

Cygnnet (OE) Limited

Cygnnet Cedar Vale

Inspection report

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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?

Good



Summary of findings

Overall summary

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

About the service

Cedar Vale is an independent hospital managed by Cygnet (OE) Limited. Cygnet Cedar Vale is registered with the Care Quality Commission for the following regulated activities:

Treatment of disease, disorder or injury

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

The hospital provides mental health services for up to 14 men with a learning disability and autistic men. Since January 2022, the provider had limited the number of people admitted to 10 due to staffing challenges.

People's experience of using this service and what we found

Right Support

Staff supported people to have the maximum possible choice, control and independence and they had control over their own lives.

Staff focused on people's strengths and promoted what they could do. However, people did not always have a fulfilling and meaningful everyday life. People did not take part in regular activities which were part of their planned care and support. Some relatives were concerned that their relative had gained weight since being at Cedar Vale and thought lack of physical activity had contributed to this. However, relatives said activities were arranged at Cedar Vale such as swimming, bowling and visits to a local farm. One relative said they would like their son to go out more often. People said they went swimming, bowling, out for walks and to visit their family with staff.

Staff worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative. Relatives told us that staff used distraction techniques to help their relative when they were distressed, and this helped to calm them down. They said staff only used medication when everything else like going for a drive or a walk had not relieved their relatives' distress.

Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced. People told us they felt safe at Cedar Vale and that staff didn't shout which helped them to feel safe. Relatives said that staff helped to keep their relative safe and staff knew their relative well.

The hospital is in an isolated location on the edge of a small village. People were reliant on staff to transport them in vehicles to access the community.

Summary of findings

The service did not always provide care and support to people in a well-equipped and well-furnished environment that met their sensory and physical needs. Some parts of the hospital could not be adapted to meet the needs of people with a physical disability and sensory needs. However, the environment was safe, clean and well-maintained. People said they liked Cedar Vale although one person said they would like to move into their own house and another person asked when they were going to move to a home.

People were able to personalise their rooms. Two people said they liked their bedroom, another person said they did not like their bedroom and wanted to paint it.

Staff enabled people to access specialist health care support in the community. Staff supported people to play an active role in maintaining their own health and wellbeing. Relatives said that staff updated them about their relative's health needs and kept them informed.

Staff supported people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.

Staff did not always manage the administration of medicines safely. Records showed staff had found tablets on the floor in a person's bedroom, the kitchen, the clinic room, and corridor. This posed a risk to people's safety.

Right Care

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care.

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs.

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

The service had enough appropriately skilled staff to meet people's needs and keep them safe.

People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs.

People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language), pictures and symbols could interact comfortably with staff and others involved in their treatment and care because staff had the necessary skills to understand them.

People's care, treatment and support plans reflected their range of needs. People received care that supported their needs and followed best practice.

People did not take part in regular activities and interests that were tailored to them. The service had started to give people opportunities to try new activities to enhance and enrich their lives.

Right Culture

Summary of findings

Staff placed people's wishes, needs and rights at the heart of everything they did. The registered manager and staff understood the importance of family to the people and made communication a priority. Relatives were concerned that their relative were so far away from their family although staff did bring their relative to see them or they could visit the hospital. They had regular phone calls with staff to keep them updated and could always email. Some relatives said they had video calls with their relatives and virtual tours of the hospital however, one relative said these did not happen even though they had requested it.

People and those important to them, including advocates, were involved in planning their care.

Relatives said they were fully involved in their relatives' care and invited to review and best interest meetings. They were involved in discharge planning for their relative.

Staff knew and understood people well and were responsive.

People were supported to have choice and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.


The needs of people formed the basis of the culture at the service. Staff understood their role on making sure that people were always put first. They provided care that was genuinely person centred. Relatives told us that regular staff were very good with their relative and had got to know them well, they said "I can't fault the staff, they work well as a team."

Staff felt valued and empowered to suggest improvements and question poor practice. There was a transparent and open and honest culture between people, those important to them, staff and leaders. They all felt confident to raise concerns and complaints.

Summary of findings

Our judgements about each of the main services

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

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Summary of this inspection

Background to Cygnet Cedar Vale

The service is commissioned through clinical commissioning groups across England. The hospital director was the registered manager and had been in position since 2020.

Each person had their own bedroom with en-suite facilities. Bedrooms were on the ground and first floors. An apartment area had been developed to accommodate up to six people. There was a separate lounge area, fully equipped life skills kitchen and shared bathrooms with a bath.

There have been five previous inspections of Cedar Vale. The most recent inspection was a focused inspection on 17 September 2019 when we looked at Effective and Caring only and rated Cedar Vale as requires improvement in Effective and Caring and requires improvement overall.

The previous comprehensive inspection was on 3 October 2018. At this inspection, we rated Cedar Vale as good overall and good in all five key questions.

The last Mental Health Act review was carried out by a Mental Health Act reviewer remotely in March 2021.

How we carried out this inspection

This inspection was announced at lunchtime before the inspectors visited in the evening and was a comprehensive inspection.

We were on site for three days. Our inspection team comprised of two inspectors, one assistant inspector and one specialist advisor. An expert by experience carried out telephone interviews with family members.

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

During this inspection, the inspection team:

spoke with four people in the service,

spoke with 12 members of staff including doctor, maintenance staff, speech and language therapist, occupational therapist, psychologist, registered nurses and support workers,

interviewed the registered manager,

looked at the quality of the hospital environment,

looked at five people's care and treatment records in detail,

looked at ten people's medicine records,

Summary of this inspection

spoke with six family members of people who used the service,

observed peoples' care,

spoke with the advocate,

looked at other documentation and records related to peoples' care and overall governance of the service.

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

Areas for improvement

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

Action the service **MUST** take to improve:

The provider must ensure that all records of people using the service are accurate, complete, and contemporaneous, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided and all staff can access these easily. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good governance)**

The provider must ensure that staff administer people's medicine as prescribed and take action when it is omitted without medical guidance. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment)**

The provider must continue to develop an individualised activity programme focused on maximising people's independence, and all people using the service are engaged in activities they enjoy including in the evening and at weekends. The provider must ensure staff always record activity offered and engaged with. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person Centred Care 1 a b c)**

Action the service **SHOULD** take to improve:

The provider should ensure that each person has their own individual laundry bag to reduce the risk of cross infection. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment)**

The provider should ensure that people's sensory needs are met and where possible reduce the changes in levels of flooring that could negatively impact on their sensory perception. The provider should ensure that the sensory room and main lounge are suitable for people to use. The provider should ensure the bathroom is a relaxing environment for people to spend time in and meet their needs. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 Premises and equipment 1 d)**

Summary of this inspection

The provider should ensure that people's weight is regularly monitored, and action taken where needed to meet the person's needs and ensure they have a healthy and nutritious diet. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 14 Meeting nutritional and hydration needs)**

The provider should continue to ensure that all relatives of people using the service are engaged where appropriate. **(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person Centred Care)**






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	Good	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Requires Improvement 

Safe and clean care environments

People's care and support was provided in a safe, clean and well-maintained environment. However, the environment did not fully meet people's sensory needs. For example, there were changes in levels of flooring and the width of corridors which could affect people's perception.

The environment could be adapted, and aids provided as needed to meet people's physical needs. However, it would be difficult for a person to use a wheelchair in some corridors and over some entrances to doors. At the time of our inspection there were no people using a wheelchair. Staff told us if a person were admitted, or a person developed the need to use a wheelchair they would be accommodated on the ground floor and be able to access all rooms there.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

Staff used observations to ensure people's safety. All people had at least one to one observation by staff during the day and night.

Cedar Vale admitted men only so there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. The ligature assessment was last reviewed in December 2021. There were several rooms that people using the service did not have access to such as the main kitchen, staff offices and the toilet in reception. In rooms that people could access where there were not anti-ligature fixtures and fittings staff always supported them in these rooms, so the risk was assessed as low.

Wards for people with learning disabilities or autism

Staff had easy access to alarms. Closed circuit television (CCTV) cameras were fitted in communal areas and there were signs to tell people this. The speech and language therapist had worked with patients using social stories in an accessible format to each person to inform them this was fitted. The registered manager did random checks of the CCTV to ensure that any incidents that occurred were managed appropriately to keep people safe.

Maintenance, cleanliness and infection control

The service was clean and well maintained. Staff made sure cleaning records were up-to-date and the premises were clean.

However, on the morning of the second day of our inspection we found the laundry room was untidy, there were bags of dirty laundry all over the floor and staff did not know which laundry belonged to individuals which meant there was a risk of cross infection. Later that morning we saw that this had been reorganised and washing had been put either in the washing machine or in the correct colour bag for type. The registered manager told us that people were to have individual laundry bags to reduce the risk of cross infection.

The laundry room had been refurbished since our previous inspection. The provider completed an infection control audit in November 2021 and found that better ventilation was needed in the laundry room. This had been identified in the providers budget for the next financial year to complete.

Staff followed infection control policy, including handwashing, and wearing masks to reduce the spread of COVID-19. The provider kept a record of COVID-19 vaccinated staff and encouraged staff to be vaccinated. The provider had trained 95% of staff in infection prevention and control.

Clinic room and equipment

The clinic room had been refurbished since our previous inspection and included a treatment area also. The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records showed that staff checked, maintained, and cleaned equipment.

Safe staffing

Nursing staff

People were kept safe from avoidable harm. The service had enough staff, who knew the people and had received relevant training to keep them safe. There were vacancies for 2.5 registered nurses although two newly qualified (preceptorship) registered nurses had been recruited but these were not due to start working there until the summer of 2022. There were 33 vacancies for support worker, five had been recruited and awaiting start dates, reducing the vacancies to 28. Due to the number of vacancies the provider had taken the decision to limit the number of people admitted to Cedar Vale to ten. The registered manager said they were not under pressure to admit more than ten people and this meant that safe staffing levels were maintained.

Managers requested staff familiar with the service and made sure all bank and agency staff had a full induction. All agency staff worked regularly at the hospital, this meant they knew the people at the service. Agency staff did not work a shift until they had completed at least two shifts where they shadowed another staff member.

Wards for people with learning disabilities or autism

The service had reducing turnover rates, and this had dropped to 1% in December 2021 whereas in the last quarter from September to December 2021 it was 11% overall. The registered manager said six staff had delayed going to university to study during the COVID-19 pandemic but had left in September 2021.

Managers supported staff who needed time off for ill health. There had been high rates of sickness at times during the COVID -19 pandemic. To ensure safe staffing levels during these times the registered manager, head of care and members of the multidisciplinary had worked shifts. The sickness level at the time of our inspection was 4%.

Managers accurately calculated and reviewed the number of registered nurses and support workers for each shift. These were adjusted according to the needs of the people using the service and their assessed observation levels.

People had regular one- to-one sessions with their named nurse.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed.

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

We observed the handover from the day to the night staff on 7th February. This lasted ten minutes during which time the registered nurse gave an update on all ten people using the service. This felt rushed and did not give staff much information about each person's needs and risks. However, staff told us they knew how to keep people safe from reviewing people's communication grab sheets, care plans and risk assessments.

Medical staff

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

Managers could call locums when they needed additional medical cover and staff told us that a locum lived locally.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. 80% of registered nurses had completed Intermediate Life Support training and a newly recruited registered nurse was booked to receive this at the end of March 2022. The provider had trained 100% of staff in basic life support and first aid.

Assessing and managing risk to patients and staff

Assessment of patient risk

People were involved in managing their own risks whenever possible. Staff completed risk assessments for each person on admission, using the Short- Term Assessment of Risk and Treatability (START) tool, and reviewed this regularly. Staff discussed individual risks of people using the service at morning meetings and at each multidisciplinary team review with the person and their relatives where appropriate.

Management of patient risk

Wards for people with learning disabilities or autism

Staff anticipated and managed risk. They had a high degree of understanding of people's needs. Staff knew about any risks to each person and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, people using the service. People's care and support was provided in line with care plans and their positive behaviour support plans.

Use of restrictive interventions

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.

The service monitored and reported the use of restrictive practices. The registered manager said that if there were incidents during the time, they or the Head of Care were working they attended these. They also viewed the closed-circuit television cameras for incidents when they were not working. They reviewed all incidences of restraint and used the examples as learning within their restrictive intervention's reduction programme. The hospital uses the Management of Actual or Potential Aggression (MAPA) form of physical intervention and 98% of staff had completed this training.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe.

Levels of restrictive interventions were reducing. There were 14 restraints used in the last quarter compared to 26 in the previous quarter.

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

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff had not used rapid tranquilisation to relieve people's distress in the last quarter and had used it twice in the previous quarter.

Safeguarding

People were safe from abuse. Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff had training on how to recognise and report abuse and they knew how to apply it. Staff kept up to date with their safeguarding training. The provider had trained 97% of staff in safeguarding and all staff who needed to do so had completed this to level 3.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw that when a person had made allegations about staff that staff responded promptly, informed the safeguarding teams and viewed close circuit television records where necessary. Staff used communication aids and involved the advocate to help the person communicate.

Wards for people with learning disabilities or autism

The provider and the local authority safeguarding team monitored incidents of safeguarding within Cedar Vale. They did not have concerns about how incidents were managed and were satisfied that any allegations of abuse were managed well to ensure people's safety.

Staff access to essential information

People's care records were a mixture of paper – based and electronic. Staff did not always have easy access to them as there was a shortage of laptops available for staff to use. However, the registered manager told us new laptops had been ordered and desk top computers were repaired during our inspection. We saw some records where a different person's name had been used and not the name of the person the record or plan was referring to. This included a communication grab sheet for one person, entries in 'Pink notes' (daily records) and in one person's risk assessment.

Records were stored securely password protected on the computer or in locked cabinets

Medicines management

People did not always receive the correct medicines. 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, record and store medicines however there were four occasions when they were not administered correctly but found on the floor and disposed of.

Staff used the principles of stopping over-medication of people with a learning disability and autistic people (STOMP) to only administer medicine that benefitted people's recovery or as part of ongoing treatment. The pharmacist checked prescribing in their audits and found that the principles of STOMP were followed.

Staff followed systems and processes to prescribe medicines safely. However, staff did not always ensure they administered medicines safely. In the medicines disposal book staff recorded that they had disposed of four tablets found on the floor in a person's bedroom, the clinic room, corridor and the kitchen in the last four weeks. Staff were not able to identify who these tablets were prescribed for or what they were. In the medicine disposal book, we found further medicines had been dropped and recorded as such with no detail of who these medicines were prescribed to or what medicines they were. This meant that people were not having all their prescribed medicines which could adversely impact on their health and wellbeing. Registered nurses said they recorded these in the disposal book but did not escalate or record as an incident. The internal medicines audit or the pharmacists audit had not identified this as a risk to people's health.

The providers medicine management policy did not refer to medicine found on the floor but referred to medicine omitted without medical guidance as a medicine error. The medicine error policy refers to a tool for staff to use to monitor the effects of medicine omitted and to report as an incident. Registered nurses may not be able to monitor the effects as they did not know who the medicine was for. However, they had not recorded these as an incident so action could not be taken to investigate why medicines were being dropped and therefore not given to the person as prescribed which could affect their health.

Staff reviewed each person's medicines regularly and provided advice to people and their carers about their medicines. This was provided in accessible formats to the individual.

Wards for people with learning disabilities or autism

Staff stored and managed all medicines and prescribing documents safely. Staff followed national practice to check patients had the correct medicines when they were admitted.

Staff reviewed the effects of each person's medicine on their physical health according to National Institute for Health and Care Excellence (NICE) guidance.

Track record on safety

The service kept people and staff safe. Following a death of a person at Cedar Vale following an epileptic seizure in January 2017, when the service was managed by another provider, and subsequent Learning from Deaths Mortality Review (LeDeR) published in December 2021, managers and staff supported the review process. They made changes across the providers' services from learning shared. The review had identified issues around the management of physical healthcare, use of equipment to support physical health needs and staff awareness of epilepsy and first aid in the event of a seizure. The provider had reviewed their epilepsy policy and updated training programmes to address these issues.

Reporting incidents and learning from when things go wrong

Staff managed safety incidents involving people who use the service well.

Staff had reported incidents fully and taken appropriate action to ensure people's safety. For example, when a person had banged their head, staff reported this and recorded the person's neurological observations and escalated to the doctor when needed.

Managers maintained patient 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.

Staff understood the duty of candour. They were open and transparent and gave people and families a full explanation if and when things went wrong. Relatives spoken with said that staff always contacted them if there was an incident, or an error had occurred concerning their relative and kept them updated.

Managers debriefed and supported staff after any incident. Staff said they had regular debriefs and reflective practice which was useful and supported them to learn from any incidents.

There was evidence that changes had been made as a result of feedback. Staff told us they look for alternative ways to work with people if there has been an incident rather than restrict the person. They change the way they approach and communicate with the person.

Are Wards for people with learning disabilities or autism effective?

Assessment of needs and planning of care

Wards for people with learning disabilities or autism

Assessment of people's needs started at admission. Care and support plans were holistic and reflected people's needs and aspirations. People, those important to them and staff developed individualised care and support plans. Care plans were personalised, holistic, strengths based and updated regularly. Staff completed functional assessments for people who needed them. They took the time to understand people's behaviours.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after. Staff assessed people's physical health assessed soon after admission and regularly reviewed this during their stay.

Staff developed a comprehensive care plan for each person that met their mental and physical health needs. Care plans were personalised, holistic and strengths-based.

Staff regularly reviewed and updated care plans and positive behaviour support plans when peoples' needs changed. Staff discussed these at the 'morning meeting' and at the multidisciplinary team review meeting.

Positive behaviour support plans were present and supported by a comprehensive assessment. Staff were aware of these for individuals and followed them. We observed staff quietly speaking with and reassuring a person who was distressed which helped the person to calm so they could have their lunch.

Best practice in treatment and care

Staff provided care and treatment for people in the service. However, the setting and design of the service did not fully reflect the CQC guidance 'Right support, Right Care, Right Culture' and work was required to ensure the service always delivered care in line with best practice and national guidance. The environment, care and treatment did not always meet peoples' needs and most people were not active enough or meaningfully occupied or always encouraged to live healthier lives. However, adapted psychological therapies were offered and staff supported people and monitored people's physical health.

People's outcomes were monitored using recognised rating scales. Staff did clinical audit and benchmarking to understand and improve the quality and effectiveness of care.

The model for the service did not fully reflect the 'Right Support, Right Care, Right Culture' statutory guidance set by the CQC. For example, the hospital was located in secluded grounds not within the local community. This meant people did not have good access to the local community. However, staff told us they had good links with the local community and engaged with them.

People's sensory needs were not always considered. There were changes in levels of flooring and the width of corridors which could affect people's perception. The registered manager had identified that the sensory room was small, and this impacted on the amount of time that people used it. There were limited aids and prompts around the building for people to use to meet their sensory needs such as textile boards. However, the occupational therapist had assessed people's individual sensory needs and provided sensory boxes and weighted blankets where appropriate. People did not use the main lounge, and this was not conducive to relaxing in. The communal bathrooms were clinical and did not provide a sensory experience for people. However, since our previous inspection a lot of work had been done to improve the environment. This included work on the doors which no longer banged so reducing the sensory impact on people. Bedrooms and ensuite shower rooms had been refurbished as had the building in the grounds known as the 'day centre' which included a daily living skills kitchen.

Wards for people with learning disabilities or autism

People were not always meaningfully occupied. This meant people did not always have a good and meaningful everyday life. The hospital had appointed a new occupational therapist who had been there permanently since November 2021. They had developed an activity timetable for each person and assessed their sensory needs. However, records did not show that people were regularly engaged in meaningful activity. The occupational therapist said therapy coordinators had not been able to input activities on the electronic records system, but they were to be trained in this within two weeks of our inspection. The occupational therapist had started more group activities including the breakfast club and one person had a paid job within the hospital. However, people were not engaged in regular activity, and we saw people inactive and sleeping excessively. The expected level of activity set by commissioners and the provider's model of care was 25 hours each week. December 2021 and January 2022 clinical governance meeting minutes reported that all patients had engaged in 25 hours of activity. However, therapy coordinators had been used to work as part of the rota to maintain safe staffing levels during staff absence. Staff said this sometimes reduced the amount of time that therapy coordinators and support workers could spend engaging people in activities. Some activities had been stopped during the COVID-19 pandemic due to government restrictions. However, people had started going swimming again and staff were looking at supporting people to go horse riding again.

The psychology team supported people at the service and staff. They had an active role in the multidisciplinary team, playing a key role in analysis of incidents and risk assessment. They were able to provide examples of the work they had completed to support people. For example, in relation to sexual health and the development of positive behaviour support plans. Staff understood peoples' positive behavioural support plans and provided the identified care and support. All staff had access to these, and they were up to date. Psychologists were involved in developing a Compassion Focussed Therapy (CFT) Manual in an easy-read format for people with learning disabilities.

Staff identified peoples' physical health needs and recorded them in their care plans. Peoples' physical health observations were recorded properly which meant staff had an accurate record of peoples' physical health risks. The provider had trained registered nurses to do blood tests so they were familiar to people and could do this at a suitable time for the individual.

Some people were diagnosed with epilepsy although they had not had seizures for some time. They had epilepsy care plans in place and staff were trained in how to support a person with epilepsy. This had been reviewed and further detail to the training included following the death of a person with epilepsy at Cedar Vale in 2017, when the service was run by a different provider. A training provider to deliver this was being sought.

Staff monitored and recorded peoples' weights. We saw that people had gained weight since their admission and relatives told us they were concerned about this. They said that physical inactivity had contributed to this. Records showed that when needed staff referred people to the dietician and they had completed assessments with guidance for staff to follow. The occupational therapist had introduced healthy eating activities and groups for people. However, relatives had concerns about healthy eating, and we observed that people were inactive, and they did not always eat healthy food.

Physical health records were up to date. People had hospital passports. When a person with a learning disability goes into hospital the Hospital Passport contains all their important information.

Staff made sure people had access to physical health care, including specialists as required.

Staff completed training in dysphagia. The speech and language therapist took a clinical lead in relation to eating and safety for people who had difficulties swallowing. Staff made sure that peoples' food was suitable and safe for them. They made records of fluids and food consumed by people to make sure they ate and drank enough.

Wards for people with learning disabilities or autism

Staff used suitable recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the hospital used the Learning Disability Model of Human Occupancy Screening Tool (LDMOHOST), the Disability Distress Assessment Tool (DISDAT) and Hayes and Lohse non-verbal Depression Scale.

Staff used technology to support people to keep in contact with their families when they were unable to see them face to face.

Staff took part in clinical audits and there was a programme of improvement taking place. There were several clinical audits and managers used results from audits to make improvements and shared learning with the staff team.

Skilled staff to deliver care

People received care, support and treatment from staff and specialists who received relevant training, including around mental health needs, supporting autistic people, human rights and reducing restrictive interventions.

Managers provided an induction programme for any new or temporary staff. Agency staff did two 'shadow' and supervised shifts before working as part of a shift.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The provider had trained 100% of staff in physical health needs and 93% of staff in supporting autistic people. The speech and language therapist supported staff to develop their skills in communication with individuals based on their communication assessment. The psychologists and occupational therapists supported staff to develop their skills in supporting people based on their individual care plans and assessments.

Managers supported staff through regular, constructive appraisals of their work. 100% of the multidisciplinary team had an appraisal in the last year. All nursing staff were to have an appraisal by the end of February 2022.

Managers supported staff through regular, constructive clinical supervision of their work. 90% of staff had received clinical supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency teamwork

People were supported by a team of staff from a range of disciplines who worked together to ensure care was delivered and outcomes achieved in line with care and discharge plans.

The service had access to a full range of specialists to meet people's needs. There were regular multidisciplinary meetings to discuss people and improve their care.

Wards for people with learning disabilities or autism

Staff made sure they shared clear information about people using the service and any changes in their care in daily 'morning meetings' through reading care plans and in multidisciplinary review meetings. However, handovers between shifts were brief and included the last 12 hours of the person only and not a full update if a staff member had been absent for a few days. Staff told us they had time to catch up during their shift to familiarise themselves with the information they needed about the person they were supporting.

Staff had effective working relationships with other teams in the organisation and with external teams and organisations. People's community teams were invited to their review meetings and participated in these. The hospital had good working relationships with the local safeguarding teams.

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

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.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. 95% of staff had completed this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

People had easy access to information in accessible formats about independent mental health advocacy and people who lacked capacity were automatically referred to the service.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand. The speech and language therapist had developed information accessible to individuals and staff used these to explain to people their rights.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. This was discussed in people's review meetings and staff completed risk assessments before people went on leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff stored copies of people's detention papers and associated records correctly and staff could access them when needed.

People who were informal were given information in a format accessible to them that explained they could leave the ward freely and they and their relatives understood this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Managers completed audits as part of their audit schedule.

Good practice in applying the Mental Capacity Act

People were supported to make decisions about their care. Staff understood the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards. For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any best interest decisions.

Wards for people with learning disabilities or autism

96% of staff had completed training in the Mental Capacity Act and staff we spoke with had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff used information developed by the speech and language therapist to maximise the opportunity for individuals to make decisions.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision.

When staff assessed people as not having capacity, they made decisions in the best interest of patients. They considered the person and their relatives where appropriate wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed to the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed audits as part of their audit schedule.

Are Wards for people with learning disabilities or autism caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

People received kind and compassionate care. We observed that staff were discreet, respectful, and responsive when caring for people.

Staff protected people's privacy and dignity and understood people's needs. The advocate told us how staff had supported a person to maintain their dignity when they refused to move from a communal area to change their clothes.

Staff supported people to understand and manage their care, treatment or condition. People were enabled to make choices for themselves, and staff ensured they had the information they needed.

Information was provided in individual easy read, symbols and picture formats to help the person to understand. Each person had a communication passport that showed staff what aids they would need to help them to understand. Staff spent time to explain to people in a way they could understand. Staff told us they limited the number of choices available to the person, so they did not confuse them, and the person was able to have a choice. For example, one person was given a choice of two sets of clothes in the morning, so it was possible for them to make a meaningful choice.

Wards for people with learning disabilities or autism

Staff gave people help, emotional support and advice when they needed it. The advocate told us they had observed staff deescalate situations and turned a potential incident into a fun session for the person that helped them to quickly calm down. We observed staff speaking with people in a calm and relaxed way that helped them to reduce their anxiety.

Staff directed people to other services and supported them to access those services if they needed help. Records showed that staff had referred a person to the dietician and had supported the person to communicate when the dietician visited.

People spoke highly of staff and the care they received. One person said that staff don't shout, and they liked staff.

Staff understood and respected the individual needs of each person. Although the information provided in the handover between shifts was limited, staff said they had an opportunity to read people's care plans. Each person also had a 'communication grab sheet' that gave information about the person and what was important to them on one sheet of paper. Staff were able to tell us what a person liked doing, what they disliked and the people that were important to them.

All staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people who used the service and would not hesitate in doing so.

Involvement in care

People, and those important to them, took part in making decisions and planning of their care. Care plans included easy read information to enable the person to be involved in their care.

People were empowered to feedback on their care and support. There were regular meetings with the people who used the service. Minutes of these were in easy read and picture format and showed that people were involved in their care. People said their views were listened to and valued.

People had easy access to independent, good quality advocacy. The advocate told us they were invited to meetings, staff always updated them about individual's needs, and they regularly visited Cedar Vale.

Involvement of families and carers

Staff supported people to maintain links with those that are important to them. People were placed a long distance away from their family, but staff supported people to visit their family if appropriate. Relatives said they could visit the hospital and had regular phone calls and emails with the manager or staff. Most relatives told us they could have video calls with their relative, but one relative said this was not always arranged by staff when they asked for it. Most relatives said they had been offered a virtual tour of the hospital and their son's bedrooms, but one relative said they had not been offered this.

Staff maintained contact and shared information with those involved in supporting people, as appropriate. Relatives told us they were always invited to their relatives review and best interest decision meetings. They said they were involved in their discharge planning. Relatives said they were always informed of any changes in their relative's health and kept updated about hospital appointments and referrals.

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism responsive?

Good 

Access and discharge

The majority of people did not stay in hospital for a long time. People had discharge plans with clear timeframes in place to support them to return home or move to a community setting. Staff liaised well with services that provide aftercare, so people received the right care and support when they went home.

Bed management

The service admitted people from across the United Kingdom. This meant people were not always located close to their families or their own communities.

Discharges had been delayed due to available placements, this meant people were often away from their families for longer than planned. Managers regularly reviewed people's length of stay to ensure they did not stay longer than they needed to. One person had been there for several years but now had a community placement identified. Most people stayed there for six to nine months. This length of time had decreased since our previous inspections and the registered manager was clear that people should not be at Cedar Vale for a long time.

The provider had limited the number of people at the hospital to ten due to staffing levels. The manager said they were not under pressure to admit further people until their staffing levels improved.

Managers and staff worked to make sure they did not discharge people before they were ready. The multidisciplinary team discussed people's discharge from the service and what needed to be in place to ensure this met the person's needs and was safe. People went on leave to their new placement before their discharge was confirmed to make sure it was appropriate to their needs and safe. When people went on leave there was always a bed available when they returned.

Staff did not move or discharge people at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of people whose discharge from the hospital was delayed. There were two people whose discharge from the hospital was delayed. This was due to the lack of available community placements to meet their needs.

Staff carefully planned people's discharge and worked with care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

Wards for people with learning disabilities or autism

People's privacy and dignity was respected by staff. Each person had their own bedroom with an en-suite shower room. People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy. The service's design, layout and furnishings did not fully support people's good care and support. The service provided people with a choice of good quality food. People could access drinks and snacks at any time.

Each person had their own bedroom, which they could personalise. Some bedrooms had very little personalisation, but staff told us this is what the person wanted as they were not able to tolerate many belongings around them. Care plans showed the reasons why individuals had few items in their bedrooms and how staff were to support them with this. People had a secure place to store personal possessions.

A full range of rooms and equipment to support treatment and care were provided but not always used. Staff told us that people did not often spend time relaxing in the main lounge and they were looking at why that was and how they could make it more homely. The sensory room was small and not often used. The registered manager and occupational therapist were looking at how this could be used more to benefit the people using the service.

Each person had an ensuite shower and there was an additional communal bathroom. There was a bath in the middle of the room with little decoration or furnishings to promote an environment that people could relax in.

The service had quiet areas and a room where people could meet with visitors in private.

People could make phone and video calls in private, although most people needed support from staff to do these.

The service had a lot of outside space that people could access easily. However, we did not observe people using the grounds and staff told us that a swing that one person used often had been put away during the winter months.

Most people needed support to make their own hot drinks and snacks and were supported by staff to do this. There was a breakfast club that involved all the people there and helped to increase their daily living skills.

The service offered a variety of good quality food although some people chose to have a limited diet. Staff tried to offer alternative choices and increase the types and colours of food. Staff followed advice of dieticians and tried to offer healthy choices.

Peoples' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

The service had recently introduced the opportunity for people to engage in paid work and supported staff to complete practical tasks. The provider explained that they wanted work opportunities to be developed further for people that met their individual needs and ability. They were preparing to work with an accreditation body so that they could offer education and training opportunities for people that were meaningful for them.

Staff helped people to stay in contact with families and carers. Families and carers visited the service and used technology to have virtual meetings with family.

Wards for people with learning disabilities or autism

Staff encouraged people to develop and maintain relationships both in the service and the wider community. Friends and families could visit when they wanted to. Recently introduced group activities meant people had the opportunity to spend time together if they chose to.

Meeting the needs of all people who use the service

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.

The service supported people with communication needs. A speech and language therapist worked there and had assessed all people's communication needs. Accessible information and aids to communication based on the individual's needs had been provided. Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service would provide aids and adaptations where needed to support people with a physical disability. The occupational therapist had assessed people's needs for aids and adaptations and looked at ways people could access the bath safely and more easily. However, the hospital is a 'listed building' and some parts of it cannot be altered so it would be difficult to access in some corridors or over some entrances to doors using a wheelchair. At the time of our inspection none of the people using the service were wheelchair users. Staff told us if a person were admitted to the service, or developed a need for a wheelchair, they would be accommodated on the ground floor of the building where there are no changes in floor level. Staff would assess the person's needs on an individual basis and modify or adapt the environment as required. A person in the ground floor bedroom would be able to access all activity rooms, kitchens and therapy rooms as required to meet their needs, without needing to use the other floor area, these areas are available in the main building and in the day centre in the grounds.

The service provided a variety of food to meet the dietary and cultural needs of individuals. People had access to spiritual, religious and cultural support if they chose to.

Listening to and learning from concerns and complaints

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.

People using the service, their relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in formats that were accessible to people using the service.

Staff understood the policy on complaints and knew how to handle them. Complaints were responded to promptly and investigated.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Wards for people with learning disabilities or autism

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

Good 

Leadership

Leaders had the skills, knowledge and experience to perform their roles and understood the services 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 said the registered manager and acting head of care were visible and approachable and they would feel comfortable to speak with them if needed to. They worked some shifts also and were in the service at times during the night so staff who worked only at night knew who they were and could approach them.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

All staff we spoke with including agency and bank staff knew and understood the providers vision and values and how these related to their work. Training on these was provided during their induction and this included bank and agency staff.

Culture

Staff felt respected, supported and valued. The provider promoted equality and diversity in its work. They felt able to raise concerns without fear of retribution.

Staff said they were respected and valued and enjoyed working at Cedar Vale.

Some staff we spoke with did not know who the providers Freedom to Speak Up Guardian was, but they knew the process and said they would use it if they needed to. Staff said they would initially go to the nurse in charge or the registered manager with any concerns but if this was not listened to would not hesitate to use the providers raising concerns process.

Where staff did raise concerns, these were listened to, and action taken to investigate. An allegation had been made recently and this was being investigated independently by an external company.

Governance

Our findings from the other key questions showed that governance processes did not always operate effectively in all areas.

For example, there was insufficient governance oversight in the following areas: Staff did not always manage the administration of medicines safely. Records showed staff had found tablets on the floor in a person's bedroom, the kitchen, the clinic room, and corridor. This posed a risk to people's safety.

Wards for people with learning disabilities or autism

People were not always supported to have a good and meaningful everyday life. Whilst the occupational therapist had assessed each person and developed new activity plans there was further improvement required, we saw people inactive and sleeping during this inspection.

There was a clear framework of what must be discussed at ward, team, or directorate level in team meetings to ensure essential information, such as learning from incidents and complaints, was shared, and discussed. Information was shared across local and regional governance meetings and team meetings.

Staff had implemented recommendations from incidents and safeguarding alerts. Learning from incidents was investigated and regularly shared.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the people. The provider worked closely and effectively with commissioners and other community services to support service users.

Management of risk, issues and performance

Staff did not always have the information they needed to provide safe and effective care. Staff used information to make informed decisions on treatment options. Where required, information was also reported externally.

Staff recorded information about people's care and treatment on the electronic records system. However, access to laptops was limited and therapy coordinators had not been trained in using the system. The registered manager said this training was being provided, a desktop computer was repaired during our inspection and five new laptops had been ordered.

The risk register showed that when risks were identified action was taken to reduce these and ensured ongoing management of risks and issues to improve the quality of care provided.

The service had plans for emergencies. For example, adverse weather or a flu outbreak. These were accessible to staff.

There were no current cost improvements taking place.

Information management

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

The service used data systems to collect data that were not over-burdensome for frontline staff.

Information governance systems included confidentiality of peoples' records.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing, and people's care.

Wards for people with learning disabilities or autism

Staff made notifications to external bodies as needed. The registered manager notified the Local Authority safeguarding team, the CQC and Clinical Commissioners of incidents.

The psychology team were involved in developing a Compassion Focussed Therapy (CFT) Manual in an easy-read format for people with learning disabilities.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers and staff had access to the feedback from people, their relatives and staff and used it to make improvements.

People were involved in decision-making about changes to the service and community meeting records demonstrated this. Information was provided to people in accessible formats so they could make decisions and choices that affected their care. People's relatives felt they were asked for feedback about the service.

Senior managers were visible in the service and people and staff could meet with them to give feedback.

Managers engaged with external stakeholders such as commissioners on a regular basis and provided information and updates in respect of people's progress. Managers and the multidisciplinary team were engaged in people's care and treatment reviews.

Learning, continuous improvement and innovation

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.

Staff were given the time and support to consider opportunities for improvements and this led to changes. Staff told us they were listened to when they made suggestions or put forward ideas.

The psychology team were involved in developing a Compassion Focussed Therapy (CFT) Manual in an easy-read format for people with learning disabilities. The plan was to use this at Cedar Vale and across the wider organisation.

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure that staff administer people's medicines as prescribed and take action when it is omitted without medical guidance.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider must continue to develop an individualised activity programme focused on maximising people's independence, and all people using the service are engaged in activities they enjoy including in the evening and at weekends. The provider must ensure staff always record activity offered and engaged with.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure that all records of people using the service are accurate, complete, and contemporaneous, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided and all staff can access these easily.