# Jeesal Cawston Park

## Quality Report

Jeesal Cawston Park
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Overall summary

Ratings are not given for this type of inspection.

We found the following areas for improvement:

- We saw environmental issues that prevented the provider from offering safe services. The seclusion room did not meet the standards of the Mental Health Act Code of Practice. The two-way communication system was not fully working in the seclusion room and the layout of the seclusion room did not enable clear observation of the patient. Ligature risks on The Lodge and courtyard had not been identified within the ligature risk assessment. Where risks had been identified, actions to mitigate the risk posed to patients were not carried out.
- Staff did not always record information thoroughly. Nine seclusion records were incomplete and staff did not record patient observations within the seclusion records. Staff did not always record episodes of restraint within patient notes. Patients' risk assessments were not always updated following incidents.
- The provider did not deploy sufficient numbers of staff to safely maintain patient observation levels.
- Managers did not accurately identify incidents and learning from incidents was not routinely shared and discussed with staff.
- Medication was not stored safely or securely.
- Physical healthcare was not consistently recorded and physical observations following patient restraint did not always take place.

# 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** | | Ratings are not given for this type of inspection. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Jeesal Cawston Park

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

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

There are 57 registered beds. 6 wards As part of our inspection we inspected two wards:

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

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

There were 51 patients in the hospital when we inspected. No patients were informal, seven were subject to Deprivation of Liberty Safeguards (where a person's freedom is restricted in their own interests to ensure they receive essential care and treatment) and 44 were detained under a section of the Mental Health Act. There were 11 patients on The Lodge, all were detained under a section of the Mental Health Act. There were 16 patients in The Manor. Thirteen were detained under a section of the Mental Health Act and three were subject to Deprivation of Liberty Safeguards.

The Care Quality Commission had carried out a full comprehensive inspection on 12 and 13 December 2017. This inspection focused on all five domains, safe, effective, caring, responsive and well led. The service we rated as good overall and we found no breaches of the regulations. At the previous inspection on 6 and 7 March 2017 we issued requirement notices for the breaches of the following regulations:

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014: Person-centred Care

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014; Premises and equipment

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: Staffing

Following the issuing of the requirement notices the provider sent us an action plan outlining the changes they had made to ensure that they met the regulations. At the inspection on 12 and 13 December 2017, we reviewed these areas of previous non-compliance and confirmed that improvements had been made.

## Our inspection team

Team leader: Ricinda Mills, Inspector, Care Quality Commission.

The team that inspected the service comprised two CQC inspectors and an Inspection Manager.

## Why we carried out this inspection

This focussed inspection was carried out to respond to the following concerning information notified to the Care Quality Commission:

- Notification of an unexpected death of a patient
- Complaints
- Information shared from other external agencies

# Summary of this inspection

## How we carried out this inspection

At this unannounced inspection we asked the following key questions:

- Is it safe?
- Is it effective?

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 two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with one patient who was using the service
- spoke with the registered manager
- spoke with five other staff members
- received feedback about the service from commissioners and the local authority
- looked at six care and treatment records of patients
- reviewed incident information
- looked at a range of policies, procedures and other documents relating to the running of the service

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Ratings are not given for this type of inspection.

We found the following areas for improvement:

- The seclusion room did not meet the standards of the Mental Health Act Code of Practice and staff had not fully completed seclusion records.
- There were ligature risks on The Lodge and courtyard that had not been identified. Where risks had been identified actions to mitigate the risk posed to patients had not been carried out.
- There had been an increase in the number of restraints across the hospital. Where prone restraint had occurred, staff did not accurately record this within patient notes and physical observations following restraint had not taken place.
- Medication was not stored safely or securely. Daily checks of equipment within the emergency grab bag were not recorded on The Manor. Not all ward areas were clean and tidy.
- The provider did not deploy sufficient numbers of staff to safely maintain patient observation levels.
- Not all reportable incidents were notified to the Care Quality Commission and managers did not routinely share and discuss learning from incidents with staff.

However:

- There was an active recruitment programme to increase the number of support workers.

### Are services effective?

Ratings are not given for this type of inspection.

We found the following areas for improvement:

- Staff did not always complete patient care records.
- Staff did not always update risk assessments following incidents.
- Staff did not accurately record ongoing monitoring and management of physical health issues. This meant that the physical healthcare needs of patients were not being met or physical health concerns shared with staff and other care providers.

### Are services caring?

This is a focussed inspection and we did not inspect this key question.

# Summary of this inspection

| | |
|---|---|
| **Are services responsive?**<br>This is a focussed inspection and we did not inspect this key question. | |
| **Are services well-led?**<br>This is a focussed inspection and we did not inspect this key question. | |

# Detailed findings from this inspection

## Mental Health Act responsibilities

This was a focussed, unannounced inspection. We did not inspect this practice area.

## Mental Capacity Act and Deprivation of Liberty Safeguards

This was a focussed, unannounced inspection. We did not inspect this practice area.

# Wards for people with learning disabilities or autism

| | |
|---|---|
| Safe | |
| Effective | |

## Are wards for people with learning disabilities or autism safe?

### Safe and clean environment

### The Lodge

The seclusion room did not meet the standards of the Mental Health Act Code of practice. The seclusion room on The Lodge had a two-way communication system. However, the two-way communication system was not fully working. This was immediately reported to managers. At the last inspection we found a two-way communication system was not working, this was reported and resolved at the time of inspection. The seclusion room had controlled heating. However this could only be adjusted from inside the seclusion room. This meant that staff had to enter the room to adjust the temperature. This posed a potential risk to the safety of staff. The layout of the seclusion room did not enable clear observation of the patient.

Ligature risks were present in communal areas in The Lodge and the courtyard. There was equipment with long cables that posed a potential ligature risk to patients in the art room and computer room. These risks had not been identified in the environmental ligature risk assessment therefore there were no plans in place to reduce or mitigate the risk these posed to the patients.

Where ligature risks such as door handles and furniture had been identified, managers told us these risks would be mitigated by keeping the doors locked so patients could only access the rooms when accompanied by staff. However, we found the art room and computer room were open. The door lock on the art room was damaged.

There were multiple ligature risks in the courtyard including exercise equipment which posed a potential risk to patients. Mangers told us that patients would be accompanied by staff in the courtyard. However, we saw unaccompanied patients in the courtyard and the door leading to the outside area was propped open.

There was not a single ligature risk assessment to cover The Lodge and courtyard area. Managers had completed separate risk assessments for these areas which meant it was cumbersome to follow.

The medication hatch within the clinic room on The Lodge was large. Mangers told us there had been a recent incident whereby a patient had attempted to access the clinic room through the medication hatch. We asked the provider to take action. We found the fridge within the clinic room was unlocked. We were concerned that patients could enter the clinic room through the hatch and access medication stored in the fridge.

There was a system in place for ensuring that staff checked the medical emergency response bag regularly. However, the defibrillator on The Lodge had not been checked for two days prior to 12 November 2018.

We found corridors and the kitchen at The Lodge were unclean and untidy. The female side of the ward had an unpleasant odour. There were cigarette butts throughout the garden.

We saw a chipped surface within the kitchen area on the Lodge. This posed an infection control risk. Food was not labelled in the fridge and the fridge contained food that was out of date.

We found there were not enough chairs in the dining room for all patients when the ward is full.

### The Manor

The ward area was clean and tidy.

The medication 'sharps' disposal bin was not labelled in the clinic room. Staff were not routinely checking emergency equipment and medication in staff's emergency grab bag. There were gaps in the checklist for eight days between 25 October and 13 November 2018.

### Safe staffing

Managers told us the number of staff required to cover shifts was based on the clinical needs of patients. Managers told us they could adjust the numbers of staff working on

the wards by deploying staff from other wards across the hospital to address staff shortages. Managers said they would use bank and agency staff to meet any additional staffing gaps.

We viewed staffing rotas. These showed that at least one qualified member of staff was present on each shift. However, not all vacant shifts were covered by the required number of staff.

Managers told us and we saw from rotas that staffing levels were sometimes low at weekends. We viewed plans for covering staffing gaps at weekends between 11 August 2018 and 12 November 2018. There were nine weekends in this time period where there were gaps in staffing levels. On all nine occasions changes were made to reduce patient observation levels.

However, these plans were not always clear as to why the decision to reduce observation levels for individual patients had been taken.

Hospital policy stated that the responsible clinician had responsibility for making the decision if observations were safe to be reduced based on clinical or safety reasons. We reviewed the treatment and support plan for one patient which recorded that staff could reduce the the patient's observation levels whilst asleep during the day "due to potential poor management of resources".

Staff reported shortfalls on the incident reporting system. There were 10 occasions between 1 August 2018 and 12 November 2018, seven were during October 2018.

The Provider was actvly recruiting to staff vacancies and hospital managers confirmed support worker posts had been offered and were awaiting clearance.

**Assessing and managing risk to patients and staff**

Between 1 October and 31 October 2018, there were 29 incidents where staff had placed patients in seclusion at the hospital. Nine records had missing or inaccurate information and did not include observation records and two records had been created in error. This meant that the electronic records did not reflect patient observations by staff during seclusion episodes or the decision staff had made to begin or end the seclusion.

One seclusion record had not been signed as completed by managers. This was because staff had not completed the restraint report within the seclusion record. Managers had identified the gap and returned it to the staff for completion.

Staff we spoke with demonstrated an understanding of the seclusion reporting process. Managers told us that training for staff to report seclusion episodes onto the electronic reporting system was part of the induction training programme.

Concerns have been raised with the Care Quality Commission by external agencies and through complaints from patients and staff relating to the safe care of patients following reduction of staff observation levels.

The provider's observation policy stated that levels of patient's observations could be reduced only by the responsible clinician, following discussion at the multi-disciplinary team and that the decision was to be recorded in the continuous clinical record. We found one example of a completed incident report which noted there was no communication with regards to a reduction in the observation levels for a patient with the nurse in charge which had resulted in damage to the patient's property. Staff did not always record general observations as they happened which could potentially put patients at risk. One record we found a gap of thirteen hours. We found gaps in observation timelines within nine seclusion records.

Staff reported that where possible they used de-escalation techniques and only used restraint with patients as a last resort when other techniques had failed.

Between 1 July 2018 and 30 September 2018 there was a total of 696 restraints across the hospital. The Lodge had the highest number of restraints with 255 episodes. This compared to a total of 546 restraints between 1 April 2018 and 30 June 2018.

The Lodge had the highest number of restraints between 1 April 2018 and 30 September 2018. This ranged between 67 to 103 episodes in a month.

There were 18 occasions when staff restrained patients in a prone position (face down) between July 2018 and September 2018 across the hospital. Eleven of these were for one patient. we reviewed 10 of these restraint reports.

# Wards for people with learning disabilities or autism

Eight showed that staff had not updated the patient's notes following the restraint. Seven of these did not include a record that physical observation of the patient had taken place following the restraint.

We saw the providers complaints analysis for the period 1 July and 31 September 2018. Sixteen complaints had been raised by patients whilst two had been raised by relatives during this time. Of these the provider had identified the use of prone restraint as a theme.

**Safeguarding**

The provider's patient safety and quality report dated October 2018 showed that 99% of eligible staff had received safeguarding training.

Between 1 August 2018 and 12 November 2018, a total of 15 safeguarding reports had been made to the local authority. Two of these reports had not been notified to the care quality commission as required by regulations.

Incidents resulting in serious injury required notification to the Care Quality Commission. However we found one incident that had not been notified.

**Medicines management**

Hospital medication audits identified two missing entries of a dietary supplement on a patient's medication chart.

The fridge in the clinic room on The Lodge was unlocked. This posed a potential risk of harm to patients through misuse of medication should patients gain access into the clinic room.

**Track record on safety**

The number of incidents across the hospital had increased. Between 1 April and 30 June 2018 there was a total of 1805 incidents across the hospital. This compared to a total of 1946 incidents between 1 July 2018 and 30 September 2018.

Of these 1946 incidents, 849 had occurred on The Lodge and 490 on The Manor.

The provider told us the number of incidents had increased due to a deterioration observed in one patient and new patients admitted with distressed behaviours.

**Reporting incidents and learning from when things go wrong**

There was an electronic system for recording incidents. Front line staff were provided with electronic devices connected directly to this system. We reviewed eight incident report forms these did not always match the description of the incident described within the patient notes. The incident reports did not demonstrate that actions had been taken. Where action was taken these were not always shared with staff.

For example, following a serious incident, managers noted on a serious incident record that plastic cups would be removed from the hospital. However, we found plastic cups on The Lodge during our visit 13 days later. This meant that managers did not ensure learning from incidents had been communicated to staff.

Managers did not ensure all notifiable incidents were reported to the care quality commission. We found two examples where safeguarding concerns had been notified to the local authority but not to the Care Quality Commission. We found a serious incident which had not been reported. This meant that managers did not identify or report incidents appropriately.

## Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

**Assessment of needs and planning of care**

We viewed six patient care records. We found all six had a risk assessment in place however, these were not all updated when risks changed or incidents occurred. For example, we saw two records where patients had attempted to self-harm and their risk assessments had not been updated to reflect this. This meant staff were not aware of changing risk levels for individual patients.

Physical healthcare records and positive behaviour support plans were in place. However, these were not fully up to date and the ongoing monitoring and management of physical health issues was not consistently maintained or recorded. We were concerned that the physical healthcare needs of patients were not being met or physical health concerns shared with staff and other care providers.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that seclusion records are fully completed.
- The provider must ensure that the seclusion room meets the standards of the Mental Health Act Code of Practice
- The provider must ensure that environmental ligature risk assessments identify all potential ligature risks to patients and that mitigating actions are carried out.
- The provider must ensure appropriate arrangements are in place for the safe storage of medications.
- The provider must ensure managers are aware of their responsibility to report notifiable incidents.
- The provider must ensure that lessons following incidents are shared with staff.
- The provider must ensure restraints are recorded in patient notes and that physical observations take place following restraint.
- The provider must ensure that patient observations are carried out safely and recorded appropriately.
- The provider must ensure that there are effective systems for the checking and recording of equipment within the emergency medicine and equipment grab bag.
- The provider must ensure ward areas are clean.
- The provider must ensure that patients' physical healthcare records are completed and up to date and that information relating to patients' physical health is shared with external healthcare providers.
- The provider must ensure that staff update patients' risk assessments following incidents.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>· The provider had not ensured seclusion records were complete and accurate.<br><br>· The seclusion room did not meet the standards set out with the Mental Health Act Code of Practice<br><br>· The provider had not ensured that environmental ligature risk assessments identified all potential ligature risks to patients and that where risks had been identified mitigating actions were carried out.<br><br>· The provider had not ensured patient risk assessments were updated following incidents<br><br>· The provider had not ensured that lessons following incidents were shared with staff.<br><br>· The provider had not ensured that restraint incidents were accurately recorded or that physical health checks took place following restraint.<br><br>· The provider had not ensured ongoing monitoring and management of physical healthcare were recorded.<br><br>· The provider had not ensured medication was stored safely.<br><br>· The provider must ensure that all emergency bags and equipment are checked in accordance with the trusts policy.<br><br>This was a breach of regulation 12. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>• The provider had not deployed sufficient numbers of staff to safely maintain patient observation levels.<br><br>This was a breach of regulation 18. |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>• The provider had not ensured all areas of the hospital were clean.<br><br>This was a breach of regulation 15. |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>• The provider did not ensure reportable incidents were notified to the Care Quality Commission.<br><br>This was a breach of (Registration) regulation 18. |