Coveberry Limited

Cedar House

Inspection report

Dover Road
Barham
Canterbury
CT4 6PW
Tel: 01227833700

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

Ratings

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

Summary of findings

Overall summary

Cedar House offers low secure services for people with a learning disability or autism who have a forensic history, challenging behaviour and complex mental health needs.

We rated it as requires improvement because:

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

The overall, model, size and scale of this service is not in keeping with right support, right care, right culture. The design and layout of the hospital building is institutional and does not support the delivery of modern, effective care for people with learning disabilities and autism. The provider has endeavoured to make improvements to the environment, but the current buildings will not meet the standards that are now expected for the provision of effective care for people who use learning disability and autism services in line with Right support, right care, right culture. Despite the improvements that have been made there is still further work to be completed; some kitchens had limited access at the time of inspection, meaning people did not have full access to kitchen facilities at all times while work was being carried out. Communal areas on some wards needing painting and repair due to damage to the walls and on Folkestone ELS ward one ceiling was damaged and there was writing on the walls and scratches on walls and windows.

The hospital had been taken over by Coveberry Limited in November 2020. Whilst the new provider had made some improvements there was still improvements to care and practice that needed to be progressed and embedded in order to ensure sustained improvement and consistently good care was provided to all people at the hospital.

The service occasionally did not have enough staff. This meant that people did not always have access to activities; staff confirmed this was the case.

We noted that due to the pandemic some refresher training for some staff such as basic life support and food safety had been delayed. Most staff had regular supervision, but some staff were not given supervision in the timeframes set in the providers policy. The hospital was in the process of ensuring staff were offered supervision appropriately. Some staff fed back they did not always feel supported and felt some pressure due to staffing challenges such as when there was a number of agency or temporary staff on shift.

Care records were in the process of being moved to a new system, so were not always consistently easy to find. This meant that should staff need to access information this could not always be done in a timely way. We saw no impact of this but if staff could not find required information in a timely manner there was a risk of people not getting care in line with their care plans.

Positive behaviour support plans (PBS) were being used, but at the time of inspection were only introduced on three of the six wards. The other wards were still using individual support guidelines (ISG) but staff told us that using PBS and the training they had for this had improved the quality of care and reduced incidents. PBS was being implemented across the service but it was a working progress and was still needed on the other wards to have a consistent and robust model of care being used across all wards.

Summary of findings

The provider had an improvement plan in place to address the improvements needed. In order to ensure further improvements and that improvements are sustained this needs to be adhered to and improvements made in a timely manner in the plan.

However;

People's care and support was provided in a clean environment. The service provided care, support and treatment from trained staff and specialists able to meet people's needs.

People were supported to be as independent and had as much control over their own lives as was possible in a secure environment. Their human rights were upheld.

People received kind and compassionate care from staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood. Staff were committed in their roles in ensuring people and their needs were always put first. The care they provided was person centred.

People's risks were assessed regularly and managed safely. People were involved in managing their own risks whenever possible. If restrictive practices were used, there was a reporting system in place and there were comprehensive reviews to try and reduce the use of these practices.

People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals. People's care, treatment and support plans, reflected their sensory, cognitive and functioning needs.

People received care, support and treatment that met their needs and aspirations. Care focussed on people's quality of life and followed best practice. Staff used clinical and quality audits to evaluate the quality of care.

Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.

People had clear plans in place to support them to return home or move to a community setting (as appropriate). However, some people had not been able to move on as quickly as would be expected due to lack of appropriate services available to them. Staff worked well with services that provide aftercare to ensure people received the right care and support in place they moved on.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to Cedar House

Cedar House is a specialist hospital managed by Coveberry Limited offering assessment and treatment in a low secure environment. The service has six wards and capacity for 39 people. The hospital offers low secure services for people with a learning disability or autism who have a forensic history, challenging behaviour and complex mental health needs. The wards were as follows:

Folkestone ward – nine-bed ward for males.

Folkestone enhanced low secure (ELS) ward – five-bed ward for males which included one annex. This ward provided a service to people who had particularly challenging behaviour.

Maidstone ward – eight-bed ward for females.

Tonbridge ward – eight-bed ward for males.

Rochester ward - six beds, two of which are contained within annexes.

Poplar ward - locked rehabilitation ward for five males. This ward was outside the secure perimeter fence.

Cedar House is registered to provide the following regulated activities;

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

diagnostic and screening procedures

treatment of disease, disorder or injury

The hospital had a registered manager in post. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations.

During this inspection we carried out a direct observation of care using the Short Observational Framework for inspection (SOFI). SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions;

What people who use the service say

People's feedback:

Most people told us that they felt safe at the service. Two people told us that at times if there were incidents, they can feel unsafe due to others behaviour, but they had not been harmed.

Summary of this inspection

People told us that they offered a range of activities on and off the site including; fishing, shopping, bike rides, camping and ball games. We were also told about the education and training department being a positive addition at the service. However; some people told us that activities could be cancelled or impacted by staffing levels at times.

Some people felt the food at the service could be better.

Staff were mostly kind and caring, some people said that sometimes there was shortness of staff, or staff from their ward get moved to other wards.

Relatives feedback:

Relatives felt that staff in the service were keeping people safe and knew people's needs well. Most relatives spoke highly of the staff and the care their loved one received. One relative felt it was the best placement that their loved one had been in and told us how much progress their loved one had made since being at the service.

Some relatives felt that visiting with restrictions due to the COVID-19 pandemic was difficult but understood why restrictions were in place. One relative told us how due to having less visits through the pandemic they were having daily calls with their loved ones instead.

How we carried out this inspection

We inspected Cedar House on 8 and 9 June 2021. This was an unannounced comprehensive inspection.

Before the inspection visits, we reviewed information that we held about the service and reviewed a range of information from other organisations.

During the inspection visit, the inspection team:

visited the hospital twice;

looked at the quality of the ward environment;

observed how staff were caring for people including observing using a tool called the short observational framework for inspection (SOFI)

spoke with six people who were using the service;

spoke with two relative's;

spoke with the registered manager, two senior managers, a consultant psychiatrist, two occupational therapists, four ward managers and 18 other staff members; including nurses and support workers;

spoke with five external professionals;

attended and observed one senior managers handover, one staff allocation meeting and one significant review meeting.

Summary of this inspection

looked at eight care and treatment records of people including medicines cards; and

looked at a range of policies, procedures and other documents relating to the running of the service.

The team that inspected the service comprised of five CQC inspectors, one CQC assistant inspector, a CQC medicines inspector, a specialist advisor who was a nurse with expertise in forensic learning disability services and one expert by experience. The expert by experience had lived experience of caring for somebody with a learning disability.

We undertook this inspection during the COVID-19 pandemic.

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

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements.

The provider must ensure that they continue to make improvements in line with their improvement plan and in a timely manner. These must then be sustained to ensure safe care and treatment for people using the service. (Regulation 17)

The provider must look to bring the built environment and model of care in line with Right support, right care, right culture. In the meantime, it must ensure that current improvements to the environment are completed so that people are in an environment that is safe, well maintained, and meets their physical and sensory needs. (Regulation 15)

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

The service should ensure that staffing levels are at a safe level at all times and that does not impact people's time engaging in activities.

The provider should ensure that all staff receive refresher training in line with the providers policy.

The provider should ensure that staff supervision is carried out in line with the providers policy and that a system to monitor this effectively is put in place.

The provider should continue to embed positive behaviour support plans across the service on all wards so a consistent and robust model of care is being used across the site.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Requires Improvement

There had been some improvements made since the new provider took the service over. These included decorating, new flooring, bathrooms and kitchens on some wards. This work was ongoing and further improvements and some repairs were still needed across the site for all wards to be fully fit for purpose, action plans were in place to have these completed.

The service had some challenges with regards to staffing, some bank staff and agency staff were used to help with this, but there were times that there were not enough staff. The provider had put in place daily allocation meetings to address and support this. In these meetings staffing numbers that had signed in for shift were assessed, and staff from other areas of the service were utilised to mitigate shortness and risk. Staff told us that they felt staffing was an issue, and that they felt that due to the lack of permanent staff moral could fluctuate.

The provider was in the process of moving people's care files to a new system following the change in provider. This meant that records were not consistently in the same place or part of a person's risk assessments and risk management plans could still be on another system making it at times a challenge for staff to find information in a timely manner should they need to. We did not see any impact from this, but this meant there was a risk that staff may not have information they needed to provide care in line with care plans.

However;

People were safe from abuse. Staff understood how to protect people from abuse and the service worked well with other agencies to do so. The service had regular safeguarding meetings with the local authority to monitor and manage any safeguarding concerns. These had recently been made less frequent due to the low level of safeguarding concerns at the service. The police and other agencies were also invited to these meetings to have a multi-agency approach. Staff received regular safeguarding training and the staff we spoke with were knowledgeable of the types of abuse to look out for and report.

People were involved in managing their own risks whenever possible. Staff anticipated and managed risk. They had a high degree of understanding of people's needs. People's care and support was provided in line with care plans. Risk assessments and risk management plans were in place and were detailed for staff to know how to manage people's risks.

Requires Improvement

Wards for people with learning disabilities or autism

Restrictive practices were only used as a last resort, for the shortest time and in situations where people were a risk to themselves or others. We reviewed documentation of restrictive practices and appropriate plans were in place to use the least restrictive practices and only when necessary. We highlighted one record that required further details with regards to facilitating basic needs while in seclusion. However; we did see evidence the basic needs were being met. Staff told us that they would always use other techniques to try and diffuse situations or incidents before practices such as restraint or medicating. The provider had sought additional training to enhance techniques already used.

The service monitored and reported the use of restrictive practices. They reviewed all incidences of restraint and used the examples as learning within their restrictive intervention's reduction program. The service monitored this through their 'reducing restrictive interventions action plan'. This document was reviewed regularly in meetings and included restricted items such as mobile phones, batteries and cutlery. People had individual risk assessments to see if these were safe to be accessed.

Staff had a shift handover to share any updates on risks. There were whiteboards in the ward offices with bullet points of current risks to people. Staff told us they knew people and their care needs well. We did note that handover notes could have been more comprehensive on some wards.

People received the correct medicines at the right time. People's medicines were regularly reviewed to monitor the effects of medicines on their health and wellbeing. Staff followed systems and processes to safely prescribe, administer, record and store medicines. The service reported and reflected on medicines incidents and any outcomes and actions were discussed by clinical teams and followed up. An external clinical pharmacy service was used to ensure the safe and effective use of medicines. The service kept an appropriate range of emergency medicines.

Staff used the principles of STOMP (stopping over-medication of people with a learning disability, autism or both). Staff only administered medicines that benefitted people's recovery or as part of their ongoing treatment. The outcome of giving a 'when required' medicine was evaluated to make sure medicines were not used unnecessarily or excessively. This information was reviewed and discussed at clinical team meetings and medicines were stopped if they were found to not be beneficial. People requiring rapid tranquilisation were monitored appropriately. When a medicine was used, there was a debrief afterwards to identify anything that could have been done differently and to reduce the likelihood of a repeat.

The service kept people and staff safe. The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers maintained people's safety and investigated incidents and shared lessons learned with the whole team and the wider service. The service apologised to people, and those important to them, when things went wrong. Staff gave honest information and suitable support, and applied duty of candour where appropriate.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Some staff did not always receive regular supervision in line with the providers policy. Some staff told us they did not feel well supported. We spoke with the provider and due to a change of systems and the way supervision was monitored this was in the process of being improved as the current process meant full oversight of staff supervision was difficult.

Requires Improvement

Wards for people with learning disabilities or autism

Due to the changeover of systems, information in people's care files were not always consistently easy to find. Some staff told they could not always access information in a timely manner. We did not see any impact of this as staff knew people well, but this was a risk if a newer or agency staff member could not find information. The provider had started to update the systems so that information would be in one place, but this had not yet been completed. Information on people's risks were in the ward offices and discussed in shift handover so staff had regular updates.

However;

People's human rights were upheld by staff who supported them to be independent and have control over their own lives as much as possible in a secure environment. People attended their authorised leave and any restrictions with regards to leave were necessary and to keep people and the public safe. People were involved in the planning of their care and had choices with what they did on a day-to-day basis.

People, those important to them, and staff developed individualised care and support plans. Care plans were personalised, holistic, strengths based and updated regularly.

Care and treatment focused on people's quality of life outcomes and met best practice. Care and support were provided in line with people's support plans. Support plans were individual and gave a good understanding of the person's needs and wishes. Short two-page positive behavioural support plans were being developed and were a snapshot of the longer support plans for staff to have key information on a person's likes, dislikes, risks and how a person may present when becoming distressed and how to approach this.

People had access to a range of psychological therapies. Support with self-care and everyday living skills were available to people who needed it. The service had a multi-disciplinary team including consultant psychiatrists, psychologists, occupational therapists and activity co-ordinators to support people with their emotional health and daily living skills. The service had an education and training department that offered formal lessons, a sensory room and an art and a crafts room.

People had good access to physical healthcare and were supported to live healthier lives. A GP visited the service weekly and carried out yearly health checks, people were supported to access the GP between visits if this was required. People were supported to attend opticians, dentists and to go to specialist appointments such as hospital appointments.

People chose the activities they took part in. These were part of their care plan and supported people to achieve their goals and aid their recovery. People could access a wide range of activities on site such as; the education and training centre, music shed, camping in a tree house, looking after animals, there was a multi-sport ball court, cycling and walks. When people did activities off site there was; visits to the beach, walks, shopping and eating out. Activities off site were currently limited to mostly outside due to the risk of Covid-19 and Canterbury being a high-risk area.

Staff did clinical audits, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care. These were discussed and monitored in meetings and shared with the wider team when changes were made.

People received care, support and treatment from staff and specialists who received relevant training, including around learning disabilities and autism, and restrictive interventions. Managers provided an induction program for new or bank staff. We found that some refresher training was overdue, this was due to some training being difficult to access such as first aid during the pandemic. The provider was arranging for training sessions to be carried out again since the lockdown had eased.

Requires Improvement

Wards for people with learning disabilities or autism

People were supported by a team of staff from a range of disciplines who worked well together to ensure care was delivered and outcomes achieved in line with care and discharge plans. The provider held daily management and multi-disciplinary (MDT) handover meetings to discuss any incidents that had occurred in the last day. This enabled them to monitor and discuss any potential changes or follow ups needed to people's care. This also was used to monitor any patterns occurring such as if a person had an increase in incidents. There were regular meetings held with the MDT and the person to review their care and discharge plans. External agencies and relatives, if appropriate, were also invited.

People were supported to make decisions about their care. Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005, including Deprivation of Liberty Standards. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions.

Are Wards for people with learning disabilities or autism caring?

Good

People were enabled to make choices for themselves and staff ensured they had the information they needed. They ensured people understood and controlled their treatment and support. People had access to their care information in a way they preferred, such as in an easy read format.

People received kind and compassionate care. Staff protected people's privacy and dignity and understood people's needs. Staff supported people to understand and manage their care, treatment or condition. People spoke highly of staff and the care they received. We carried out three observations as well as general observations of staff caring for people. Staff treated people with compassion and kindness and knew the people they were delivering care and treatment. We saw staff explain to one person the reasons for participating in therapies and used a gentle approach to encourage this person.

People, and those important to them, took part in making decisions and planning of their care. People were empowered to feedback on their care and support. They felt listened to and valued. People could feedback to the service in a number of ways. This was through residents' meetings, an advocate, people could attend the clinical improvement group and feedback on how improvements could be made in the service.

People had easy access to independent, good quality advocacy. Staff supported people to maintain links with those that are important to them.

Staff maintained contact and shared information with those involved in supporting people, as appropriate. We saw evidence that staff had regular contact with other agencies and relatives to keep them updated on people. Some staff had contact with people's relatives as often as daily if this was appropriate.

However:

We did observe one staff member who was not interacting at all with a person that was on continuous observation.

Requires Improvement

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism responsive?

Good

People had discharge plans in place to support them to return home or move to another appropriate setting. Staff liaised well with services that provided aftercare, so people received the right care and support when they moved on. People's discharge was discussed and planned in meetings with the person, their relative if this was appropriate and multi-agencies to agree and plan for a person's future. We saw that some people had extended leave to try out a placement before they were officially moved on. Others had been supported to spend time in the new environment on a regular basis to get used to it and to help reduce the anxiety of the move. People's discharge plans were individualised to their needs.

People's privacy and dignity was respected by staff. Each person had their own bedroom that had a sink in, bathrooms were shared. People could personalise their room and if it was appropriate and safe, they could keep their personal belongings in there. People had access to quiet areas for privacy. People had a choice of colours they could have their rooms painted in. We saw some people who could not have pictures on the wall had large stickers in line with their interests.

The service met the needs of all people using the service, including those with needs related to equality characteristics. Staff helped people with advocacy, cultural and spiritual support. People's communication needs were always met. People had access to information about their rights in appropriate formats such as easy read. 10 people had smart tablets with an app called 'brain in hand'. This app was personalised to the individual. The app included a diary with daily schedules and any psychology sessions, meetings and community inclusion they have. There is also an 'unplanned' tab. This is to help the person in unplanned events such as the weather being too bad to go on an outside activity or if they are feeling anxious. The service had recently begun to access smart boxes. These are communication devices where pictures are translated into words.

People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. The service treated all concerns and complaints seriously investigated them and learned lessons from the results. They shared the learning with the whole team and the wider service. The complaints procedure was on display in each ward. It included pictures and words to help people understand the process. Staff told us they had supported people to raise a complaint if they asked for support.

People could access drinks and snacks at any time. Once a week there was a 'food experience' day where there was a wider choice of foods and people told us they enjoyed this.

Positive behaviour support (PBS) was being introduced across the wards following training and coaching from a specialist in this area. Staff that worked on the wards using PBS fed back that this was a positive addition to the service and that staff felt more confident in managing incidents. PBS was replacing individual support guidelines (ISG) and this approach was still being used on the wards that had not yet had PBS plans created.

However;

Some people told us that the food at the service was variable and was not always enjoyable.

Requires Improvement

Wards for people with learning disabilities or autism

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

Requires Improvement

The environment and model of care was not in line with Right support, right care, right culture. Improvements across the service were not yet complete. Management needed to continue with improvements in a timely manner and complete, embed and sustain these into the service to ensure consistent and safe care and treatment of people who use the service.

There was not yet one model of care being used consistently across all wards. The service was continuing to improve by rolling out PBS across all wards.

Ward managers were not based on the wards they managed. Staff from different wards gave us mixed feedback with regards to how visible ward managers were. Some staff told us they did not always feel supported, respected or valued.

However;

Leaders had the skills, knowledge and experience to perform their roles and understood the service they managed. They had a vision for the service and for each person who used the service. They were visible in the service and approachable for people and staff.

Staff knew and understood the provider's vision and values and how to apply them in the work of their team. All managers and staff we spoke with were passionate about the care people received and had this at the forefront of the work they did on a day-to-day basis.

The provider promoted equality and diversity in its work. There were opportunities for career progression. The provider was committed to supporting staff to progress in their careers. We saw that some care staff had been supported to do nurse training, there were senior care staff roles as a step up, and this year the provider had taken on nurse associates and trainee nurse associates as new roles. Nurses were offered support to complete further clinical training. Most staff we spoke with felt able to raise concerns without fear of retribution.

Our findings from the other key questions showed that governance processes helped to keep people safe, protect their human rights and provide good quality care and support. The provider knew further improvements were needed but had plans in place to continue to improve the service.

Staff had the information they needed to provide safe and effective care. They used information to make informed decisions on treatment options. Where required, information was also reported externally. The provider worked closely with external agencies such as the local authority safeguarding teams, the police and commissioners and had an open and transparent way of communicating to ensure all relevant agencies worked together to achieve good outcomes for people in the service.

People, and those important to them, worked with managers and staff to develop and improve the service. The provider sought feedback from people and those important to them and used the feedback to develop the service.

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider has endeavoured to make some improvements to the environment but despite improvements there was still further work to be completed to ensure people are in an environment that is safe, well maintained, fit for purpose and meets their physical and sensory needs Regulation 15 (1) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider needs to bring its environment and model of care in line with Right support, right care, right culture and progress current improvements in a timely manner and complete, embed and sustain improvements required Regulation 17 (1)