Good

Huntercombe (Granby One) Limited

Cedar House

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-280143781	Cedar House	Cedar House	CT4 6PW

This report describes our judgement of the quality of care provided within this core service by Huntercombe (Granby One) Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Huntercombe (Granby One) Limited and these are brought together to inform our overall judgement of Huntercombe (Granby One) Limited.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the service as good because:

- Overall, we observed lots of improvements since our last inspection. We noted that the culture had improved significantly and staff had worked hard to embed the behaviour support plans which staff told us had supported them to deliver person centred care.
- The service maintained a secure environment appropriate for a low secure setting. Environments were safe, clean and well-maintained.
- The service operated with sufficient numbers of appropriately qualified staff. They were trained and supervised to be able to support people with learning disabilities or autism.
- The service managed patients' risks on an individual basis. The service contained seclusion facilities and staff were trained in physical interventions. These were used as a last resort and patients were debriefed and supported following episodes.
- Staff were aware how to report incidents, raise safeguarding concerns and manage complaints. All incidents were reviewed and investigated and the service used outcomes to learn lessons and improve practice.
- The service had a team of staff who oversaw patients' physical health needs. They were appropriate qualified and could recognise and access specialist physical health support when necessary. This team upskilled colleagues with a programme of training.
- The service supported patients with care plans that covered all aspects of care and needs. They used a positive behavioural support approach and prescribed medicine in line with national guidance.
- The psychology team offered a range of individual and group interventions that were relevant to the patients at the service. The occupational therapy team ran a course which focussed on patients' individual recovery needs.
- The service provided career progression opportunities. Support workers could gain nursing qualifications funded by the provider and nurses could attend leadership courses. All staff could access training in individual areas of interest, such as family work.
- Staff interacted with patients positively and patiently. They followed details plans to help them deliver care to patients in a consistent way. Patients were supported to understand and be involved in their care plans.
- The service had developed a family liaison nurse role to support communication between patients, their families and the service. They also had an onsite advocacy service that supported patients to give feedback and express their views.
- The provider actively looked for solutions to meet the challenge of accommodating their patients after they left hospital. They were converting property, on another local site, into bespoke bungalows where patients could be accommodated.
- The service provided an environment that promoted recovery and comfort, complete with information in an easy read format. Patients could personalise their rooms and choose their meals. Patients had access to the local community and this was encouraged to support their integration back into the community.
- The provider had a vision, values and strategy that was patient-centred and installed in staff during induction and supervision. Their audit framework was based on regulations, national guidance and extracting learning opportunities.
- Staff morale was high and the service had many initiatives to promote their well-being. The service participated in peer review schemes, contributed to research projects and used innovation to improve patient experience.

However,

Summary of findings

- The service was routinely using seat belt clips for two patients to stop patients undoing their seat belts whilst driving. They did not recognise this as a form of restriction and, therefore, had not assessed patients to ensure they were agreeable to them being used.
- The service did not have care plans that fully promoted safe care and treatment for patients with symptoms and histories of epilepsy. However, the service acknowledged this and submitted an action plan to bring this area of care in line with national guidance.
- The service completed seclusion records in line with national guidance. However, we found one instance where a female member of staff was observing a secluded male who was exhibiting sexually inappropriate behaviour. The was contrary to the provider's seclusion policy.
- We found some solution medicines had been opened without an opening date being recorded. This meant staff could not be assured they were safe to administer to patients.
- Agency staff, on occasions, were entering notes on the electronic patient's record system under substantive staff's login details. This was due to them not using the agency login protocol. Furthermore, training in general data protection regulation was lower than the provider's target.
- We found that some forms, that documented patients' consent to treatment, would have benefitted from being updated. Similarly, some financial capacity assessments would have benefitted from being reviewed.
- Two out of seven carers we spoke with were unhappy about the service. They felt that their relatives had been their too long with little progress and felt the service had been unsupportive of their efforts to form an external carers' group.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as good because:

- The service maintained a secure environment appropriate for a low secure setting. Staff managed environmental risks through observations based on patients' needs. Staff carried radios and alarms to ensure they could relay and respond to risk issues.
- The service operated single sex environments. All were clean with appropriate equipment and medicines to manage emergency situations. The service had one seclusion room which met national standards.
- The service calculated staffing numbers depending on patient numbers, risk, observation levels and community visits. When staffing was below requirements, due to sickness, the service had systems in place to ensure staffing prioritised risks.
- The service had access to sufficient medical cover day and night.
- The service provided staff with a comprehensive training programme that equipped them to support people with learning disabilities or autism. Completion rates averaged over 90%.
- The service monitored episodes of seclusion and physical interventions and staff were trained to carry these out safely and as a last resort. Patients received debriefs after being involved in these interventions.
- All patients had comprehensive risk assessments. Patients were supported to understand their own risks. The service individually risk assessed patients in areas such as access to batteries to avoid applying blanket restrictions.
- Staff were trained in safeguarding adults and children and knew how to raise concerns. The service was supported by an external safeguarding lead and police officer and used these individuals to ensure all concerns were investigated fully.
- The service reviewed incidents daily and put actions in place to reduce risk of further incidents. The psychology team analysed incidents and supported staff to learn lessons and improve practice.

However,

- The service was routinely using seat belt clips to stop two patients undoing their seat belts whilst driving. They did not recognise this as a form of restriction and, therefore, had not assessed patients to ensure they were agreeable to them being used.

Summary of findings

- The service did not have care plans that fully promoted safe care and treatment for patients with symptoms and histories of epilepsy. However, the service acknowledged this and submitted an action plan to bring this area of care in line with national guidance.
- The service completed seclusion records in line with national guidance. However, we found one instance where a female member of staff was observing a secluded male who was exhibiting sexually inappropriate behaviour. The was contrary to the provider's seclusion policy.
- We found some solution medicines had been opened without an opening date being recorded. This meant staff could not be assured they were safe to administer to patients.

Are services effective?

Good

We rated effective as good because:

- The service supported patients with care plans that covered all aspects of care and needs. The whole service adopted a positive behavioural support approach that focussed on supporting challenging behaviour in a consistent way.
- The service prescribed medicines in line with national guidance. We found that sedating medicines were used only as a last resort in were accompanied by appropriate physical observations. Patients could access information about medicines in easy read format.
- The psychology team offered a range of individual and group interventions that were relevant to the patients at the service. The occupational therapy team ran a course which focussed on patients' individual recovery needs.
- The service had purchased an application that supported patients to monitor their own anxiety and develop their own coping strategies. Patients were supported by dedicated staff to update the application to meet their changing needs.
- The service had good access to patients' physical health needs that could not be delivered on site. All appointments attended by patients outside of the hospital were recorded and included in their individual health action plans.
- Staff were appropriately qualified and received regular supervision. New staff attended a three-week induction programme that covered all aspects of supporting people with learning disabilities or autism.

Summary of findings

- The service provided career progression opportunities. Support workers could gain nursing qualifications funded by the provider and nurses could attend leadership courses. All staff could access training in individual areas of interest, such as family work.
- The service had good oversight of documents and requirements outlined by the Mental Health Act and Mental Capacity Act. All staff had training on these legislations and were supported by senior staff with extensive training.

However,

- Agency staff, on occasions, were entering notes on the electronic patient's record system under substantive staff's login details. This was due to them not using the agency login protocol. Furthermore, training in general data protection regulation was lower than the provider's target.
- We found that some forms, that documented patients' consent to treatment, would have benefitted from being updated. Similarly, some financial capacity assessments would have benefitted from being reviewed.

Are services caring?

Good

We rated caring as good because:

- Staff interacted with patients positively and patiently. They treated them with respect and supported them to be independent where appropriate. The majority of patients gave feedback that mirrored what we observed.
- Staff knew their patients care and treatment requirement. The service gave them appropriate training to staff and the multi-disciplinary team produced details plans to help them deliver care to patients in a consistent way.
- The service provided appropriate accessories, such as bedding, to ensure patients maintained personal hygiene. Where this was an issue robust care plans and monitoring were applied to keep hygiene issues to a minimum.
- The service involved patients in their care and were looking at improving patients understanding in how and why staff supported them in specific ways.
- The service had developed a family liaison nurse role to support communication between patients, their families and the service. They also had an onsite advocacy service that supported patients to give feedback and express their views.

Summary of findings

However,

- Two out of seven carers we spoke with were unhappy about the service. They felt that their relatives had been their too long with little progress and felt the service had been unsupportive of their efforts to form an external carers' group.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The provider actively looked for solutions to meet the challenge of accommodating their patients after they left hospital. They were converting property, on another local site, into bespoke flats where patients could be accommodated.
- The service provided an environment that promoted recovery and comfort. Patients had access to activity areas, large gardens and structures, such as tree houses, that they had requested.
- The service encouraged patients to access the local community and had a fleet of vehicles for patient use. Patients who were preparing for discharge used community access to support their integration back into the community.
- Patients could personalise their rooms and had choices over food options that met their individual needs. They had access to many activities centred around leisure, fitness and learning.
- The service displayed relevant information in easy read format. Patients had access to advocacy, support with making complaints.
- The service audited all complaints and gave feedback back to complainants. They used themes to identify learning and training for staff. Staff knew how to support patients in making complaints and complements.

Are services well-led?

Good

We rated well-led as good because:

- The service had a senior management team who were visible and approachable. Staff felt supported by them. The provided funded opportunities for all staff to progress into senior roles within the organisation.
- The provider had a vision, values and strategy that was patient-centred and instilled in staff during induction and supervision. Their audit framework was based on regulations and national guidance.

Summary of findings

- Staff morale was high and staff embraced the positive behavioural approach in supporting patients. They felt the provider was open and felt confident they could raise concerns and be listened to. The service had many initiatives to promote staff well-being.
- The provider had a clear governance framework that monitored all clinical areas. They held regular meetings to maintain oversight of any areas of improvement from ward to board level.
- The service managed day to day risks and performance through daily senior management meetings and allocating a senior nurse on site who had the autonomy to make decisions around moving staff resources to manage risks.
- The service participated in peer review schemes, contributed to research projects and used innovation to improve patient experience.

Summary of findings

Information about the service

Cedar House is a specialist hospital, managed by The Huntercombe Group offering assessment, treatment and rehabilitation services in a low secure environment. It currently has six wards and capacity for 40 patients. However, two bedrooms on one ward were currently being converted into a bespoke unit for one patient, which would bring the capacity down to 39 patients.

The hospital offers secure inpatient services for people with a learning disability or autism, who have offending or challenging behaviour and complex mental health needs.

- Folkestone ward provides a service for 14 male patients. Six of these patients have bedrooms in a separate part of the ward called the enhanced low secure ward. This area of the ward offers a service to patients who have particularly challenging behaviour and has higher staffing levels.
- Maidstone ward provides a service for eight female patients. However, this will reduce to six after the conversion work is completed.
- Tonbridge ward provides a service to eight male patients.
- Poplar ward is a locked rehabilitation ward for five male patients. This ward is outside the secure perimeter fence.
- Rochester ward has three male patients as well as a single annex for one male patient.
- Ashford ward has one male patient.

We inspected the services provided at Cedar House eight times between June 2011 and January 2018. At the time of the last inspection, Cedar House was rated as requires improvement overall with a rating of requires improvement for our safe and caring key questions and good for effective, responsive and well led key questions.

Following the inspection in January 2018, the Care Quality Commission informed the provider that:

- They must ensure all ward areas maintain appropriate levels of cleanliness and staff use cleaning equipment correctly to avoid risk of cross infection.
- They must ensure that all patients have access to clean bed linen to maintain their dignity and systems are in place to ensure soiled linen is detected and changed in a timely manner.

We also informed the provider that:

- They should ensure fixtures and fittings are maintained to a satisfactory standard (broken televisions).
- They should ensure all paperwork associated with the use of seclusion is completed.
- They should ensure when staff accompany patients to hospital they take written information about patients' physical health history to give to receiving healthcare professionals. The service relied on staff to verbally handover the patients' history which could potentially lead to errors.

We issued the provider with two requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 - Safe care and treatment
- Regulation 10 HSCA (RA) Regulations 2014 - Dignity and respect

A registered manager and accountable officer were in post at Cedar House.

Our inspection team

The team that inspected the service included two Care Quality Commission inspectors, one Care Quality Commission inspection manager, two nurse specialist advisors with expertise in relation to secure settings and one pharmacist specialist advisor.

Summary of findings

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all six of the wards and looked at the quality of the ward environment and saw how staff cared for patients
- spoke with eight patients and seven carers
- spoke with the hospital manager, nursing and care manager, charge nurses and ward managers
- spoke with 34 staff members, including doctors, nurses, support workers, activity workers, education staff, occupational therapists and their assistants, psychologists and their assistants, social workers and administration staff
- spoke with a group of 13 staff on induction
- received 10 comment cards from patients
- attended and observed five multidisciplinary clinical meetings
- attended and observed four patient meetings and therapy groups
- looked at 12 care records of patients
- reviewed 37 medicine charts.
- looked at five records containing Mental Health Act and Mental Capacity Act documentation
- looked at five staff supervision records.
- looked at 20 seclusion records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 8 patients during the inspection and received 10 comment cards from patients. Approximately 80% were positive about their time at Cedar House. They told us staff were caring and kind and that they felt safe. However, approximately 40% felt that more staff were needed although they felt there were enough to facilitate their leave and outings. Patients generally felt involved in their care and felt listened to. They had opportunities make suggestions at community meetings and some told us this had led to changes in areas such as food choice, although they still felt this could be further improved. Patients, who were asked, knew how to complain and all said they had been provided with this information.

We spoke to seven carers with relatives at the service. Five were very positive, felt involved in their relatives care and well-informed. One had been supported by the service to take forward a complaint. However, two carers felt the service had let down their relatives. They felt they had been there too long without making any progress. One felt the service had not supported their attempts to start an external carers' group.

Summary of findings

Good practice

- The service had developed one of their staff into a family liaison nurse. They had recognised the benefit of this role when they had regular communication with a family following a serious incident. The family liaison nurse offered a consistent approach to contact with families and they tailored their approach to suit individual families' needs.
- The service had purchased 13 licences for a software application called 'brain in hand'. It provided patients with an individual plan for coping with distractions and stressful situations. Patients accessed the software on a tablet device so could problem solve independently. The software alerted staff if the patient was indicating they were not resolving their distress so they could respond and offer support.

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that all forms of mechanical restraint, used on patients, are care planned appropriately and covered by their mechanical restraint policy.
- The service should ensure that patients with symptoms or histories of epilepsy have care plans that fully promote safe care and treatment.
- The service should ensure that staff adhere to appropriate data protection regulations when using the provider's electronic systems. They should further improve training compliance in this area.

Huntercombe (Granby One) Limited

Cedar House

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Cedar House	Cedar House

Mental Health Act responsibilities

- Staff with appropriate training received and examined Mental Health Act paperwork on admission. All these admissions are planned.
- The service had a designated Mental Health Act administrator who had extensive training and knowledge in the Act. They worked on site and ensured that adherence around issues such as patient rights, tribunals, section papers, renewals were followed.
- Staff could access advice and support from the Mental Health Act administrator who had their own support from the provider's Mental Health Act legislation manager. All staff received training on the Mental Health Act during their induction.
- The service had a clear system for recording patients' leave conditions. Copies of Section 17 leave forms were kept in patients' individual folders. Staff followed a procedure of assessing patients' risk and recording what they were wearing to reduce the risk of unauthorised absence. Following a recent absconsion the service had service had reviewed how they coordinated searches for patients in the community.
- The service had completed the appropriate forms that specified whether patients consented, refused to consent or did not have the capacity to consent to treatment. However, some forms where patients were not able to consent to treatment would benefit from being updated. For example, some forms contained medicine groups that the patient was no longer being prescribed.
- We looked at five records and four showed that patients consistently received information regarding their rights under the Mental Health Act. The outlier received their rights after five months on one occasion. The provider's policy stated this should happen every three months or sooner if there was a trigger such as a tribunal or change to status or mental state. The service used easy read information to support patients' understanding. The service involved carers in this process if patients lacked capacity. All five records were completed correctly and up to date in all other areas.
- The Mental Health Act administrator completed quarterly audits which looked at 10 records. This allowed all records to be audited within a calendar year. The provider's Mental Health Act legislation manager also conducted an annual full audit for assurance.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff received training on the Mental Capacity Act. There was a policy available for staff to refer to for guidance. Staff had reasonable knowledge the Acts guiding principles, however, patients' care records suggested that most decisions round capacity were made by senior clinicians.
- Between 1 April 2018 and 30 September 2018, the service had made no Deprivation of Liberty Safeguards applications.
- The service carried out comprehensive capacity assessment for all patients where they could not reasonably assume capacity. However, we found that some financial capacity assessments were over three years old. Whilst the details within the assessments still applied at the time we reviewed them, the service could not evidence that these had been formally reviewed since they were completed.
- We saw examples of assessments that deemed patients had capacity to get a tattoo and make their own will. Another assessment deemed a patient did not have capacity to decide on a specific diet to support a health condition. In this case, a best interest meeting was held and the patient's views were captured in the corresponding care plan. The service appropriately assumed capacity and this was evidenced with a patient who partook in a specific behaviour. No capacity assessment took place, however the corresponding care plan focussed on protecting them potential abuse.
- The service monitored adherence to the Mental Capacity Act and the Deprivation of Liberty Safeguards through monthly clinical governance meetings.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The service provided a controlled main entrance with a double airlock operated and overseen by dedicated and specifically trained staff. This ensured security was maintained within the hospital. This environment contained lockers for storing personal belongings, a seating area, available water, bathroom facilities and a variety of relevant leaflets and information.
- The hospital was contained within a secure perimeter fence. This enabled safe and secure access for patients and staff around the whole site. The locked rehabilitation ward, Poplar ward, was in a self-contained building outside of the secure fence close to the controlled main entrance.
- Staff could observe all ward areas which were accessed by patients. They followed observation levels individually risk assessed for all patients. We observed staff regularly walking round the ward completing visual checks on patients.
- The service managed ligature risks adequately. A ligature risk is an anchor point which patients can tie things from to assist self-harm. All staff had completed training on managing ligature risks and new staff were introduced to the subject during induction. This meant staff were aware of the risk areas within the environments they worked. The service carried out ligature risk assessments using a recognised audit tool in September 2018. The hospital had many anti-ligature fixtures in bedrooms and bathroom areas and ligature cutters were available to staff. Staff carried out daily environmental risks and concerns were escalated to maintenance.
- The service complied fully with national guidance on mixed sex accommodation by providing gender specific environments.
- All wards had access to clinic rooms that contained emergency resuscitation equipment and emergency medicines. Staff followed regular audits to ensure they were in working order and complete.
- The service had one seclusion suite on Folkestone ward. It had easy clean fixtures and provided privacy for patients in seclusion. Staff could observe all areas of the suite and were able to communicate with patients through a two-way intercom. The suite had a toilet and shower, appropriate lighting controls, air conditioning and a clock.
- Following our comprehensive inspection in January 2018, we told the provider they must ensure all ward areas maintain appropriate levels of cleanliness and staff use cleaning equipment correctly to avoid risk of cross infection. During this inspection, we found all ward areas were clean and tidy. The service had contracted domestic staff and night staff followed clear cleaning schedules to ensure this level of cleanliness was maintained. The service had also simplified the self-catering arrangements on Tonbridge ward. Patients were still able to self-cater but this was done on a rota system to reduce the amount of patients' food in the kitchen area at one time.
- Staff adhered to infection control principles. Hand cleaning facilities were available throughout the wards, including the entrances. They monitored health and safety throughout the hospital, including fire drills and hazardous waste management audits.
- Staff carried alarms and radios. This allowed them to summon support and respond to colleagues when required. Staff felt the systems provided an adequate level of safety for patients and staff.

Safe staffing

- The service employed 28 qualified nurses and 137 senior support workers and support workers across the six wards. At the time of our inspection, there were vacancies for six qualified staff and 13 support workers. However, eight permanent support workers and five flexible support workers were completing their induction. One ward manager vacancy was in the interview process. We spoke with the staff on induction and the majority heard about the role through friend

and staff visiting their universities. The service used many initiatives to recruit staff such as giving existing staff 'refer a friend' incentives, attending open days at universities and advertising on the local bus route.

- The service calculated staffing numbers depending on patient numbers and increased levels of observation. The service employed a rota manager who completed staff rotas two months in advance. They had access to a bank of flexible staff and had a clear system to record their availability. They also had access to agency staff if required.
- Between 2 July 2017 and 30 September 2018, 957 (approx. 3%) shifts were covered by bank staff; 796 (approx. 2.5%) were covered by agency staff; and 224 (under 1%) were not covered.
- We audited staff rotas during a recent four-week period. The service was understaffed on five occasions. However, the daily senior nurse on site report showed that measures, such as charge nurses and educational staff providing support, maintained a safe environment for patients. The staff rotas also showed that all shifts were originally booked with surplus staff to allow for sickness and absence.
- Between 1 October 2017 and 30 September, the sickness rate for nursing staff was 5%, with the highest sickness rate on Poplar ward with 8%. Senior managers interviewed staff returning from sickness. They reported that sickness rates had decreased by nearly 2% from the previous year.
- Qualified nurses were available to all wards to carry out administration of medicine. We observed staff in patients' communal areas on all wards. Patients generally felt staff were available to talk to if they needed support or reassurance. The service employed clinical administration staff to allow staff to spend time with patients.
- Staff numbers were sufficient staff to escort patients on leave in the community. During our inspection, we saw this was planned at the start of shifts to ensure all patients got opportunities to use their escorted leave. Patients also had access to many activities in the therapy area known as the Cedar Academy. We observed patients engaging with reading classes, and a textiles group. The service employed educational staff and occupational therapists and these activities were rarely cancelled.
- The service employed three full-time consultants who were available to wards. Staff felt they were easy to access routinely and in emergencies. The service had sufficient on call arrangement to provide medical support for patients outside of normal working hours.
- The service provided staff with 28 mandatory training courses relevant to their roles. These included delivering safe physical interventions, safeguarding, immediate life support, the Mental Health and Mental Capacity Act and positive behavioural support. The majority of these courses had completion rates of between 90% and 100% and all were above 80%. The service had a system in place to allow staff to complete training within their contractual hours. The service's human resources staff monitored training and sent reminders via email. Staff, who were 100%, were entered into a monthly prize draw to promote compliance.

Assessing and managing risk to patients and staff

- Between 1 April 2018 and 30 September 2018, there were 45 incidents of seclusion with 42 being for patients on Folkestone ward. The other three were for patients on Maidstone ward. The service had exclusion criteria for admissions, on wards other than Folkestone ward, for patients that may require seclusion. However, a procedure was in place manage the risk of transferring patients from their wards to seclusion.
- Between 1 April 2018 and 30 September 2018, there were 269 incidents of restraint on 21 patients. None of these restraints were carried out in the prone position, which is face towards the floor. This can limit an individual's ability to expand their chest and breathe. Most restraints (179) were carried out on Folkestone ward on 15 patients. Staff completed physical healthcare checks in line with national guidance following restraint. Physical intervention trainers were available to staff and offered advice, additional training and support ensure restraints were necessary and safe. The service audited restraints and had seen a gradual decrease from 98 in January 2018, to 36 in December 2018. One patient required regular prolonged episodes of restraint as they had been deemed to high risk to be

placed in seclusion. The service had referred this patients to a more appropriately secure environment. However, in the meantime were completing learning reviews following these restraints. Furthermore, they were introducing safety pods and leg guards to make the restraints less stressful for the patient and staff. A safety pod is a mechanical restraint tool designed to help reduce injury to patients that display challenging behaviour. This had been discussed at length by the provider's senior managers and we were assured their mechanical restraint policy would be updated accordingly.

- The service was using seat belt clips for two patients to prevent them removing their seat belts whilst in vehicles. However, staff did not recognise this as a form of restriction and had not completed appropriate assessments to ensure patients were agreeable for these to be used. Therefore, the use of these seat belt clips were not care planned for individual patients. We discussed this with the hospital manager who agreed to address this issue by including it within the mechanical restraint policy and instructing staff to care plan the use.
- The service had adopted a positive behavioural support (PBS) approach throughout the hospital. This is a person-centred approach to people with a learning disability who may be at risk of displaying challenging behaviours and seeks to understand the reasons for their behaviour so that unmet needs can be met. All staff had been trained in PBS and this extended to new staff on induction who had the opportunity to review the PBS plans for patients on their ward. Staff were encouraged to enhance their knowledge and the service had 12 PBS practitioners and 37 PBS coaches who had undertaken extra training through The Centre for the Advancement of Positive Behaviour Support (CAPBS) endorsed by The British Institute of Learning Disabilities. The practitioners had completed PBS projects, many of which had been centred around supporting individual patients on their wards. Staff were universally enthusiastic about the PBS approach and felt it had changed the culture of the service. They felt patients and staff were happier and safer and had benefitted from the consistency that PBS installed. We were shown evidence that there had been a decrease in incidents and decrease in staff sickness over the last year. Staff shared plans to train patients and PBS so they had an understanding of how they were being supported. Also, the PBS practitioners were working on condensing individual patient's PBS plans into a 'one page profile' to improve consistency of staff delivery.
- Between 1 April 2018 and 30 September 2018, there was no incidents whereby patients required rapid tranquilisation to manage aggressive or challenging behaviour.
- We reviewed 12 electronic care records across all of the wards. Comprehensive risk assessments were in place for all patients. The service used the historical, clinical risk management tool that assessed risk factors for violent behaviour. It also identified protective factors to reduce future risk and support risk management plans. Where required, the service used recognised tools to assess and manage the risk of behaviours such as sexual offending and fire-setting. All these assessments were reviewed regularly and documented in patients' individual support guidelines. Patients were encouraged to take ownership of their individual risks and we observed this in a violence prevention group facilitated by a forensic psychologist. Patients could self-rate their risk in different domains and compare it with the psychologist's view. This led to a meaningful discussion around the reason they were currently in hospital.
- The service did not apply blanket restrictions to manage patient safety. The service managed restrictions on patients through individual risk assessments. For example, the service followed protocol to manage the risk of patients swallowing batteries. We observed the battery management policy being followed on the female ward where this risk was deemed high. We saw examples of patients being assessed for access to batteries. The service had also identified patients at risk of this behaviour and transferred them to more appropriately secure settings. The service also had a monthly reducing restrictive practices group. We saw minutes that showed the service was trying to get improve lighting in the courtyard so patients could use it in winter. Furthermore, there were plans for patients to be trained in breakaway techniques to reduce patient on patient assaults.
- Staff were trained to conduct patient searches in a supportive and dignified way in a private area of the ward. Staff conducted patient searches according to individual need. Any risks identified from items that

were restricted were managed by room searches. A support worker who offered beauty therapy told us there were robust checks in place to ensure their products did not bring harm to patients.

- Between 1 April 2018 and 30 September 2018, there was no incidents whereby patients required rapid tranquilisation, via injection against their will, to manage aggressive or challenging behaviour. When sedating medicine was given orally, staff followed national guidance on monitoring patients' physical health.
- We reviewed 20 records of seclusion incidents and all were completed comprehensively. They gave clear rationale for the seclusion, were least restrictive as they were reviewed regularly and ended when appropriate and they evidenced that patients had been offered debriefs after the seclusion had ended. We found one record where a female staff member was observing a male patient in seclusion who was exhibiting sexually inappropriate behaviour, this was contrary to the provider's seclusion policy.
- A total of 94% of staff had received training in safeguarding adults and children. Staff demonstrated a good understanding of how, and in what circumstances, to raise a safeguarding issue. The service was supported by a safeguard lead from the local authority. They visited the ward, managed minor issues locally and escalated more serious issues when appropriately. Between 1 December 2017 and 30 November 2018, the service reported 15 safeguarding concerns, none of which required formal escalation to the local authority. We saw examples of safeguarding incidents being managed within the service. A patient, who expressed sexual interest in another patient, was moved to another ward. Another allegation of staff abuse was investigated by the service's allocated police liaison officer who viewed CCTV and concluded no abuse had taken place. The service chaired a monthly multi-agency safeguarding meeting to ensure engagement from all relevant stakeholders.
- The service generally managed medicines, including controlled medicines, safely. They were stored securely and at an appropriate temperature. Medicine fridges were fitted with electronic thermometers which alerted staff if the temperature was not within range. Alerts for faulty medicines and devices were actioned in a timely manner. However, we found some solution medicines had not had the date they were opened recorded. This meant staff could not be assured they were safe to administer to patients. All medical devices were regularly calibrated to ensure they gave accurate readings.
- The service had processes in place to accommodate visits from children. The social work team assessed all requests the child would be safe. Separate and secure family rooms were available away from the ward areas.

Track record on safety

- Between 1 October 2017 and 30 September 2018, the service reported 15 serious incidents requiring investigation. There were seven incidents of battery ingestion or insertion; five incidents of deliberate self-harm; two incidents of absconsion whilst on leave and one incident of overdosing whilst on leave. All investigations carried out established the root cause of the incidents and subsequent learning. For example, the service was reviewing national guidance on self-harm and suicide prevention with the view to potentially upskilling staff in this area.

Reporting incidents and learning from when things go wrong

- Staff had a good understanding of what would be classed as an incident and how to report it on the electronic system. We observed all incidents, from the last 24 hours, being reviewed in the daily senior managers' meeting. Incidents were signed off and any updates required to patients' clinical documentation were delegated to the ward managers. Ward specific incidents were also discussed in the ward's weekly clinical improvement group. We observed a holistic approach to identifying learning from incidents which considered the individual patient, the environment and any systemic issues. A monthly newsletter was circulated to all staff which summarised key issues and lessons learnt.
- We attended meetings and reviewed minutes of meeting and saw staff discussed incidents in an open and transparent way which was in line with the provider's duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people (or other relevant persons)

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

of 'certain notifiable safety incidents' and provide reasonable support to that person. Any duty of candour requirements were recorded during the incident review process, such as informing relatives. All staff had completed training in duty of candour.

- The psychology team audited all incidents reported and produced spreadsheets that could be used to support local ward governance, the hospital's governance and the wider provider's governance.

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Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- The full-time health promotion nurse, who was trained in general nursing, oversaw a clear physical health pathway throughout the hospital. All patients had a comprehensive physical health assessment on admission, that covered baseline observations, height, weight, nutrition, risk of pressure ulcers, electrocardiogram and feet and oral hygiene.
- The service effectively responded to patients' physical healthcare needs and used a recognised early warning score tool to quickly identify any changes in a patients physical condition. The health promotion nurse responded to physical health issues and escalated them to the visiting GP, who saw approximately ten patients a week, or general hospital where appropriate. The service had a designated room with appropriate medical equipment that was appropriate for facilitating these appointments. In between the visiting GP attending, the physical health lead nurse would assess patients with physical health needs and staff would consult with the GP if needed.
- The provider had funded five support workers to undertake their associate nurse practitioner training. They worked closely with the health promotion nurse to support patients' physical health and well-being. This team also provided physical health training to nursing staff in line with identified needs discussed in a quarterly physical health improvement forum. They also delivered health and wellbeing sessions to patients within the recovery college and distributed seasonal health information to all the wards such as flu information in winter.
- The service generally monitored patients' ongoing physical health effectively. The visiting GP completed an annual physical health check appropriate for adults with learning disabilities. Patients, where possible, attended the GP's local surgery in the community. All physical health information was included in individual patients' physical health action plans. We saw many examples of identified physical health issues having related care plans to support staff manage physical health issues. However, we found that five patients, with histories of epileptic symptoms, only had brief care plans that identified medicine as the main control. We were concerned that activities, such as bathing, were not included in the care plans. Staff told us that these patients would only use the shower, but they had limited knowledge of individual patients' epileptic history or diagnosis. We raised our concerns with the hospital manager and they responded with a clear action plan to review these care plans and provide appropriate training to staff.
- We reviewed 12 care records and found that patients, care plans were personalised, holistic and recovery focused. All patients had their care and recovery needs monitored by recognised tools such as the outcome star, individual health action plans, my shared pathway and this is me. We saw a wide range of care plans covering all aspects of care. Out of the 12 records reviewed we found one that required care plan review.
- The service produced psychologically led individual support guidelines for all patients. The were detailed and informed staff how to best support and manage patients' unique behaviours. The guides had an emphasis on positive strategies that staff should use and the rationale behind them. These documents were written in easy read and pictorial formats, All staff received training in positive behavioural support in order to consistently follow these guidelines. Staff recognised they were lengthy documents and the positive behavioural support practitioners were working on summarising them into one-page profiles.
- The service used a recognised electronic patients' records system, CareNotes, which allowed staff to securely access and update patient information. The system allowed information, that had been completed on paper, to be uploaded onto individual patients' records. All staff were provided with a secure email account where they could communicate with internal and external colleagues. However, during our review of care records we found instances whereby agency staff had completed entries under substantive staffs' logins and only 54% of staff had completed general data protection regulation training. Staff had access to an intranet site where they could access information such as policies.

Best practice in treatment and care

Are services effective?

Good

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- We reviewed all prescription charts for patients within the service and found the service followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines. All patients were prescribed medicine within ranges recommended by the British National Formulary and we saw that medicines with sedating properties were only used as a last resort with staff using positive behavioural support techniques in the first instance. We found one chart that did not indicate any known allergies and a few charts where the reason for missed doses was not recorded correctly. The service provided patients with easy read and pictorial information on medicines. The service had a policy around self-administration of medicine to support patients' independence in this area. A contracted pharmacist visited the service weekly and conducted comprehensive audits around medicine management. They also provided staff with three training sessions a year in areas such as rapid tranquilisation and updates to national guidance.
- The service had a contracted team of psychologists who offered a range of psychological interventions to patients. This included four assistant psychologists who told us they had extensive learning opportunities at the service. The team offered individual and group therapy aimed to treat and improve behaviours and conditions such as violent behaviour, sexual offending, moral development, post-traumatic stress disorder and fire-setting. We observed a violence prevention group attended by three patients. It was a structured 28-week course based on evidence-based research. We also saw case studies whereby patients had significantly reduced their self-harming behaviour after being treated with eye movement desensitization and reprocessing therapy.
- The service employed a lead occupational therapist (OT) who was supported by two OTs, three educational staff who worked in the Cedar Academy (the education and activity suite), and four activity co-ordinators who were ward-based. All patients were assessed with a recognised tool to ascertain their strengths and weaknesses in everyday tasks and had a corresponding plan. The lead OT was revamping the service's recovery college to make it more structured 12-week course around personal recovery. The team had also produced easy read pictorial timetables to promote activities within the Cedar Academy and were hoping to extend activities to evenings and weekends.
- The service had become smoke-free 18 months ago. The health promotion nurse was also the smoking cessation lead and was supported by nine staff who had also completed this training. Patients had been involved as peer representatives and co-produced a nicotine reduction programme appropriate for people with learning disabilities. The service now offered electronic cigarettes and we saw evidence these had been researched to ensure they were deemed the safest options.
- The service provided good access to physical healthcare that could not be delivered internally, such as diabetes and tissue viability nurses. All patients were registered with a local dental surgery with specialised training in providing dental care to people with learning disabilities. Patients could access reviews and treatment for vision, audio and speech and swallowing concerns. All healthcare appointments in the community were summarised by accompanying staff on a health appointment feedback form that was uploaded to the patients record. Following our comprehensive inspection in January 2018, we told the provider they should ensure when staff accompany patients to hospital they take written information about patients' physical health history to give to receiving healthcare professionals. During this inspection, staff told us they now took patients' physical health action plans so receiving services had access to patients' full physical health history.
- The service recorded and monitored patients' general well-being by using the health of the nation outcome scales for secure services and learning disabilities. This assessed 12 health and social domains and enabled the service to monitor patients' progress or deterioration and, subsequently, their responses to interventions.
- The service had purchased 13 licenses for technology aid to support patients call 'brain in hand' app. Patients had personal devices with the app and were offered personalised assistance to manage their anxiety. The app alerted allocated responders to support patients if their action indicated they were distressed. All patients had a weekly session with a senior support worker to discuss and make changes to the settings on their app. The service was trialling the app on phone devices so patients could use it whilst on leave in the community.

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The service collated data on patient outcomes who were using the app and patients had presented their experiences of using the app at corporate events and new staff inductions.

- The service followed the provider's quality assurance framework and audited clinical effectiveness and treatment practice in line with The National Institute for Health and Care Excellence guidelines. This ensured all assessments and care plans were person-centred and met their current needs. The service produced quarterly reports which monitored occurrences such as incidents, physical interventions and seclusion. The service had participated in the peer review scheme run by the Quality Network for Mental Health Low Secure in May 2018 and was due to be reviewed in May 2019.

Skilled staff to deliver care

- The service employed, contracted or had service level agreements with staff with professional backgrounds in medical, nursing, psychology, occupational therapy, social work and pharmacology to provide care and treatment to the patients. Staff with training in sport science and teaching were also employed. Staff could access speech and language therapy input through liaison with the visiting GP.
- Staff were experienced and appropriately qualified. The service provided regular training in line with national guidance on learning disabilities or autism. They were currently focussing on upskilling staff in physical health awareness.
- New staff completed a comprehensive three-week induction programme. The programme covered all aspects of supporting people with learning disabilities or autism and allowed new staff to familiarise themselves with individual patients' positive behaviour support plans. Following induction, staff completed a six-month probation period where they were mentored and expected to complete workbooks to evidence competency in their role. This was in line with the care certificate, which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. We spoke with 13 staff, in their final week of induction, and they felt adequately prepared for their roles.
- All staff received individual and group supervision on a regular basis with 97% also having received an appraisal within the last year. The service allowed one senior support worker to do flexible hours to allow them to offer regular supervision to night staff. We reviewed five staffs' supervision records and found they were comprehensive with evidence of identified issues being followed up until resolved. Supervisors gave advice on clinical practice, developmental needs, personal well-being and any concerns with colleagues. The charge nurses were provided with external group supervision from a psychologist to address their managerial needs. In addition, each ward had weekly reflection and patient focus sessions where themes from incidents were discussed. These were led by psychologists and allowed staff to de brief and access individual and team support. These sessions took place at 7.30am so both day and night staff could attend. All wards had monthly team meetings where clinical and business matters, across the ward, service and organisation were discussed.
- The service offered career progression opportunities for support workers. They funded support workers to do their three-year nursing degree and two-year associate nurse practitioner training. They had also secured funds to upskill current qualified nurses to mentor the trainees. Support workers were also able to progress to senior support workers and access extra training in areas such as positive behaviour support, physical interventions and conflict management. One qualified nurse had been supported to develop the role of family liaison nurse.
- The service had not needed to performance manage any staff in relation to clinical practice within the last year. However, the hospital manager acknowledged that non work-related sickness was an ongoing issue so performance managed staff if this was an individual issue. Between 1 October 2017 and 30 September 2018, nine support workers had been suspended and full investigations had been conducted. Four received disciplinary action, three were required to repeat training and two had no further action.

Multi-disciplinary and inter-agency team work

- The service had regular multi-disciplinary meetings attending by relevant professionals. Patients had individual ward rounds every month to discuss their aims and goals and comprehensive reviews every six

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months where all disciplines produced reports to outcome patients' progress. The senior management team reviewed all patients in a daily morning meeting and delegated any immediate actions to ward staff.

- We attended two handover meetings and found they effectively prepared staff to manage risks and provide care and treatment on their shift. These handovers were also used to plan patients' leave and activities during the shift. The allocated senior nurse on site produced a daily handover summary which outlined any patient related incidents and staffing issues.
- The service worked effectively with agencies such as NHSE and facilitated their care and treatment reviews on the hospital site. These aimed to reduce lengthy stays in hospitals and reduce health inequalities for people with learning disabilities or autism. Case managers from NHSE and care coordinators from patients' local community teams regularly attended meetings.
- The service worked alongside external agencies to improve patient experience. They had arrangements with the local general hospital to ensure patients were seen quickly in accident and emergency. They used the experience of the local authority safeguarding team and mental health police liaison officer to resolve patient related incidents with the correct outcomes.

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

- Staff with appropriate training received and examined Mental Health Act paperwork on admission. All these admissions are planned.
- The service had a designated Mental Health Act administrator who had extensive training and knowledge in The Act. They worked on site and ensured that adherence around issues such as patient rights, tribunals, section papers, renewals were followed.
- Staff could access advice and support from the Mental Health Act administrator who had their own support from the provider's Mental Health Act legislation manager. All staff received training on the Mental Health Act during their induction.
- The service had a clear system for recording patients' leave conditions. Copies of Section 17 leave forms were kept in patients' individual folders. Staff followed a procedure of assessing patients' risk and recording what they were wearing to reduce the risk of unauthorised absence. Following a recent absconsion the service had service had reviewed how they coordinated searches for patients in the community.
- The service had completed the appropriate forms that specified whether patients consented, refused to consent or did not have the capacity to consent to treatment. However, some forms where patients were not able to consent to treatment would benefit from being updated. For example, some forms contained medicine groups that the patient was no longer being prescribed.
- We looked at five records and four showed that patients consistently received information regarding their rights under the Mental Health Act. The outlier received their rights after five months on one occasion. The provider's policy stated this should happen every three months or sooner if there was a trigger such as a tribunal or change to status or mental state. The service used easy read information to support patients' understanding. The service involved carers in this process if patients lacked capacity. All five records were completed correctly and up to date in all other areas.
- The Mental Health Act administrator completed quarterly audits which looked at 10 records. This allowed all records to be audited within a calendar year. The provider's Mental Health Act legislation manager also conducted an annual full audit for assurance.

Good practice in applying the MCA

- All staff received training on the Mental Capacity Act. There was a policy available for staff to refer to for guidance. Staff had reasonable knowledge the Acts guiding principles, however, patients' care records suggested that most decisions round capacity were made by senior clinicians.
- Between 1 April 2018 and 30 September 2018, the service had made no Deprivation of Liberty Safeguards applications. in the previous six months to January 2018.
- The service carried out comprehensive capacity assessment for all patients where they could not reasonably assume capacity. However, we found that some capacity assessment were over three years old.

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Whilst the details within the assessments still applied at the time we reviewed them, the service could not evidence that these had been formally reviewed since they were completed.

- We saw examples of assessments that deemed patients had capacity to get a tattoo and make their own will. Another assessment deemed a patient did not have capacity to decide on a specific diet to support a health condition. In this case, a best interest meeting was held and the patient's views were captured in the corresponding care plan. The service appropriately assumed capacity and this was evidenced with a patient who partook in a specific behaviour. No capacity assessment took place, however the corresponding care plan focussed on protecting them potential abuse.
- The service monitored adherence to the Mental Capacity Act and the Deprivation of Liberty Safeguards through monthly clinical governance meetings.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, privacy, dignity, respect, compassion and support

- We spent time on all wards and saw many positive interactions between patients and staff. Staff showed patience and treated patients with respect and professionalism. Staff were observed engaging in activities, providing practical support and encouraging independence with patients.
- We spoke with 8 patients during the inspection and received 10 comment cards from patients. Approximately 80% were positive about their time at Cedar House. They told us staff were caring and kind and that they felt safe. However, approximately 40% felt that more staff were needed although they felt there were enough to facilitate their leave and outings.
- Staff worked on designated wards and displayed a good understanding of individual patients' care needs. They had access to patients' individual support guidelines and worked cohesively to follow them. Staff were universally positive about the positive behavioural support approach the service had taken and felt better equipped to recognise and respond to challenging behaviour. They reported the consistent approach had led to a more relaxed environment for patients and staff alike.
- Following our comprehensive inspection in January 2018, we told the provider they must ensure that all patients have access to clean bed linen to maintain their dignity and systems are in place to ensure soiled linen is detected and changed in a timely manner. During this inspection, we saw significant improvements in this area. A patient with recognised hygiene issues was monitored every hour to ensure cleanliness was maintained. They had increased the number of duvets available and used disposable bedding when the patient was experiencing episodes of significantly poor personal hygiene.

The involvement of people in the care they receive

- The service followed clear procedure when admitting patients. All admissions were planned and patients, and their carers, received information about the service beforehand. The information welcomed patients, introduced key members of staff, outlined care and treatment options and available leisure activities.
- Staff involved patients in their care planning and individual support guidelines and this was monitored through the audit framework. Patients reviewed their own plans monthly alongside members of the mulit-disciplinary. Patients' received copies of their care plans that contained pictures and symbols to support understanding which patients told us they understood. The service was planning to give patients training in positive behavioural support so they could have a better understanding of their individual support guidelines.
- The service provided advocacy services which offered both general advocacy and independent advocacy around issues around the Mental Health Act. A general advocate visited the service regularly and information was displayed on all wards about local advocacy services available. An advocate was available for four days a week.
- The service had supported a member of staff to develop a family liaison nurse (FLN) role. It had developed after the service recognised the benefit of having a single point of contact for family members following a serious incident the previous year. The FLN distributed a questionnaire to all carers to enquire what they wanted from the role and had been able to provide support to carers dependent on their requirements. This varied from giving weekly updates, advocating for families in ward rounds or giving regular time for carers to offload. The FLN showed a diligent and consistent approach and had a dedicated phone number and email address to be contacted on. Carers we spoke with reported it had been very supportive. The FLN had used their role to help get information on how best to support patients, for example how best to promoting tooth brushing. They were also in conversation with a parent, with an expertise in attention deficit hyperactivity disorder, to deliver training to staff. The service informed encourage relatives to give feedback via the 'friends and family test'. This was offered by advocates and the FLN when relatives attended six monthly progress reviews.
- The service gave patients opportunities to give feedback. They carried out an annual patient survey and feedback was consistent with what patients told us

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

during inspection. All wards had weekly community meeting attended by patients and staff. We attended this meeting on Poplar ward. It was joint chaired by a patient and staff member with another patient allocated time keeper. Patients were enthusiastic about their involvement in staff inductions and attending the provider's governance meeting. They discussed who was leading the monthly food theme night and plans for getting a ward wormery. At the end they nominated their Huntercombe hero, a staff member who had helped them, and complimented each other on their weekly achievements. The agenda was produced in an easy read format with pictorial aids. We were informed that this format was similar on all other wards.

- Staff, who delivered physical intervention training, and advocates had produced an easy read questionnaire for patients to feedback their experiences of physical interventions. This would help them design a more patient-centred debrief after they had been restrained.
- The service encouraged patients to express their views in decisions that affected the service and had regular 'conversation into action' forums to discuss potential improvements to the service. For example, patients had decided to spend allocated funds on the newly constructed tree house. Patients gave presentations to new staff during induction, sat on recruitment panels and spoke at board meeting about treatment initiatives that affected them. The service had developed a patient counsel lead, peer trainer roles and planned to provide training to patients in positive behavioural support and breakaway techniques. Some patients shadowed members of the maintenance and catering team to gain work experience.

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Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- At the time of our inspection, the service had no vacant beds. Between 1 April 2018 and 30 September 2018 bed occupancy was 100% when considering the closure of two beds on Maidstone ward and temporary closure of one bed on Folkestone ward. The service had admitted two patients and discharged five patients within this period. The average length of stay for the patients on Poplar locked rehabilitation ward as of February 2019 was 647 days.
- The service generally admitted patients from the local and neighbouring counties to support contact with patients' community teams and families. When this was not the case, the service was proactive in maintaining contact. When patients went on home leave there was no risk of their bed being taken.
- The service reported a delay for seven patients who were appropriate for discharge. Reasons for these delays were, lack of appropriate community settings; disputes with community teams around aftercare responsibilities; funding constraints; lack of appropriate legal frameworks in the community to supervise risks; and insufficient forensic expertise in community teams. The provider recognised the national challenge of identifying appropriate community settings for their patients and was currently converting some accommodation in a nearby location to be used for this purpose. The hospital manager sat on the local 'Transforming Care Community Infrastructure group', where delayed discharges, their reasons, and potential solutions were discussed with local transforming care leads.
- Patients on Poplar ward were encouraged to spend time in the local community in preparation for their discharge from hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards had large communal areas equipped with entertainment such as TVs, pool tables, computer games and board games. The service had a separate educational and activity suite accessible by all patients. The provider had a scheme whereby services could apply for funds to create therapeutic projects. The service had used this to build a music studio, beauty and spa salon, permanent camping tent with electricity and a tree house with electricity.
- All wards had quiet areas where they could spend time on their own and receive visitors. The service provided telephones that could be used by patients to make calls in private.
- The six wards, within the secure perimeter fence, had access to large outside gardens. Poplar ward had access to its own large garden area. All wards had individual access to smaller garden areas where patients were able to do gardening or keep pets.
- The service provided food of a good quality. Patients told us they enjoyed the food and could give feedback directly to the chef. Many patients visited the hospital canteen for their meals and told us they enjoyed this opportunity to leave the ward. The service provided food in line with individual patients' nutritional needs. Patients on Tonbridge ward had self-catering opportunities. This was done on a rotational basis with two patients and two staff preparing a collective meal between them. Wards also arranged food theme nights supported by the catering team. All wards had facilities where patients could access snacks and cold or hot drinks at all times. All wards had access to facilities where patients could do their laundry independently or with support from staff.
- The service allowed patients to personalise their rooms and we saw many examples of this. One patient, changed their mind about the colour they wanted the walls and the service arranged redecorating. Patients on Poplar ward, Ashford ward and some on Maidstone ward had en-suite bathrooms. The service assessed patients' ability to hold a key to their own room so they could access at all times. Patients without keys relied on staff to give them access. The service provided appropriately secure storage facilities to keep patients' possessions safe.
- The service provided patients with a comprehensive range of activities during the week. These were facilitated by occupational therapists, education staff and a gym instructor within the separate activity and educational suite - the Cedar Academy, the service's gymnasium, sensory room and outdoor tarmacked

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

area. Many of the educational courses were accredited with the award scheme development and accreditation network (ASDAN). These ASDAN courses provided to fun way to learn new skills in maths, literacy, art and science. We were told that the occupational therapy team were looking at extending activities at the Cedar Academy to weekends and evenings. The service had access to a fleet of vehicles where patients could access activities in the community such as bowling, country walks, shopping and fishing. Staff used their own skills, such as nail painting and bringing in pets to provide ward activities for patients.

Meeting the needs of all people who use the service

- The service was able to admit patients with mobility needs. All wards, facilities and grounds were accessible by people with mobility needs. Some bedrooms were available with mobility aids.
- The service displayed relevant information to support patients, and their carers, in ward areas and the main entrance. Information, where possible, was displayed in easy read and pictorial formats. The service produced a magazine that advertised events such as the hospital talent show and summer fete and this was available on all wards.
- The service displayed information on advocacy and how to complain. Staff were able to access interpreters when required and had resources to support patients with varying religious and cultural beliefs, including a dedicated multi-faith area.
- The service provided patients with meals that met individual dietary needs connected to health conditions or religious or cultural requirements.

Listening to and learning from concerns and complaints

- Between 1 October 2017 and 30 September 2018, the service received 103 complaints. These included both formal and informal complaints. Of these, 88 were from patients with 24 being upheld including two being referred to the ombudsmen, 18 being partially upheld and 46 not being upheld. The other 15 were from family members with one being upheld, two being partially upheld and 12 not being upheld. The provider identified themes from complaints as attitude and behaviour of staff, failure to follow procedure and communication. These were addressed through supervision and training. Overall, the numbers of complaints had reduced since the previous year.
- The service supported patients to make complaints and ensured they received feedback. A patient survey found all patients knew how to complain with 69% feeling they could approach staff with their concerns. Visible easy read information on how to raise complaints was available on the wards and through welcome leaflets and patients were also supported by the onsite advocacy service to make complaints. Staff received training on induction to highlight their role in supporting patients to make, and resolve, complaints.
- Staff knew how to handle complaints. They initially tried to resolve them informally and supported patients to submit them formally if necessary. The provider carried out audits of the formal complaints and gave feedback to staff for learning purposes.
- The staff from the wards received four compliments in the previous year.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- Senior managers and nursing staff had appropriate knowledge and experience in areas they carried responsibility.
- Senior managers and charge nurses were visible on the wards and staff found them approachable. They commented there had been an improvement in this area over the last year. Ward managers had attended a coaching programme to help them support their staff. Charge nurses ran daily clinics where staff could discuss work or personal issues and access support with performance or sickness. The hospital manager monitored regular episodes of sickness in a fair and supportive manner.
- The provider developed their qualified staff by funding a nurse leadership programme run by the Royal College of Nursing. Staff had opportunities to share good practice with colleagues from other settings and undertake a project to bring back to their service. Support workers had funded opportunities to progress into qualified staff.

Vision and strategy

- The provider's vision was 'nurturing the world one person at a time' and their values were understanding, innovative, excellence and reliability. These were displayed around the service.
- The provider had developed an audit framework in line with the regulations it was inspected against and based on national guidance. The framework was overseen by the provider's quality and safety team who advised services on areas needing improvement.
- Staff were aware of the vision and values of the organisation. These were discussed during induction and continually during supervision and team meetings. New staff now attended a regional corporate induction to help them feel more engaged with the wider organisation.
- The provider was committed to supporting the local health and social care plan. They had plans to convert property at another local site into accommodation to move their current patients away from the hospital setting.

Culture

- Staff felt valued by the service and were enthusiastic about a new pay structure that encouraged staff retention, rewarded competency and was in line with NHS wages.
- Staff were positive and proud to work for the organisation. They had embraced the new positive behavioural support approach and recognised how it improved patient experience. The service had an open culture where staff were supported to improve their performance.
- Staff could raise concerns and had regular forums where they could make suggestions for service improvements. The staff survey showed an increase of staff who would be happy for a relative to receive the standard of care provided. It also showed staff felt they were supported in doing their job.
- The service considered the wellbeing of their staff. They had a 'feel good Friday' every three months where staff could access massages from colleagues with appropriate training and other activities to promote relaxation. Many staff were able to work flexible hours to support their personal circumstances. The service recognised staff birthdays and had an initiative that encouraged staff to complement each other.
- Staff were aware of the whistleblowing process and information on how to contact the regulators was displayed around the service.

Governance

- The provider had appropriate processes and systems in place to monitor governance from individual wards up to board level. All wards had clinical improvement groups that discussed and implemented the ward strategy. They completed quality scorecards which provided data on incident analysis and trends, supervision and mandatory training compliance, staff sickness rates and complaints. This information fed into the service's clinical governance meeting which fed into the divisional governance meeting which in turn fed into the provider's quality and assurance strategy.
- All ward charge nurses told us that they were encouraged by their managers to operate autonomously in managing their wards and received good support from the hospital director and senior clinical staff.

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Management of risk, issues and performance

- The service monitored risks and physical interventions through their electronic incident reporting system. The senior management team reviewed these daily and themes were escalated to the wards clinical improvement groups. Patients in long term segregation were reviewed by this team weekly. All notifications required by regulatory bodies were identified and allocated to appropriate staff to action.
- Ward managers could compare the quality scorecards across the service and share, or access, good practice if necessary. At the time of our inspection, all wards were meeting targets for the provider's key performance indicators.
- The senior nurse on site monitored safe staffing levels on a shift to shift basis. They could move staff to other wards to manage staff shortage or pressure. The service had a reliable communication system that allowed staff to be moved around the site in response to risks.
- The service had a risk register that could be contributed to by ward managers. Staff could discuss items, they felt needed escalating to the risk register, via team meeting and supervision. Items on the risk register included ongoing staffing issues and delayed discharges. All items had corresponding action plans.

Learning, continuous improvement and innovation

- The service was an accredited member of the Royal College of Psychiatrists quality network for low secure mental health services. They participated in yearly peer reviews and produced actions plans based on findings.
- The psychology team contributed to research by submitting data collected from outcomes of their group interventions to appropriate national studies.
- The service run a number of innovative projects. These included the 'brain in hand' app, the positive behavioural support training and the development of the family liaison nurse.