar House

Cedar House is a specialist hospital managed by Coveberry Limited. The hospital provides assessment and treatment in a low secure environment for people with a diagnosis of learning disability and autistic people, including those who have a forensic history, those requiring positive behaviour support, and complex mental health needs.

At the time of the inspection they had 18 people at the service.

At the time of the inspection the service had 5 operational wards, along with three purpose-built annexes. These included:

- Folkestone ward – a nine-bed ward for males and included one annexe which was non-operational at the time of our visit
- Maidstone ward – an eight-bed ward for females
- Tonbridge ward – an eight-bed ward for males
- Rochester ward – a six-bed ward for males, two of which were contained within annexes
- Poplar ward – a step down unit for five males. This ward was located outside the secure perimeter fence.

Enhanced Low Secure (ELS) ward, which provided five beds for males, remained closed at the time of the inspection and we did not visit this ward.

Cedar House is registered to provide the following regulated activities:

1. Assessment or medical treatment for persons detained under the Mental Health Act 1983
2. Diagnostic and screening procedures
3. Treatment of disease, disorder or injury

The hospital had a registered manager in post at the time of our inspection.

The CQC last inspected the location in November 2022 when we found that the provider had made some improvements, but not fully met all the requirement notices. The provider had introduced a new comprehensive governance system but had not embedded this into the hospital's daily practice. The provider recognised that they had actions to complete and that more work was needed to embed the improvements, to ensure they would be sustained permanently. Following the inspection in November 2022, the conditions on the registration of the hospital which prohibited the service from admitting people without prior written agreement from CQC were removed. The provider was also issued with requirement notices. We told the provider to make the following improvements:

- The provider must ensure the lighting across the hospital is suitable for the people admitted to the hospital. (Regulation 15)
- The provider must ensure that restrictive practices are reviewed and restrictions on people's access to the community is based on individual risk. (Regulation 13).
- The provider must ensure that care plans are consistent in quality. (Regulation 9)
- The provider must ensure that people and relevant others are involved in planning their care and that this is clearly recorded. Where people refuse to engage in completing their care plans, this must be clearly documented (Regulation 9).
- The provider must ensure that staff are up to date with their training in immediate life support and medication administration and reach the compliance rate set by the hospital (Regulation 18)

Summary of this inspection

- The provider must ensure that all staff received regular supervision. (Regulation 18).
- The provider must embed in practice the new clinical model which the guidance set out in Right Support, Right Care, Right Culture. (Regulation 9).
- The provider must ensure that people have regular access to necessary therapies, including psychology, occupational therapy and speech and language therapy. (Regulation 18).
- The provider must ensure that all people are able to utilise their Section 17 leave and all rationale for cancelled Section 17 leave must be documented clearly. (Regulation 17)
- The provider must ensure that all risks, including emerging and developing risks, are included on the hospital risk register. (Regulation 17).
- The provider must ensure that the model for effective governance of performance, risks, quality of care and learning from incidents is fully embedded in practice. (Regulation 17)

During this inspection we found some improvement and many of the requirement notices had been met. However, at the last inspection in November 2022 we highlighted the need for sustained improvement for governance processes to be fully embedded and this had only been partially achieved.

What people who use the service say

Overall the feedback we received from people using the service was positive, which showed an improvement since the last inspection in November 2022 when feedback from people was mixed.

Ten out of the 11 people we spoke to felt that staff were respectful, caring and compassionate. Most people told us they felt valued by staff who showed genuine interest in their well-being and quality of life. Although, 2 out of the 11 people told us that night staff were less supportive.

Most people said there were lots of activities to do and that there was enough staff to facilitate this. Although, 1 person said that community leave could sometimes be cancelled because of not enough staff who could drive the company vehicles.

Most people told us that staff were working on plans for them to move on and that they had been involved in decisions surrounding those plans.

Some people said that the food had improved and that there were lots of options. Although, most people also told us that they would prefer more healthy options.

How we carried out this inspection

The team that inspected the hospital comprised of three CQC inspectors, one specialist advisor and one expert by experience.

Before the inspection visit, we reviewed information that we held about the hospital and recent inspection reports.

During the inspection visit, we completed the following activity:

- Visited all wards and looked at the quality of the ward environments.
- Spoke with a total of 11 patients who were using the service.

Summary of this inspection

- Spoke with 23 members of staff including the registered manager, senior leaders, 3 ward managers, clinical director, consultant forensic psychologist who was also the clinical therapies lead, 4 registered nurses, an occupational therapist, an assistant psychologist, risk and quality lead, positive behaviour support (PBS) lead, 6 senior support workers, and 2 support workers. We also spoke with agency staff.
- Reviewed 7 sets of care records including risk assessments across all wards.
- Inspected the clinic rooms on 4 out of the 5 wards.
- Observed a range of meetings including a patient review meeting, a community meeting and a patient engagement meeting.
- Reviewed a range of incident records across the hospital.
- Reviewed a range of documentation and policies relating to the running of the hospital.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure ligature risks are safely assessed and managed. Regulation 12(2)(d)
- The provider must ensure that records relating to the care and treatment of people following incidents are complete and accurate. Regulation 12(2)(b)
- The provider must ensure that staff complete section 17 leave forms appropriately to ensure risk is assessed safely prior to people leaving the hospital grounds. Regulation 12(2)(a)
- The provider must ensure that staff are sharing key risks of people using the service during handover meetings to keep them safe. Regulation 12(2)(b)
- The provider must ensure that staff record clinic room temperatures so that medicines are stored safely. Regulation 12(2)(d)(g)
- Managers must ensure that all staff are compliant with mandatory training for the safe administration of medicines. Regulation 12(2)(c)
- The provider must ensure that all staff complete the required competencies in line with their own policy before administering medicines unsupervised. Regulation 12(c)
- The provider must ensure that décor which poses a risk of infection is addressed. Regulation 12(2)(d)(h)
- The provider must ensure the lighting is suitable for the people admitted to the hospital, and that measures to reduce or remove the risks within a timescale that reflects the impact on people using the service are effective. Regulation 12(2)(d)
- The provider must operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. The provider must ensure that there is a systematic review of the quality of audits, ensuring that actions are pulled through with clear ownership of who is completing the actions. Regulation 17(1)(2)(a)

Action the service SHOULD take to improve:

- The provider should ensure that staff check and record that all cutlery is accounted for to ensure the safety of people using the service.

Summary of this inspection

- The provider should ensure that all people using the service have direct access to cold drinks.
- The provider should continue to make changes to ensure that the food is consistently of high quality and that healthy options are available.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Wards for people with learning disabilities or autism

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

Is the service safe?

Requires Improvement

Our rating of this service stayed the same. We rated it as requires improvement because:

Safe and clean care environments

Improvements were needed to the way that staff identified and managed environmental risks. However, the wards were visibly clean and well furnished.

Safety of ward layouts

Staff did not complete or regularly update thorough risk assessments of all ward areas to remove or reduce any risks they identified. For example, ligature audits available on Tonbridge, Maidstone and Folkestone wards, dated October 2022, showed generic actions which mostly stated, *'Locally managed – Level 2 and 3 observations maintained at all times. Patients on 1:1 observation are deemed not to be a compensating factor. Higher risk patients on 1:1 observations. When door handles are replaced they are to be replaced with anti-ligature door handles.'* On Maidstone and Folkestone wards, door handles were already to anti-ligature specification so this was not accurate. Audits stated that they had been reviewed following incidents. However, it was not documented which actions had been completed and we saw no evidence of these actions being reviewed. This meant that there was a risk of unnecessary delay in completion of actions and an increased risk of harm to people using the service. We fed this back to senior leaders who told us that all ligature audits had been reviewed in the month prior to our visit, and that these were in the process of being printed to share with ward staff. However, whilst the updated audits were dated March 2023, actions at the end of the document on Folkestone ward had still not been reviewed.

Whilst governance processes to ensure the safe assessment of environmental ligature risks was not robust, staff we spoke with knew about any potential ligature anchor points and could tell us how they would mitigate the risks to keep people safe. Search and ligature training was part of the mandatory training schedule and at the time of our inspection over 96% of all staff had completed this training.

Staff did not always complete the security checklist to ensure that cutlery was safely accounted for. On Folkestone ward, for the month prior to our inspection there were 21 out of 32 signatures missing on forms. This meant that the provider could not be assured that all cutlery was accounted for to ensure the safety of people on the ward.

Requires Improvement

Wards for people with learning disabilities or autism

Blind spots on the wards were mitigated with closed circuit television (CCTV) which was remotely observed, and mirrors. The provider could have areas of the wards under constant observation, if there were heightened risks, and the remote staff would contact the ward if they had safety concerns. The provider could request footage if they needed to review issues. The provider received regular reports from the remote observation that highlighted good and negative issues within the hospital which could then be used for staff learning.

The service complied with the Department of Health and Social Care guidance on eliminating mixed-sex accommodation in hospitals.

Staff had easy access to alarms and people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

The hospital environment was still tired looking in some areas and needed refurbishment. Areas on Tonbridge ward had paint peeling off the walls, the skirting boards were chipped in a bedroom which was unoccupied, the bathrooms had painted panels under the sinks which were bubbling, which could pose an infection risk. However, ward areas were visibly clean and we saw cleaning staff working across the hospital.

Staff followed the hospital's infection control policies, including handwashing. There were appropriate infection prevention control (IPC) measures throughout the wards and in the kitchen for food preparation.

Seclusion room

The only seclusion room in the hospital was located on Enhanced Low Secure ward (ELS) ward which remained non-operational at the time of our inspection. Senior leaders told us referrals for new admissions were assessed with this in mind, and that the service was clear in their message to commissioners that they did not have seclusion facilities.

Clinic room and equipment

Clinic rooms were fully equipped, and there was accessible resuscitation equipment and emergency drugs on the wards that staff checked regularly.

Safe staffing

Managers did not ensure that all staff completed basic training in line with the provider's policy to keep people safe from avoidable harm. However, the service had enough nursing and medical staff, who knew the people using the service well.

Nursing staff

Managers did not always ensure staff had completed a full induction so that they understood the service before starting their shift. We observed a new member of nursing staff administering medicines unsupervised despite having completed only 1 out of 3 medicines competency observations as set out by the provider's policy. This staff member had not completed all required mandatory training including immediate life support (ILS). We fed this back to senior leaders during the inspection.

Requires Improvement

Wards for people with learning disabilities or autism

Staff did not always share key information to keep people safe when handing over their care to others. Handover records lacked detail and consistency across wards. The 'Situation, Background, Assessment, Recommendation' (SBAR) forms used on Tonbridge, Maidstone and Folkestone wards did not record key risks for people and only recorded a basic update of activities undertaken throughout the day for each person. This meant that staff starting a shift, as well as new or agency staff, would not be aware of key risks including any physical health monitoring for individuals.

The service had enough nursing and support staff to keep people safe. Staff fed back that they had more time to undertake one-to-one sessions and activities with people. This was due to the reduced capacity of people residing at the hospital because of recent discharges and the hospital not having admitted anyone new. Senior leaders told us that they would be able to manage staffing levels appropriately when taking new admissions because their approach involved increasing the capacity of people using the service at a slow and steady rate. The provider had also taken steps to recruit international nurses following the introduction of overseas nursing programme by the UK government. Many were working towards gaining their registration with the Nursing and Midwifery Council (NMC) to become registered nurses in the UK. They had support in place to help the overseas' staff adjust to working in an unfamiliar environment. The overseas' staff we spoke to said that the provider had offered them good support. All the staff we spoke with felt that the staffing levels had improved.

Ward managers told us they could adjust staffing levels according to the needs of the people for each shift. If they needed to increase staffing, they could do this immediately and then the additional staffing would be reviewed at the daily meeting.

Rotas were completed 8 weeks in advance. Ward managers met weekly with the rota team to review the week ahead and discuss the staffing needs of each ward. Rotas recorded which staff were trained in ILS and staff who were able to drive the company vehicles to escort people on community leave. We reviewed a month of rotas from April to May 2023. On 8 occasions the hospital was short of 1 registered nurse on day shifts, and on 9 occasions short on a night shift. However, on these occasions ward managers and the head of nursing supported the ward staff.

When managers needed to use bank and agency staff they requested people who knew the service well. From November 2022 to May 2023, use of agency nurses was 24%. The service had used no agency support workers.

The service had enough staff on each shift to carry out any physical interventions safely.

At the time of the last inspection, we received mixed feedback from staff and people using the service about the frequency that section 17 leave was cancelled. During this inspection we found that this had improved. People we spoke with told us that their escorted leave or activities were rarely cancelled, even when the service was short staffed. Senior leaders had better oversight of any leave which had been cancelled, which was discussed daily during the senior management handover meeting and recorded on a section 17 log.

The staff turnover rate for the 6 months prior to our inspection was low at 6.25% for nurses, although for support workers this figure was higher at 16.5%.

Levels of staff sickness for the 6 months prior to our inspection were low at 1.6% for nurses and 6.8% for support workers.

Medical staff

Requires Improvement

Wards for people with learning disabilities or autism

The service had appropriate medical cover and a doctor available to go to the wards quickly in an emergency. Each patient was registered with a local GP.

The hospital had 2 full-time consultants, to act as responsible clinicians and to oversee people's care. The service had a vacancy for another speciality doctor, which they intended to recruit to as their capacity increased with new admissions.

Staff had access to an on-call consultant psychiatrist out of hours during evenings and weekends and knew how to contact them when required.

Mandatory training

At the time of the last inspection, staff were not compliant with mandatory training for immediate life support (ILS) and medication administration. During this inspection, 96% of staff were compliant with ILS training. However, mandatory training for the safe administration of medications was 40% and we did not see any mitigation for why this figure remained so low.

Overall, mandatory training compliance for all training was just over 80%.

The mandatory training programme was comprehensive which met the needs of people and staff.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to people safely. However, they used restraint only after attempts at de-escalation had failed.

Assessment of risk

Staff were not always assessing risk effectively prior to section 17 leave. For example, we found 4 section 17 leave forms which had been completed and signed in advance on Poplar ward. This meant that there was a risk of patients being allowed to leave the hospital without the proper risk assessments conducted in a timely manner prior to leave.

Staff completed risk assessments for each person using a recognised tool, and reviewed this regularly, including after any incident. Where appropriate people had a Historical Clinical Risk Management (HCR20) in place. This is a structured tool for assessing the risk to others for individuals with a forensic history, and to monitor their response to treatment and interventions. People's risks were discussed regularly during patient review meetings (PRMs), with input from the multi-disciplinary team (MDT).

Management of risk

Staff we spoke to knew about any risks to each person and developed plans with the people admitted to the service to prevent or reduce any risks. Staff kept a one-page profile in people's folders in the nursing offices, so that staff who were new to the ward could understand key risks. However, staff did not always record that key risk information was shared during handover meetings to keep people safe.

At the time of the last inspection, we found that there had been at least 15 incidents relating to staff on night shifts sleeping in the month prior to the inspection. Although we were told that the service had a plan in place to address this

with staff, this was not included on the risk register. During this inspection, we found that this had improved. Whilst incidents of staff sleeping during night shifts continued to be reported, these had reduced. From March 2023 to May 2023, 9 instances had been recorded. This risk was included on the service's risk register and senior leaders told us the process they would follow should an individual be found to be sleeping on shift. The hospital director regularly undertook random night inspections to check staff were acting in a professional capacity and instances of unprofessional behaviour were monitored and reported by the provider's third-party CCTV provider.

Staff followed procedures to minimise risks where they could not easily observe people. The service had CCTV in place to mitigate the risk in areas that were difficult to observe.

Staff followed the hospital policies and procedures when they needed to search people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

At the time of our inspection there were no people being nursed in long term segregation.

The service had a reducing restrictive practise log for each ward.

Access to kitchen areas across the wards was dependant on individual risk assessment. However, on Maidstone ward 2 people who were assessed as a risk of scalding were unable to access the kitchen unsupervised despite the kettle being locked away separately. It was not clear whether kitchen access for people had been reviewed with this in mind, given that the risk had been eliminated because the kettle was not available for people accessing the kitchen anyway. On Tonbridge ward, people were risk assessed and given keys to the kitchen where appropriate but were unable to access locked cupboards in the kitchen containing their food because the same key was used for cupboards storing chemicals. This had not been identified by the provider's internal governance processes. We fed this back to senior leaders during the inspection who assured us that they would take action to address this.

Where staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network Training standards.

Staff considered less restrictive options such as de-escalation techniques, before limiting people's freedom. Staff restrained people only when these failed and when necessary to keep the person or others safe. All staff who used restraint were trained using a recognised system that was approved by the British Institute for Learning Disabilities.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom.

Staff followed NICE guidance when using rapid tranquilisation.

At the time of our inspection, the hospital did not have any seclusion facilities which were operational and this was not part of the new admissions criteria.

If staff restricted a person's freedom, they took part in post incident reviews and considered what could be done to avoid the need for its use in similar circumstances.

Requires Improvement

Wards for people with learning disabilities or autism

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received and kept up to date with training on how to recognise and report abuse, appropriate for their role. Just under 94% of staff were up to date with their safeguarding vulnerable adults training and 85.5% were up to date with their safeguarding children training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff told us they would discuss their concerns with their manager and knew how to access the hospital social worker who was the safeguarding lead. Managers took part in serious case reviews and made changes based on the outcomes.

Staff followed clear procedures to keep children visiting the ward safe. There were visitor's room away from the wards where people could meet with their visitors including children.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Access to essential information

Staff had access to clinical information

At the time of the last inspection the provider was experiencing a nationwide cyber-attack on the electronic records system. Since then, this had been resolved nationally and the service were using it to record people's care notes and records.

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 we spoke to felt that they had easy access to all the information they needed to meet people's needs.

Overall staff kept accurate, complete, legible and up-to-date records, and stored them securely. However, 1 person's risk assessments following 2 incidents of self-harming were unavailable to view on the system. We fed this back to managers during the inspection who told us they would investigate this.

Medicines management

Staff did not always follow systems and processes to safely administer, record and store medicines. However, staff regularly reviewed the effects of medications on each person's mental and physical health.

Staff failed to record the clinic room temperature on Folkestone ward on 7 occasions in April 2023 and on 12 occasions in May 2023. This meant that the provider could not be assured that medicines were being stored safely. Staff on Folkestone and Rochester wards did not use folders supplied by the pharmacy to monitor, order and record stock, and medicines with a short date were not being recorded on these wards. This had not been identified by the provider's internal governance processes.

Managers did not ensure staff were adhering to the provider's policy for new staff nurses. We observed a member of nursing staff administering medicines unsupervised despite having completed only 1 out of 3 medicines competency observations as set out by the provider's policy.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Medication was reviewed regularly and high dose monitoring forms were in place for any people on high dose anti-psychotics. The clinical pharmacist was able to provide clinical input and advice.

Staff made sure people received information about medicines in a way they could understand and people received support from staff to make their own decisions about medicines wherever possible. Staff also had access to drug specific easy read medicines sheets for people using the service. One person with diabetes had picture cards explaining the procedure for finger-prick blood testing and self-care information.

Staff reviewed the effects of each people's medicine on their physical health according to NICE guidance. Staff monitored ongoing physical health issues and took action to meet peoples' needs.

Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services. Staff could access advice about medication from the pharmacist during their visits and could contact them when they were not on site.

Staff learned from safety alerts and incidents to improve practice. Following a complaint from a person using the service, the provider had implemented a clozapine audit to ensure safe monitoring. This was completed by the clinical pharmacist and staff we spoke to were aware of the audit and required monitoring.

Track record on safety

Reporting incidents and learning from them when things go wrong

Staff recognised what incidents to report. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support. However, records were not always accurate and a systematic process for sharing lessons learned with the whole team and wider service was not embedded.

Staff knew what incidents to report and how to report them. However, records relating people's care and treatment following incidents were not always complete or accurate. For example, a person's risk assessment documents following 2 incidents of ligaturing were not available to view on the system, the incident report for the second incident stated that an automated external defibrillator (AED) was used but did not record what for, and the incident was categorised as 'Level 5 no harm' despite the incident report stating an AED had been required. The ligature audit for the ward was reviewed almost 5 weeks after the second incident. However, there was no record of what actions were identified or implemented.

Staff understood the duty of candour. When things went wrong, staff apologised and gave people honest information and suitable support.

Incidents were discussed during monthly clinical governance meetings. However, a systematic process for sharing lessons learned with staff at ward level was not embedded. The record of the discussion in team meeting minutes about any previous actions or lessons learnt on the agenda was not well recorded. Therefore, it was not clear what aspects of

any actions had been considered in the meetings such as the mitigation of risk or emerging themes from incidents or complaints and lessons learnt. We received inconsistent feedback from staff as to whether team meetings were happening routinely. Learning was shared via email and 'lessons learnt' documents were printed and kept in the nursing offices. However, there was no oversight to ensure staff had read or understood the information. Two staff members on Tonbridge ward who told us they had read the lessons learnt document from April 2023 were unable to recall what was included. On Tonbridge ward, the information recorded in the paper document for lessons learnt in April 2023 was different to what was displayed on the interactive board. Whilst 1 member of staff on Folkestone ward was able to discuss learning at a ward level, they were not aware of how learning was shared hospital wide.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

Assessment of need and planning of care

Care plans reflected patients' voices, which were reviewed regularly through multidisciplinary discussion and updated as needed.

At the time of the last inspection, the quality of the care plans varied. During this inspection we found that this had improved. All 7 care plans looked at across all wards showed consistency in quality, evidence of people's involvement and reflected people's needs and goals.

Staff completed a comprehensive mental health assessment of each person. Staff regularly reviewed and updated care plans when people' needs changed. The service had implemented a new care plan document which incorporated all information in one document including positive behaviour support (PBS) plans and risk assessments.

People had their physical health needs assessed and regularly reviewed. Staff used recognised tools to identified physical health needs. For example, staff used the National Early Warning Score (NEWS2) which is a tool used to indicate if a person's physical health is deteriorating and needs further assessment by a doctor. People with identified physical health needs had care plans to meet the need which staff supported them with. For example, one person had a stoma care plan and another person had information about the management of their diabetes clearly recorded.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice, although the new clinical model was not fully embedded. Staff supported people with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Previously the service's provision of psychological therapies had not been fully rolled out or embedded into the hospital's practice due to gaps in staffing. Since the last inspection, we found that the provision of therapies had improved, which aligned with the new clinical model of care. The service had appointed a consultant forensic psychologist who started in January 2023, and had undertaken the role of clinical therapy lead. The therapies team had

been restructured which included 3 full-time assistant psychologists who supported the consultant forensic psychologist, 2 occupational therapists (OT), 5 technical instructors who supported the OTs, 1 positive behaviour support (PBS) lead, 1 PBS practitioner and a PBS senior support worker. All people were allocated 2 hours of therapy per week. People ready for discharge were able to access psychology groups which ran 3 times per week.

Therapy staff attended breakfast meetings on each ward with people and staff to plan their day including therapy, hospital-based activities and community leave. This was written up on the boards in the ward communal areas to remind people what was planned. Staff fed back to senior leaders each day whether planned activities for the previous day had gone ahead and if cancelled, why this was. Activities that were being facilitated outside of the hospital included rural walks and shopping. People could also go to the pub, cinema, take coastal walks and go to the zoo when it was risk assessed as safe to do so.

The service had developed a new clinical model that included a focus on people' choice and control, keeping safe and quality of life. It incorporated the principles of 'right support, right care, right culture', which described standards for delivering better quality services for autistic people and people with a learning disability. The new model of care defined the hospital as a specialist unit for people with learning disability and autism with 3 treatment pathways: forensic, challenging behaviour and trauma informed care. However, at the time of our inspection the service were yet to admit any new people and the clinical model had not been fully embedded, although 1 person was due to be admitted in 6 weeks following our inspection. There was a clear admissions process which was underpinned by the new clinical model of care, despite this still being in its infancy. Although, this had not been tested.

Staff were not always aware of the principles of 'right support, right care, right culture'. Most staff below ward manager level were unable to tell us about the new clinical model and how this underpinned their work with people using the service. However, staff understood people's positive behavioural support plans and provided the identified care and support. Senior leaders told us how they were working to improve staff understanding of the new clinical model to embed into their practice.

Staff made sure people had access to physical health care, including specialists as required. The hospital was visited regularly by a GP who liaised with the consultants at the hospital if a person needed to be referred to a specialist.

Staff met people's dietary needs and assessed those needing specialist care for nutrition and hydration. The hospital had appointed 2 speech and language therapists (SALT). Whilst the people at the hospital told us there were always lots of options on the menu, most people wanted more healthy options.

Staff identified people' physical health needs and recorded them in their care plans.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes such as the Health of the Nation Outcome Scales (HoNOS). HoNOS is a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning.

Skilled staff to deliver care

Managers made sure the service had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Staff received support in the form of continual supervision, appraisal and recognition of good practice. At the time of the last inspection, supervision compliance rate for all staff was below 60%. During this inspection, we found that this had improved. For April 2023, compliance was at 79.4%. All staff we spoke with told us that they received supervision in line with the provider's policy,

The service had implemented a new model of supervision where support workers were supervised by senior support workers, senior support workers by nurses, and nurses by ward managers. Although, 1 member of staff told us they were supervised by another colleague of the same grade and another staff member told us some staff had not been having supervision because they did not trust the staff who were allocated to supervise them. The service had rolled out coaching sessions to staff who had supervision responsibilities, although staff told us this was not compulsory to attend.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. Staff received a full induction before working on the hospital wards and this included learning disability and autism training. Training in therapeutic boundaries had been introduced for all staff which was being facilitated by the clinical therapies lead.

The service provided good prospects for professional development and career progression including graduate and post-graduate funding and nursing associate roles. One member of staff told us that they had accessed training on leadership to enable further career development.

Managers recognised poor performance, could identify the reasons and dealt with these. There were policies in place for managing poor performance.

Multi-disciplinary and interagency teamwork

Staff worked together to benefit people and had effective working relationships with staff from services providing care following a person's discharge.

Staff from different disciplines worked together as a team to benefit people. Since the last inspection the new multidisciplinary team had been embedded and they supported each other to make sure people had no gaps in their care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service held regular patient review meetings (PRMs) for each person where the team formally reviewed people's care and treatment with them, including their MHA status and rights, medicines, and discharge plans. We observed a PRM meeting which was person-led.

Ward teams had effective working relationships with other teams in the organisation. Staff told us they could get support from other teams when required.

Ward teams had effective working relationships with external teams and organisations including commissioners, care co-ordinators, local authority safeguarding teams and the police. Staff told us how they were supporting people in their new placements and we saw that staff were actively supporting people to settle into their new placements.

People had health hospital passports that enabled health and social care services to support them in the way they needed.

Requires Improvement

Wards for people with learning disabilities or autism

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.

At the time of the last inspection in November 2022 people and families told us section 17 leave (permission for detained people to leave the hospital) was often cancelled. The provider only recorded how often section 17 leave was accessed and not how often it should be accessed, so could not tell us how often it was cancelled and how quickly the person would then have the leave rearranged. During this inspection we saw that this had improved. Staff recorded all planned section 17 leave and senior leaders had oversight of leave that was cancelled and whether this had been rearranged. Leave was mostly cancelled due to an increase in the person's risk due to inappropriate behaviour or because of the service not having staff available at that time who were trained to drive the company vehicles. This was also reflected in the feedback we received from patients and families who told us that leave was rarely cancelled and when it was, it was always rearranged.

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.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support.

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

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's care records each time.

People had easy access to information about independent mental health advocacy, and staff ensured people had an Independent Mental Health Advocate (IMHA) or were offered one as needed.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Care plans included information about after-care services available for those people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

Requires Improvement

Wards for people with learning disabilities or autism

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the five principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards, when required.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff respected the rights of people with capacity to refuse their medicines and ensured those with capacity had the option to consent to receiving medicines. Overall T2 and T3 paperwork was clear and evident in people's clinical records, although in one person's folder the T2 paperwork was not readily available for staff to access. A T2 form must be completed by the responsible clinician when a detained person is consenting to medication, a T3 form must be completed by a Second Opinion Appointed Doctor if the detained person is refusing or is incapable of consenting to treatment. We fed this back to staff at the time who provided us with the document which was then placed at the front of the person's folder.

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered the person's wishes, feelings, culture and history. We saw examples of appropriate capacity assessments in people's clinical records.

Staff ensured that an Independent Mental Capacity Advocate was available to help people if they lacked capacity to make decisions for themselves and they had nobody else to represent their interests.

Is the service caring?

Good

Our rating of caring improved. We rated it as good because:

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They respected people' privacy and dignity. They understood the individual needs of people.

We spoke with 11 people across all wards who felt that staff were respectful, caring and compassionate. The provider had completed a person survey within the 6 months prior to our inspection. One hundred percent of participants said yes when asked if staff were kind to them.

At the time of the last inspection in November 2022, we saw that some newer staff did not engage with people using the service as much. We raised this with the provider who assured us they would take action to address this. During this inspection we saw that this had improved. Newer staff were supported by a mentor and we observed staff giving time to people using positive, respectful language at a level people understood and responded well to.

Staff supported people to understand and manage their own care, treatment or condition. They knew people well and understood their individual needs. During a hospital-wide patient engagement meeting, we observed an individual share that staff always tried to put the needs of people using the service first.

Requires Improvement

Wards for people with learning disabilities or autism

Staff gave people help, emotional support and advice when they needed it. People using the service told us they felt valued by staff who showed genuine interest in their well-being and quality of life. Two out of the 11 people told us that night staff were less supportive, although they were available when people needed them.

People we spoke with said they felt able to raise concerns without fear. Staff said they could raise concerns about disrespectful, discriminatory, or abusive behaviour towards people without fear of the consequences.

Staff followed policies to keep people information confidential. Information was kept securely on the wards.

Involvement in care

Staff involved people in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of people

At the time of the last inspection, some care plans did not demonstrate how people had been involved in developing their care plans and were clearly written in professional language. During this inspection we found that this had improved. All 7 care plans looked at showed people's involvement, that they were co-produced and reflected their voices.

People were empowered to make decisions about the service when appropriate and felt confident to feedback on their care and support. The service's recent person survey was mostly positive with participants saying they felt safe, can do things for themselves and feel listened to by staff.

The previous person survey identified that people did not like the food and did not get to speak with an occupational therapist. The most recent survey identified that just over 92% of participants said they got to speak with an occupational therapist. However, only 30% of participants said they liked the food. The service had developed daily forms for people to feedback on the food. Overall, most people we spoke with told us that there were plenty of food options, although the quality could still be better with more healthy options.

Staff involved people in care planning and empowered them to make choices for themselves. We observed a patient review meeting which was led by the person using the service, who had completed a feedback form prior to the meeting to aid discussion.

Wards held weekly community meetings and patient engagement meetings which were attended by people and staff across all wards. Staff told us this was a new meeting looking at how to engage people more in decisions about the service.

Staff made sure people could access advocacy services

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Requires Improvement

Wards for people with learning disabilities or autism

We spoke with 4 family members who all told us that they were happy with the service and felt their loved ones were safe.

Previously family members told us they were not involved in developing care plans and were not always sure what was in them. During this inspection all family members we spoke with told us that staff informed and involved them appropriately. One family member told us that they were regularly encouraged to speak up to give their feedback.

Staff supported people to maintain links with those important to them. All family members we spoke with told us that they spoke regularly with their loved one and had regular contact with staff including the hospital's social worker and clinical forensic psychologist.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

Access and discharge

Staff planned and managed discharge well.

Since the last inspection in November 2022, the service had discharged 7 people into community placements or transferred them to other services which better met their needs. Senior leaders recognised that 15 out of the 18 people remaining at the service were on a delayed discharge pathway, due to the length of time they had been at the service. The hospital continued to work closely with commissioners to ensure that people who were ready for discharge had a plan in place, and to prevent unnecessary delays to discharge.

When people went on leave there was always a bed available when they returned.

People were moved between wards during their stay only when there were clear clinical reasons or it was in their best interests.

Staff supported people when they were transferred between services. Staff supported people when visiting new placements and kept in touch to support once they were discharged.

The service was continuing to work with commissioners to ensure they offered a service that was needed in the local area and complemented local services. There was a clear focus on transition and discharge within the new clinical model.

Facilities that promote comfort, dignity and privacy

The environment did not fully meet the needs of people using the service.

At the time of the last inspection, the lighting throughout the hospital was too bright and not appropriate for autistic people. Staff were unable to dim the lighting to make it more pleasant for the people residing there. During this

inspection we found that this had not improved. The provider had conducted an updated autism friendly audit in April 2023. The audit identified again that the lighting needed to be changed and the service still planned to replace all lights with dimmable switches as wards were refurbished. However, plans to address this had not progressed and audits in place did not identify the current impact for people individually. One person told us that the lighting caused them to get headaches.

The lights in the corridor on Folkestone ward were off during our visit and the corridor was very dark. Staff confirmed that the lights were controlled from the nursing office, which meant that people were unable to turn the lights on and off themselves.

Most bedrooms were not en-suite and people had to share bathroom facilities. However, wards were single-sex and there were enough bathroom and toilet facilities for the number of people. Maidstone ward had 2 accessible bedrooms on the ground floor which were en-suite, for people who were unable to use the stairs. Each person had their own bedroom which they could personalise. People could keep their personal belongings safe and had access to lockers.

There were limited additional rooms on the wards for people to spend time or have therapy. However, staff enabled flexibility and helped people to have freedom of choice and control over what they did where possible. There was an onsite academy that people could access for activities. At the time of the last inspection, we heard mixed reports about how often the academy was being used. During this inspection we found that this had improved. The academy was kept open until 9pm so that people could spend time there during the evenings when they wanted to.

The service had a room where people could meet visitors in private, including children.

People could make phone calls in private.

Wards had an outside space that people could access easily. However, some of the gardens needed some work to make them more pleasant and user friendly.

People on Folkestone and Maidstone wards who were unable to access the kitchen unsupervised did not have direct access to cold drinks. Senior managers assured us that cold drink facilities had been provided immediately following our visit and that water coolers were to be installed on the wards as a longer-term solution.

Patients' engagement with the wider community

Staff supported people to access the community.

At the time of the last inspection, staff told us that people could only access the community during daylight hours. This limited people's access to the community, including people who were close to being discharged. During this inspection we found that this had improved. Staff and people using the service fed back that this blanket restriction had been removed and were able to access the community at any time when it had been granted by the responsible clinician.

Staff encouraged people to develop and maintain relationships both in the service and the wider community, including family and carers. Most people told us that staff helped them stay in contact with their families. However, the person survey showed that 3 people said they could not talk to their families and 5 people said they could not meet their families. It was not clear why these people could not keep in contact with their families.

Requires Improvement

Wards for people with learning disabilities or autism

Staff made sure people had access to the community and were developing education and work opportunities within the community. One person told us they were undertaking work experience. At the time of the inspection most activities were based within the hospital with people accessing section 17 leave twice per week. Staff also shadowed people in the community to help them develop skills. However, staff told us that a lack of staff qualified drivers could sometimes impact on where and when people could go out.

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication and advocacy.

Staff discussed ways of ensuring targets for people were meaningful. They spent time with people understanding how they could be achieved and spoke knowledgably about tailoring the level of support to an individual's needs.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. We saw that people could access information in easy read formats.

Staff provided information on the wards using visual cues to help people know what was going to happen during the day and who would be supporting them.

Staff made sure people could access information on treatment, local services, their rights and how to complain.

Managers made sure staff and people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual people. Food was standing agenda item during weekly community meetings. However, people we spoke to told us that the quality of food still needed improving.

At the time of the last inspection, the person survey identified that people could not access a church or mosque. The most recent survey conducted in 2023 identified that just over 61% of participants said they could go to church or mosque.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them. However, it was not always clear how lessons learnt were shared with the whole team and wider service.

People and relatives knew how to complain or raise concerns, and staff supported them to do so. The person survey showed that all participants knew how, and who to complain to if they were unhappy.

The service clearly displayed information about how to raise a concern in ward areas. However, all of the participants who took part in the recent person survey said they had not seen it.

Staff understood the policy on complaints and knew how to handle them. People received feedback from managers after the investigation into their complaint.

Requires Improvement

Wards for people with learning disabilities or autism

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. People were encouraged to contribute to hospital wide patient engagement meetings and weekly community meetings on each ward.

The service treated concerns and complaints seriously and investigated them. However, staff we spoke with were unable to provide examples of any lessons learned which had been implemented to improve the service.

Is the service well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement because:

Leadership

Leaders had the necessary skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and were visible to staff and people. However, leaders had still not fully embedded all identified improvements.

Leaders remained focused on taking actions to address the findings of the last inspection report and making improvements to the hospital environment and improving care. We saw that some of these improvements were implemented but others still required further work by the leadership team.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. Staff we spoke to said that the hospital leaders were supportive, visible and present on the wards and could access them when they needed to.

Since the last inspection in November 2022, the senior leadership team had been joined by a new clinical director and consultant forensic psychologist. Senior leaders continued to be supported by colleagues from NHSE/I improvement team who continued to support the hospital to embed governance processes and quality improvement.

Vision and strategy

Staff did not always know or understand the provider's vision and how it applied to their work with people using the service. However, managers were working to improve this.

Leaders had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible. The service had developed the 'Cedar House Improvement Method' (CHIMe), which set out the strategy and vision for the service in driving improvement and embedding the new model of care. The new model of care defined the role of the hospital within the local care system, which included the principles of right support, right care, right culture. Leaders were being supported by NHSE/I to facilitate learning for staff.

The senior leadership team met regularly with staff to share updates on hospital improvements both face to face, via email and by posting updates on noticeboards. However, staff we spoke to were not able to inform us of the provider's vision or describe how the new model of care should be applied in the process of their work.

Requires Improvement

Wards for people with learning disabilities or autism

Culture

Staff felt respected, supported and valued and they could raise any concerns without fear.

Staff felt supported and valued by senior staff, which supported a positive culture. Staff said the senior leadership team were more approachable, that staff morale had improved and felt that the culture had continued to improve. Staff told us they felt able to raise concerns with managers without fear of what might happen as a result. However, only 43.4% of participants who completed the recent staff survey between January and March 2023 said they would recommend Cedar House as a place to work. Part of the service's improvement plan included prioritising support for staff, for example regular supervision, offering well-being sessions and ensuring staff take their breaks, to improve morale and culture further.

Leaders encouraged supportive relationships amongst staff. Staff were able to access weekly one-to-one sessions with the consultant forensic psychologist to support well-being.

Governance

Our findings from the other key questions demonstrated that governance processes required further improvement and embedding to enable the provider to assess, monitor and improve the quality and safety of the service.

During the last inspection in November 2022, the senior team had only recently implemented a governance structure which needed embedding. At this inspection, whilst we saw that some improvement had been made, governance processes still required improvement to hold staff to account, kept people safe, protect their rights and provide good quality care and support.

There was now a clear governance structure in place with routes of escalation, reporting and decision making. Ward managers and the senior management team had access to data relating to the quality and safety of the care delivered through attendance at monthly clinical governance meetings. These meetings ensured that standard agenda items such as staffing, complaints, safeguarding, incidents, outcomes of audits, medicines management and service level risks were routinely reviewed and discussed. However, the record of the discussion about items on the agenda was not well recorded at ward level. Therefore, it was not clear what aspects of any governance item which had been considered in the meeting, such as the mitigation of risk and welfare or emerging themes and lessons learnt from incidents or complaints, had been reviewed or shared with ward staff.

Staff took part in a programme of clinical audits which fed directly into the quality assurance framework for the hospital, although some of the concerns identified during our inspection had not been flagged through this process. Senior managers were committed to continuing to embed the governance structures received continued support from the NHSE/I service improvement team to do so.

Managing of risks, issues and performance

The hospital had an up-to-date risk register in place. However, systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of people required further improvement.

The service had recently reviewed its risk register and the risks identified were appropriate.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed.

Staff were able to explain their role in respect of individual people without having to refer to documentation.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

At the time of the last inspection the provider was experiencing a nationwide cyber-attack on the electronic records system. Since then, this had been resolved nationally and the service were using it to record people's care notes and records. However, systems and processes in place to provide leaders assurance about the quality and safety of the service, experience of service users and accurate record keeping, were not robust.

The service had taken part in a quality visit by commissioners in the month prior to our inspection.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff encouraged people to be involved in the development of the service. People had the opportunity to give feedback about the service via weekly community meetings. The service had recently started a patient engagement meeting which was hospital-wide, and people were able to give feedback and make suggestions on improving the service.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership, to give people using the service a voice and improve their health and life outcomes. A peer support relationship had been maintained with leaders at a local NHS trust which provided a similar service to Cedar House. Some staff had visited the service for professional development and sharing of learning.

Staff engaged in local and national quality improvement activities.

The hospital had completed its six-monthly staff survey which had been undertaken between January and March 2023. Fifty-four members of staff including clinical, non-clinical and administrative staff had taken part in the survey. However, responses were mixed and we did not see that the provider had developed an action plan to specifically address some of the concerns identified.

Learning, continuous improvement and innovation

The provider invested sufficiently in the service, embracing change to deliver improvements, although these were ongoing.

Staff we spoke to told us that the main improvements since the last inspection in November 2022 had been staffing levels, improved discharge planning and a consistent multidisciplinary team.

Requires Improvement

Wards for people with learning disabilities or autism

Cedar House was part of 2 quality networks, the Quality Network for Forensic Mental Health Services and the Quality Network for Inpatient Learning Disability Services. These networks provided opportunities for the hospital to be reviewed by peers and to share good practice and innovation across similar services.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not operate effective governance systems to enable the provider to assess, monitor and improve the quality and safety of the service. The provider did not ensure that there was a systematic review of the quality of audits, ensuring that actions were pulled through with clear ownership of who was completing the actions. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure ligature risks were safely assessed and managed. Regulation 12(2)(d) The provider did not ensure that records relating to the care and treatment of people following incidents were complete and accurate. Regulation 12(2)(b) The provider did not ensure that staff completed section 17 leave forms appropriately to ensure risk was assessed safely prior to people leaving the hospital grounds. Regulation 12(2)(a) The provider did not ensure that staff were sharing key risks of people using the service during handover meetings to keep them safe. Regulation 12(2)(b) The provider did not ensure that staff recorded clinic room temperatures so that medicines were stored safely. Regulation 12(2)(d)(g)

This section is primarily information for the provider

Requirement notices

Managers did not ensure that all staff were compliant with mandatory training for the safe administration of medicines. Regulation 12(2)(c)

The provider did not ensure that all staff completed the required competencies in line with their own policy before administering medicines unsupervised. Regulation 12(c)

The provider did not ensure that décor was in a state of repair which did not pose a risk of infection. Regulation 12(2)(d)(h)

The provider did not ensure the lighting was suitable for the people admitted to the hospital, and that measures to reduce or remove the risks within a timescale that reflected the impact on people using the service were effective. Regulation 12(2)(d)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We have issued a warning notice to the provider. The provider must improve the quality and assurance systems to ensure that they are assured risks and record keeping are effectively managed. The provider failed to ensure the systems and processes in place were robust enough to make sure ligature risks were safely managed. The provider failed to ensure the systems and processes in place were robust enough to ensure oversight of the quality and safety of the service and experiences of service users and accurate record keeping. Regulation 17(1)(2)