Jeesal Cawston Park

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Inadequate
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

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

Summary of findings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This service was placed in special measures in September 2019. Insufficient improvements have been made. The rating from this inspection remained Inadequate and the service has remained in special measures due to the lack of sufficient improvement. Therefore, we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

Jeesal Cawston Park provides a range of assessment, treatment and rehabilitation services for adults with learning disabilities and autistic spectrum disorder.

We rated Jeesal Cawston Park as inadequate because:

- During this inspection we found further significant concerns. The provider had also not made all the improvements it was required to make following our previous inspections. We began enforcement proceedings against the provider and issued a Notice of Proposal to cancel the hospital's registration as a provider.
- Staff did not manage risks to patients well. In the month prior to the inspection, and the two weeks following inspection, the service continued to report incidents where patients were harmed, or exposed to risk of harm, due to observations not being completed correctly. The service had not addressed the risk of fire. We saw fire risk assessments for all areas of the hospital which indicated there was a moderate to substantial risk to life from fire. We requested evidence of any actions that had been taken to address these risks, but managers were unable to provide these.
- The service did not have enough nursing and support staff to ensure that it could meet patients' care and treatment needs. Staff described difficulties in meeting the demands of their roles because of staff shortages. Staff did not provide enough activities for patients. There was a lack of activities particularly at weekends and evenings, including for patients in long-term segregation.
- Staff did not use processes to safely prescribe, administer, record and store medicines. Staff recorded as required medicines (PRN) reviews inconsistently. Staff had not effectively monitored patients on high dose anti-psychotic therapy and had not clearly documented the rationale for giving a patient in long term segregation the maximum dose of anti-psychotic medicine.
- Staff did not always respect patient's privacy and dignity. Staff left patients in long term segregation in undignified situations.
- The provider had not ensured that all staff were trained in Makaton or Signalong to communicate with patients whose main form of communication was Makaton.
- There was a lack of effective leadership and governance. There had not been a consistent senior leadership team in place at the hospital since July 2019. Staff told us they were not always clear about their roles and accountabilities, and changes in leadership made it difficult to be confident about processes and procedures and their responsibilities in relation to these. Managers did not have effective oversight of staff management of patient risk and the service did not have effective systems and processes, such as regular audits of the service provided, to assess, monitor and improve the quality and safety of the patients at the hospital and to manage performance effectively. At the time of inspection, a new Chief Operating Officer (COO) had been appointed and had been in post for four weeks. We spoke with the COO during the inspection and they demonstrated a good understanding of the challenges that the

Summary of findings

service faced and had begun to make a plan to manage them. However, it was too early to say whether these changes would be effective and sustainable.

However:

- Most patients told us that staff were kind and caring and we observed some positive interactions between staff and patients.
- The service had improved discharge planning since the last inspection.
- The service had created two new sensory rooms for patients and provided training for 22 members of staff to enable them to support patients effectively to use the sensory rooms and sensory equipment.

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	**Inadequate** 	We rated this service as inadequate.

Summary of findings

Contents

Inadequate

Jeesal Cawston Park

Services we looked at
Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Jeesal Cawston Park

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

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

There are 57 registered beds.

• The Grange – a 15 bedded locked ward accepting male patients only

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

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

• The Manor Flats – has six individual living flats, where patients are supported to live independently

• The Yew Lodge - has three self-contained flats, where patients are supported to live independently

• The Manor Lodge – has three self-contained flats, where patients are supported to live independently.

There were 34 patients in the hospital at the time of inspection.

The Care Quality Commission inspected Jeesal Cawston Park Hospital in June and July 2019. Following that inspection, we rated the service as inadequate and, due to our concerns, we issued the hospital with a warning notice for a breach of regulation 17 Good Governance of the Health and Social Care Act (2008) and placed it into special measures. We told the provider they must make improvements to the leadership and governance processes to keep patients safe. We carried out a further inspection in November 2019 to follow up on the warning notice and to assess whether the provider had made the required improvements. During that inspection, we found significant concerns that required urgent action. We took further enforcement action in November 2019 against the provider to require that they must not admit any patients to any ward at the hospital without prior written agreement of the Care Quality Commission. We told the provider they must provide evidence of compliance with regulations before this would be reviewed. The enforcement action remained in place following this inspection.

During this inspection period, we found further significant concerns that required action. We began enforcement proceedings against the provider and issued a Notice of Proposal to cancel the hospital's registration as a provider in respect of the regulated activities:

a) Treatment of disease, disorder and injury; and

b) Assessment of medical treatment for persons detained under the Mental Health Act 1983.

The Care Quality Commission has a duty under Section 3 of the Health and Social Care Act 2014 (HSCA) to consider the safety and welfare of all patients at the hospital. We looked at this throughout all our inspections of this provider.

Our inspection team

The team that inspected the service comprised of two CQC inspection managers, three CQC inspectors, a specialist professional advisor who had current experience of working with people with learning disabilities and autism and an expert by experience.

Summary of this inspection

Why we carried out this inspection

This inspection was a full, comprehensive inspection to assess the quality of care and to monitor whether the provider had made the required improvements following the inspections in February, June to July and November 2019.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

During the inspection, the inspection team:

- visited all wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with five carers of patients who were using the service
- spoke with the chief operating officer and managers or acting managers for each of the wards
- spoke with 25 other staff members; including doctors, nurses, occupational therapists, psychologist and speech and language therapy assistants
- received feedback about the service from 3 care co-ordinators or commissioners and feedback from the local safeguarding authority
- spoke with an independent advocate
- looked at 10 care and treatment records of patients
- carried out a specific check of the clinic rooms and medicine management on all wards
- and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Most patients told us that staff were kind and caring and we observed some positive interactions between staff and patients.
- Patients told us they had a choice of food and most patients liked the food at the hospital.
- Patients enjoyed the activities that were available to them including cooking, art, woodwork, horticulture and sports activities. However, some patients told us there were not enough activities and sometimes these were cancelled due to staff shortages.
- Two patients told us that sometimes certain members of staff spoke to them in a rude manner.
- Four carers told us they were happy with the care that was given to their family members and staff were friendly, caring and approachable.
- One carer told us that her family member did very little activities, did not have a weekly activity plan and had not left the hospital site for over a year. As a result, they often said they were bored and spent a lot of time in their room.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Staff did not manage risks to patients and themselves well. In the month prior to the inspection and the two weeks following inspection, the service continued to report incidents where patients were harmed, or exposed to risk of harm, due to observations not being completed correctly.
- The service had not addressed the risk of fire. We saw fire risk assessments for all areas of the hospital dated 16 April 2019 which indicated there was a moderate to substantial risk to life from fire. We requested evidence of any actions that had been taken to address these risks, but managers were unable to provide these. This meant that patients were at potentially serious risk of harm from fire without any mitigation in place.
- Staff had not identified The Grange seclusion room had an opening window which was a safety hazard, and an external restrictor both of which were potential ligature anchor points. There is an increased risk of a patient harming themselves with a ligature if staff are not fully aware of all the ligature points within an environment.
- The service did not have enough nursing and support staff to ensure that it could meet patients' care and treatment needs. Staff described difficulties in meeting the demands of their roles because of lack of staff.
- Staff did not use processes to safely prescribe, administer, record and store medicines Staff were recording as required medicine reviews inconsistently. Staff had not effectively monitored patients on high dose anti-psychotic therapy and had not clearly documented the rationale for giving a patient in long term segregation the maximum dose of anti-psychotic medicine.
- During the inspection, a manager acknowledged that lessons from incidents had not been consistently learnt across the hospital and more work was needed to improve and embed practice in this area.

However:

- Staff had completed and kept up-to-date with their mandatory training.
- The use of restraint had decreased, and staff had improved the recording of restraint since the last comprehensive inspection.

Summary of this inspection

- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff did not keep human resources (HR) files complete and in good order. We looked at five HR files and four out of five were incomplete. Staff could not find all the information we requested at the time of the inspection. We were not assured that the service had robust processes in place to ensure the employment of fit and proper persons.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all patients had a care plan which was accessible and in an easy-read format. At the time of inspection, staff had completed easy read care plan for all the patients on The Grange. However, most of the patients on the other wards did not have access to a care plan in this format.
- Staff did not ensure that all patients had adequate physical health care. An external stakeholder raised a concern about a patient who had begun to experience a health problem which had an impact on their dignity. There was no evidence that staff had attempted to address this or investigate if there may be an underlying cause.
- The provider had not ensured that all staff were trained in Makaton or Signalong to communicate with patients whose main form of communication was Makaton.

However:

- Staff had ensured positive behaviour support plans were present in all care plans, where appropriate, and were supported by a comprehensive assessment.
- Managers had increased the induction period for new staff from two weeks to two weeks and three days, including enhancement in the areas of supportive observations, personal behavioural support, reducing restrictive practices, patient de-briefing and active support. supportive observations for all new staff. This was an improvement since the last inspection.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff had improved recording of mental capacity, which had been a concern at the last three inspections.

Are services caring?

Inadequate

We rated caring as requires improvement because:

Summary of this inspection

- Staff left patients in long term segregation in undignified situations. One patient in long term segregation had a care plan which stated that they should wear anti-rip clothing at all times. Staff had not documented reviews or attempts to use alternative strategies. External stakeholders raised concern that patients were sleeping on urine- sodden furniture and the lounge and entrance smelled strongly of urine, although this wasn't apparent
- Staff did not always use appropriate communication methods to support patients so could not always communicate with some patients despite offering a specialist service for patients with communication difficulties.

However:

- During the inspection, we observed some kind and positive interactions between staff and patients on the wards.
- An independent care and treatment review (by an external body) for one patient in long term segregation reported that the patient had supportive relationships with staff and was making good progress.
- Staff mostly informed and involved families and carers appropriately. We spoke with five patients' family members or carers. Four of carers we spoke to felt that they were involved appropriately with the care of their family member and were invited to meetings and care reviews as appropriate. One carer felt that they did not always get the information that they needed from staff.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Staff did not provide enough activities for patients. There was a lack of activities provided for patients, particularly at weekends and evenings.
- Staff did not provide enough activities and opportunities for gradual introduction to the main ward environment and the community to patients in long term segregation.
- The design, layout, and furnishings of long term segregation environments did not create a therapeutic environment. This had previously been raised as a concern. Long-term segregation environments were bare and sterile and did not meet patients' needs.

However:

- Staff had improved discharge planning for patients since the last inspection, including introducing a new recording form for

Summary of this inspection

section 17 leave. The form recorded the risk assessment prior to the patient leaving the ward and greater detail regarding the outcome of the leave to assist staff to evaluate a patient's readiness for discharge.

- Since the last inspection, the service had made improvements to the ward environments to better meet the needs of patients with autism. The service had created two new sensory rooms for patients and provided training for 22 members of staff to enable them to support patients effectively to use the sensory rooms and sensory equipment.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- There had not been a consistent senior leadership team in place at the hospital since July 2019. Staff told us they were not always clear about their roles and accountabilities and changes in leadership made it difficult to be confident about processes and procedures and their responsibilities in relation to these.
- During the inspection, we saw evidence where leaders had not taken action to address a concern and where it was not clear who was responsible for this action. For example, managers had not addressed the risk of fire.
- Manager did not have effective oversight of staff management of patient risk and the implementation of the supportive observation policy. In the month prior to the inspection and the two weeks following inspection, the service continued to report incidents where patients were harmed, or exposed to risk of harm, due to observations not being completed correctly.
- Many staff were not satisfied with the culture of the organisation because of the frequent changes in leadership and because of a lack of clarity about their roles and responsibilities. The results of the August 2019 employee engagement survey reported that only 52% of respondents either agreed or strongly agreed that they were satisfied with the culture in their workplace.
- The service did not have effective systems and processes, such as regular audits of the service provided, to assess, monitor and improve the quality and safety of the at the hospital.

Summary of this inspection

- Managers did not manage performance effectively and did not have effective systems in place to identify, monitor and reduce risks relating to performance. For example, the service had high sickness rates, staff phoning in sick at the last minute and difficulties with staff not turning up for work with no reason.
- Managers had not ensured the safety and dignity of patients in long term segregation.

However:

- Staff we spoke with mostly felt personally respected and valued. Staff told us that colleagues supported each other, and managers were visible and approachable.
- Managers did not have sufficient oversight of recruitment processes and procedures. We looked at five personnel (HR) files and four out of five were incomplete. Managers could not be assured that fit and proper persons were employed if HR records were not complete and important information, such as references, were missing.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff provided patients with written information and a verbal explanation of their legal position and rights at the time of their detention/admission and every three months. Staff provided a fresh explanation at key times as recommended in the Code of Practice (4.29). For example, we saw evidence of this at the time of renewal of detention.

The Mental Health Act administrator and the speech and language therapist developed easy read Mental Health Act leaflets in two formats, one of which they called 'super easy read'. There was extra information in the Mental Health Act leaflets for patients who were in long-term segregation.

The Mental Health Act administrator completed an audit of Mental Health Act processes on each ward every three months including audits of Mental Health Act section papers, section 132 information, consent to treatment and section 17 leave.

The legal advisors for the hospital were due to complete a full audit of Mental Health Act processes.

There was a new recording form for section 17 leave which we saw being used at the time of inspection. The form recorded the risk assessment prior to the patient leaving the ward and the outcome of the leave to enable evaluation. However, the form did not state what the patient risks were. We raised this with managers at the time of inspection and they advised they would add this information to the form.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of the time of inspection, 89% of staff in this service had received training in the Mental Health Act. The training compliance reported during this inspection was higher than the 78% reported at the last inspection.

An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had improved recording of mental capacity, which had been a concern at the last three inspections. The speech and language therapy team had conducted an audit to review the standards of how mental capacity was assessed and documented. Following this, a capacity assessment tab had been added to the provider electronic recording system and all staff members had been reminded of the need to upload all capacity assessments completed to the correct location in the electronic recording system.

Capacity assessments for specific decisions (not consent to treatment) completed in January and February 2020 were carried out in accordance with the Mental Capacity Act. There were two particularly good examples by the speech and language therapist which showed the patient's communication difficulties were taken into account and strategies used, for example talking mat and symbols to assist the patient to understand.

Two patients were assessed as lacking capacity to consent to sharing information in a care and treatment review. Their responsible clinician's recorded that a best interests decision was made by the multi-disciplinary meeting with no indication of who was involved in making the decision.

An advocate was involved in a best interest's decision about one patient's use of social media.

The responsible clinicians assessed patients' capacity to consent when there were changes in the treatment plan.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires improvement
Caring	Inadequate
Responsive	Requires improvement
Well-led	Inadequate

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

The service had not addressed the risk of fire. We saw fire risk assessments for all areas of the hospital dated 16 April 2019 which indicated there was a moderate to substantial risk to life from fire. We requested evidence of any actions that had been taken to address these risks, but managers were unable to provide these. This meant that patients were at potentially serious risk of harm from fire without any mitigation in place.

Staff had not identified that The Grange seclusion room had an opening window which was a safety hazard and an external restrictor both of which were potential ligature anchor points. There is an increased risk of a patient harming themselves with a ligature if staff are not fully aware of all the ligature points within an environment. The environmental audit dated 2 January 2019 and the 'risk assessment for seclusion environment' dated 15 June 2019 were examined and did not include this risk. This was raised as a concern during the inspection and managers advised they would add the window to the relevant risk assessments.

Since the last inspection, managers had introduced an environmental daily audit which was completed by senior support workers and audited by ward managers during their fortnightly managers quality and safety review. Further work had been completed by the speech and language therapist and occupational therapist to ensure that environmental risks had been identified from a specialist clinical perspective. During the inspection, we checked the daily environmental audits on The Manor for the previous two weeks and saw that the audit had been completed every day with no gaps. We reviewed the managers fortnightly quality and safety reviews from 28 December until 7 February on all wards and saw evidence that managers had checked the daily audits with no issues noted. However, staff had not recognised all environmental risks, for example the window in the seclusion room in The Grange.

All of the wards complied with the Department of Health's guidelines on mixed sex accommodation, including provision of a female only lounge on The Lodge and The Manor.

There were numerous blind spots and points that could be used to self-ligature throughout the hospital. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff used their knowledge of patients, individual risk assessments and zonal observations to mitigate risks, including ligature risks. The Lodge and The Grange were more secure environments and, on these wards, convex mirrors were used throughout communal areas to enhance patient safety.

The ligature risk assessment action plan for The Grange, which was updated in July 2019, referred to all window handles to be replaced with anti-ligature type handles. The target date for this was 31 March 2020 however ward staff were unaware of when this work had been scheduled.

Staff had easy access to alarms and patients had easy access to nurse call systems. There were patient call bells in each bedroom.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Seclusion rooms

There were two seclusion rooms at the hospital on The Lodge and The Grange. The seclusion room on The Grange had recently re-opened following refurbishment.

The seclusion room on The Grange did not meet the required standards as outlined in the Mental Health Act (1983) Code of Practice (2008). The room had an opening window which was a safety hazard and an external restrictor both of which were potential ligature anchor points. Staff had not identified these risks as part of the environmental audits.

Both seclusion rooms had windows which provided natural light. There were no blinds in either room and the windows were frosted to promote privacy. However, there was a possibility of shadowing if the light was on in the seclusion room. There were external shutters for the window in The Lodge and staff told us they closed the shutters whenever anyone was in seclusion but not all staff were aware of this. This could have an impact on a patient's privacy and dignity.

Both seclusion rooms allowed clear observation and had two-way communication. Staff had resolved the issue of the two-way communication system on The Lodge not working since the inspection in June 2019 and ensured that the temperature controls were accessible for staff. We saw that managers had also provided written guidance for staff on how to operate the communication system and temperature controls.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Clinic rooms were mostly clean and well-organised. However, we found an oxygen cylinder incorrectly stored on the floor of the clinic room on The Grange. This was bought to the attention of staff on the day of the inspection and.

Staff had made regular checks of emergency equipment and all appropriate equipment was present and in date. All signatures were in place on the weekly checklists. This was an improvement since the last inspection.

Ligature cutters were available on all wards. On The Manor, the ligature cutters were kept in the clinic room. Staff told us that only two members of staff, including the nurse in charge, held keys to the clinic room on each shift. This could lead to a delay in other members of staff, who did not hold the keys, getting access to the ligature cutters in an emergency.

Safe staffing

The service did not have enough nursing and support staff to ensure that it could meet patients' care and treatment needs.

The service reported a vacancy rate of 44% for qualified nurses and 12.5% for support workers. Levels of sickness were high and had increased since the time of the last comprehensive inspection. At the time of the inspection, the average staff sickness rate for permanent staff between December 2018 and January 2019 was 25%. This was significantly higher than the sickness rate of 3% reported at the last comprehensive inspection in February 2019. Managers also reported challenges with staff not turning up for work without giving a reason. Between November 2019 and January 2020, staff did not turn up for an average of 42 shifts without giving an explanation.

Between September 2019 and November 2019, 3,563 shifts were filled by bank or agency staff to cover sickness, absence or vacancy for qualified nurses or support workers. This is higher than at the last comprehensive inspection when 2,796 shifts were filled by bank or agency staff for a comparable time period. Between September 2019 and November 2019, 542 shifts went unfilled.

Where possible, managers requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Inadequate

Wards for people with learning disabilities or autism

We spoke with 12 members of nursing and support staff and six members of staff described difficulties in meeting the demands of their roles because of lack of staff. Staff members told us that it could be difficult to facilitate trips and activities for patients because of staff shortages and sometimes patient leave was cancelled or postponed. A quality and safety review undertaken by a ward manager on 27 January stated that staffing required improvement as staff turnover was 'bad' and the agencies that the service used could not meet the staffing requirements for the service. Staffing difficulties also had an impact on the ability of staff to take their full break allocation. During the inspection, we saw an example of one day in the week prior to inspection where all the staff on duty on The Manor missed their second break due to a high number of staff calling in sick. This meant that all the nursing and support staff on The Manor that day worked a 12 hour shift with only one break. This could have an impact on staff wellbeing and subsequently have an impact on patient care as fatigued staff are more likely to make errors and not be able to give quality care to patients. The service held a 'Our Voice' patient meeting on 13 February 2020. Patients on both the Manor Flats and The Lodge said that off-site trips got cancelled, some at short notice, due to not enough staff or drivers.

Managers told us that they had changed recruitment practices and were working with the human resources department to introduce a new people strategy which aimed to address the high levels of sickness and staff absent without leave. However, it was too early to say whether this would be effective.

Staff did not keep human resources (HR) files complete and in good order. We looked at five HR files and four out of five were incomplete. Staff could not find all the information we requested at the time of the inspection. Some of the information that was missing was provided after the inspection, but we were concerned that staff could not easily find all the information, which should have been contained within the files. Staff were not able to provide all of the missing information. There was no evidence of staff supervision or training within two out of five HR files. There were missing references in two out of five HR files. We were not assured that the service had robust processes in place to ensure the employment of fit and proper persons.

Medical staff

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

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

The service set a target of 75% for completion of mandatory and statutory training. Of the training courses listed none had failed to meet the provider target. Figures provided by the service showed a compliance rate of above 80% for the majority of mandatory training - this included completion of training by bank and agency staff. The lowest compliance rate was for effective communication at 77.4% but was still above the provider target. At the time of the inspection, 86.2% of staff had completed face to face training in autism awareness.

Since the last inspection, managers had provided additional training for existing staff in supportive observations which required staff to complete a competency workbook on this topic. At the time of the inspection, the service reported that 82.8% of staff had completed this workbook. The workbooks had been completed by a wide range of staff including agency, bank, support workers and nurses. During the inspection, most staff we spoke with told us they had completed their workbook and could explain to us the rationale for completing it and had found it helpful. However, two members of staff we spoke with couldn't remember completing a workbook and were unaware of the new supportive observation policy.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always manage risks to patients and themselves well. In the month prior to the inspection, and the two weeks following inspection, the service continued to report incidents where patients were harmed, or exposed to the risk of harm, due to observations not being completed correctly. At the last inspection, the service was issued with a Notice of Decision which prevented further admissions as we were concerned at the high number of incidents that had occurred where patients had caused harm to themselves, or were exposed to risk of harm, due to observations not being carried out correctly. Since the

last inspection, managers had introduced an action plan to address these concerns, including providing further staff training, in the form of a workbook, and carrying out additional audits and spot checks. However, in the month prior to inspection, and the two weeks following inspection, we were notified of five further incidents where a patient was caused harm, or was exposed to the risk of harm, due to observations either not being completed as per the patient's support plan or where staff did not have the sufficient skills and experience to understand the meaning behind a patient's behaviour. These incidents involved staff who had completed the workbook in supportive observations.

During the inspection, a patient told us that staff who were completing supportive observations were using their tablet computers (which should be used to complete observations records) to carry out personal internet searches or play games. Managers confirmed they had been made aware of this as a concern and following this had restricted access to the internet for nursing and support staff. However, this had caused difficulties with staff not being able to complete online training, so internet access was re-instated, however managers had not introduced any system for monitoring inappropriate use of the internet. Managers could not be assured that staff were not being distracted by the internet while they should be concentrating on patient observations.

During the inspection, we saw evidence that staff shortages could affect the ability to carry out patient observations in line with patient support plans. On one night in the week prior to inspection, due to staff sickness, a member of staff had to carry out 1-1 observations with a female patient as well as simultaneously carry out general observations on four male patients for a period of approximately three hours. This could have an impact on patient safety as the member of staff could not enter the male corridor with the female patient in order to carry out the routine checks required. There was a note on the allocation sheet that a manager was informed of this but no note of any actions that were taken, if any. It was unclear from observation sheets if, and how, observations were carried out safely at this time.

Staff we spoke with on inspection who were engaged in supportive observations with patients demonstrated good knowledge of patient risks and knew what observation level the patient was on. We observed that staff could easily find information regarding patients, including their risks and observation levels, on the provider's electronic recording system. We saw evidence that senior staff had carried out audits and spot checks on staff carrying out observations during the early hours of the morning and at weekends. However, because incidents had still occurred, and measures were not in place to monitor staff use of the internet on their tablet computers, we were not assured the measures that managers had put in place were sufficient to ensure that all staff understood and managed risk appropriately. We were concerned that there was not yet a culture of safety across the hospital and that staffing challenges continued to have an impact on staff being able to safely carry out their duties, including supportive observations.

Assessment of patient risk

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at 10 care and treatment records and saw that staff had updated assessments on a regular basis and after incidents.

Use of restrictive interventions

The use of restraint had decreased. Between 1 July 2019 and 31 December 2019 there was a total of 725 incidents of the use of restraint across the hospital. The number of restraint incidences reported during this inspection was lower than the 1098 reported at the time of the last inspection.

The service had a 10-point strategic action plan for reducing restrictive practices. The Positive Behaviour Support Steering Group had an oversight for the implementation of this strategy. This action plan was based on the recommendations in 'Positive and Proactive Care: reducing the need for restrictive interventions'

There were zero incidences of prone restraint. This was a reduction from the 24 incidents of prone restraint reported at the last comprehensive inspection. Prone restraint is no longer taught as a technique for managing violence and aggression at the service.

Staff had improved the recording of restraint since the last comprehensive inspection. We looked in detail at six restraint records and saw that staff had recorded episodes of restraint in more detail and improved the recording of physical observations and debrief after restraint

Staff did not complete an incident form after each episode of administration of rapid tranquilisation. Staff had used rapid tranquilisation on 18 occasions between 23 September 2019 and 31 December 2019. The independent pharmacy that provides a service to the hospital carried out an audit of rapid tranquilisation on one unit in December 2019. Rapid tranquilisation had been signed administered on two dates, however no corresponding incident form could be located. The pharmacist looked at nine incident forms as part of the audit. There was universal documentation of de-escalation attempts and offering oral as required (PRN) medicine to the patient. Physical observations were documented on seven incident forms. On one occasion there was evidence that the patient had refused observations and they had been taken later during the same day. On one occasion the patient refused observations and they were monitored visually. Rapid tranquilisation observation forms were completed on five occasions. All incidents had been reviewed by a doctor in a timely manner.

Between 1 July 2019 and 31 December 2019 there had been 24 instances of seclusion. The number of incidences of seclusion had slightly decreased from the 29 that was reported at the last comprehensive inspection.

We looked at two seclusion records for one patient who was secluded in The Lodge in the week prior to the inspection. In both instances there was a clear rationale for the seclusion and reviews were carried out in line with the Mental Health Act Code of Practice. There was a problem with how the information was recorded on the providers electronic recording system which indicated that a support worker had instigated one of the seclusions. There was a file note to show the decision was made by a registered nurse. Both records indicated that support workers had made the decision to terminate seclusion, which would be a breach of the Code of Practice (26.144) but it was not clear whether this also was a recording error. The speciality doctor was consulted on both occasions.

Three patients were in long term segregation at the hospital at the time of our inspection. Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multidisciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis.

An approved clinician reviewed each patients' situation at least once every 24 hour period in accordance with the Mental Health Act Code of Practice and we did not find any gaps in reviews. However, some entries did not state who had completed them (they were put onto the provider's electronic recording system by the administration staff) therefore it was not clear whether the patient was reviewed by an approved clinician.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. At the time of inspection, 96% of staff had completed safeguarding training. This is an improvement since the last focussed inspection in June where safeguarding training for staff was raised as a concern.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Between 31 December 2018 and 31 December 2019, the Care Quality Commission received 156 safeguarding notifications from this service. This is similar to the 155 notifications reported at the last comprehensive inspection. The Safeguarding authority for Jeesal Cawston Park has established there were approximately 18.5 safeguarding concerns per month being raised by the hospital over 2019.

We sought feedback from the safeguarding authority prior to the inspection and the safeguarding authority confirmed there was an ongoing section 42 enquiry for the organisation which is chaired by the Director of Social Work. The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. The section 42 enquiry had

reported serious concerns regarding this service due to a high number of safeguarding referrals being received and multiple concerns which independently have not all necessitated a safeguarding enquiry. The themes identified by the safeguarding authority related to long term concerns around observations on patients being reduced, staff not correctly carrying out observations, incidents of alleged physical abuse by staff, and concerns about physical healthcare needs not being met.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff had access to the equipment and information technology needed to do their work. Staff had access to portable tablet computers. They could input observations and effectively access patient care and treatment plans.

Medicines management

Staff did not use processes to safely prescribe, administer, record and store medicines

We reviewed 16 patient medicine records. In three of the medicine records we looked at staff had not recorded a review of as required (PRN) medicine. We spoke with a doctor about the process for reviewing PRN medicine and they told us that each patient had a review of their medicine in the monthly multi-disciplinary team meeting. However, it was unclear where the PRN review was recorded. Staff had recorded a review of PRN medicine on some patient's medicine charts, but this was missing in three patient medicine records. Staff were recording PRN medicine reviews inconsistently and this could have an impact on patient wellbeing as they could be taking PRN medicine longer than necessary.

Managers told us that the service was working towards achieving the aims of stopping over-medication of people with a learning disability, autism or both (STOMP). The service had conducted a High Dose Anti-Psychotic Therapy (HDAT) audit in January 2020. As part of this audit, seven patients were identified as being prescribed high dose anti-psychotic medicine and of these seven, six patients were receiving duel anti-psychotic therapy and one was receiving three anti-psychotics. Staff had not effectively monitored patients on HDAT. During the audit, it was noted that ECG compliance was poor and there was non-completion of documentation of HDAT, HDAT monitoring forms, details of a treatment plan and a rationale for prescribing HDAT within clinical notes for each patient. Following the audit, HDAT was discontinued in four patients. Long term use of HDAT can have an impact on a patient's health and wellbeing due to side effects such as increased sedation, weight gain and cardio-vascular problems.

Staff had not clearly documented the rationale for giving as required (PRN) medicine for patients in long term segregation. Furthermore, staff had not clearly recorded why an increase in the dosage of a sedative PRN medicine was given to one patient. The patient was prescribed a sedative medicine to be given as required with a maximum dose within recommended limits. The patient had been receiving 1mg of this medicine for several weeks, at the discretion of the nurses in charge. From 20 January staff increased the dose more often to 2mgs. We looked at records for five consecutive days from 24 January and observed that the patient was given an increased dosage on each day, however there was no record of distressed behaviour prior to the medicine being given and no rationale recorded for the increased dosage.

Staff had not clearly documented the rationale for giving a patient in long term segregation anti-psychotic medicine. External stakeholders had raised concern that the patient was on the maximum dosage of an anti-psychotic medicine despite not having been diagnosed with any psychotic illness. During the care and treatment review, the responsible clinician gave a contradictory account of why this medicine was prescribed, i.e. advised it was for mood and then for agitation. The patient was also prescribed a further PRN anti-psychotic to be given both orally and intramuscular injection.

Prescription charts had a photo of the patient to aid with identification for staff not familiar with the patient, and a mental capacity assessment form. There were no missing signatures on the records that we looked at.

Medicines including controlled drugs and emergency medicines were stored securely. We found an oxygen cylinder incorrectly stored on the floor of the clinic room on The Grange. This was bought to the attention of staff on the day of the inspection and they took action to address this.

Staff monitored the temperatures of medicine storage fridges.

Medicines were disposed of appropriately.

Inadequate

Wards for people with learning disabilities or autism

The external pharmacist provided clinical and medicine management audits to comply with best practice and regulatory requirements. Feedback was given to the Ward Manager on the day of the audit and reports provided to staff via confidential access to their website. We viewed the audit and found it to be up to date and complete.

Track record on safety

Between January and December 2019, 32 serious incidents were reported via the Strategic Executive Information System. A serious incident is an incident that has resulted in serious physical or emotional injury or damage to property essential to the security and effective running of the unit. Of the total number of incidents reported, the most common type of incident was disruptive/ aggressive/ violent behaviour and apparent/actual/suspected self-inflicted harm.

The number of serious incidents reported during this inspection was lower than the 59 reported at the last inspection.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff recorded incidents onto the electronic patient information system. All staff, including agency staff, were provided with portable tablet computers connected directly to this system so they could complete incident reporting immediately after an incident.

Each recorded incident was reviewed by the senior management team in their daily morning meeting as well as by the psychology department. Incident data was used to inform various forums including patients' individual multi-disciplinary team meetings, Positive Behaviour Support plans, functional assessments and case conferences with the staff team. Data regarding incidents for each patient was available for all staff members to review via a desktop or tablet computer.

Specific information on lessons learned were shared on information screens across the hospital, via incident de-briefing of staff and through supervision. A lessons learned bulletin was also displayed within the wards to aid learning, discussion and inform clinical practice. During the November 2019 focussed inspection, we reviewed four recent learning lessons bulletins and found these were poorly worded, had multiple grammatical errors and lacked clarity regarding the detail of the incident, i.e. what happened, and the learning points. During this inspection, we reviewed a further six lessons learnt bulletins. Although the spelling and grammar was improved, the bulletins continued to lack detail, including the date of the incident and full details of what happened. The action points, i.e. 'for use by units to aid discussion and reflection and inform clinical practice', were identical on all lessons learnt bulletins and did not identify who was responsible for implementing any learning points or actions and did not specify a date any actions should be completed. During the inspection, a manager acknowledged that lessons had not been consistently learnt across the hospital and more work was needed to improve and embed practice in this area.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour training was mandatory for managers in the service. Staff are introduced to the duty of candour regulations during the company induction and are reminded during their work practice.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff had not ensured that all patients had a care plan which was accessible and in an easy-read format. At the time of inspection, staff had completed easy read care plan for all the patients on The Grange. However, most of the patients on the other wards did not have access to a care plan in this format. Staff told us that they were working towards producing easy read care plans for all patients and the patient snapshot survey for February 2020 was about 'helping me to understand my care plan'.

The speech and language therapy team had provided guidance and training on easy read care planning, however the provider action plan reflected that this was not being used consistently. Ongoing training had been offered to staff to use an online app to write accessible care plans, however attendance at this training had been poor. It was a requirement from the June 2019 inspection that the provider should ensure staff were suitably trained to write

easy read care plans and the provider had an action point following this inspection to take a multi-layered approach to embedding easy read care plans throughout the hospital. However, a deadline had not been set for this action. At the time of this inspection, managers had set a target of February 28 for this action to be completed. We were not assured that this deadline would be met as, at the time of inspection, only 34% of staff were trained and the majority of patients still did not have an accessible or easy read care plan.

Since the last comprehensive inspection, staff had updated and streamlined all patient care plans. Managers had also included a section which required the staff member completing the plan to record the outcome of a conversation with the patient to ensure patient involvement with the care plan. We reviewed 10 care and treatment records for patients and saw that these had all been updated and there was evidence of staff recording of patient views in each domain.

Staff completed a comprehensive assessment of each patient either on admission or soon after.

Positive behaviour support plans were present in all care plans, where appropriate, and supported by a comprehensive assessment. A positive behaviour support plan is based on the results of a functional assessment and uses positive behaviour support approaches. The plan contains a range of strategies which not only focus on challenging behaviour but also include ways to ensure the person has access to things that are important to them. One patient did not have a positive behaviour support plan, but there was a rationale present of why they did not have one, i.e. they did not meet the criteria for this. The service had made a change to staff training in completing positive behaviour support plans. Staff, including bank and agency staff, received two days of initial training in positive behaviour plans during their induction. This initial training was then followed up by further training during staff probation so in total staff received 120 hours of training in positive behavioural support.

Best practice in treatment and care

Staff did not ensure that all patients had adequate physical health care. An external stakeholder raised a concern about a patient who regularly experienced urinary incontinence. There was no evidence that staff had attempted to address this or investigate if there may be an underlying cause. The patient may have had an underlying health condition that had not been addressed, and experiencing incontinence had an impact on this patient's dignity. The external stakeholder also raised a concern regarding the patient's weight which had increased significantly since being admitted to the hospital.

Staff provided a range of care and treatment suitable for the patients in the service. The service used a care pathway for all patients which began at the point of referral and included an initial multi-disciplinary meeting to review the referral. Within the week of admission, each patient had a nursing assessment and a medical review.

All new patients had a psychology initial assessment where appropriate. Psychological therapies were offered, as recommended by the National Institute for Health and Care Excellence. The range of interventions included, anger and anxiety, bereavement and emotional and distressed behaviour. Psychologists were involved in writing positive behaviour support plans.

The service had enrolled in the National Autistic Society accreditation programme and had begun a pre-accreditation assessment. A meeting to review progress with the pre-audit had taken place on 4 February 2020. Monthly meetings were scheduled at the multi-disciplinary team meetings to review and populate each section with the relevant information.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward.

The provider had not ensured that all staff were trained in Makaton or Signalong to communicate with patients whose main form of communication was Makaton. This was a concern at the focussed inspection in June and July 2019. As of 22 January 2020, eight nursing and support staff had been trained from The Manor, The Grange and The Bungalows. Further staff require training in Makaton before the provider can become compliant with this requirement notice from the last inspection.

At the time of inspection, 86.2% of staff had training in autism awareness

Since the last inspection, managers had increased the induction period for new staff from two weeks to two weeks and three days, including enhancement in the areas of personal behavioural support, reducing restrictive

practices, patient de-briefing and active support. Managers had also re-introduced induction training in supportive observations for all new staff. This is an improvement since the last inspection.

The average rate of clinical supervision of 85.3% was lower than the 100% reported at the last comprehensive inspection in February 2019. We spoke to eight members of nursing and support staff. Six members of staff we spoke with told us they had regular supervision. However, one member of staff said they had not had any supervision since they started working at the hospital three months previously. Another member of staff told us that they had not had supervision for four months. Both members of staff told us they believed the reason they had not had supervision was because their line manager was too busy. Clinical supervision can help staff to manage the personal and professional demands created by the nature of their work. This is particularly important for those who work with people who have complex and challenging needs. Many patients at the hospital had complex needs and lack of regular supervision could make it more difficult to manage the demands of working with these patients which could have an impact on staff wellbeing and affect the quality of patient care.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection, the average appraisal rate was 92.6%.

Staff told us they had good opportunities for personal and professional development. The hospital had funded support workers to complete their nurse training via the Open University. The service supported staff on nursing apprenticeship programmes and had invested in other apprenticeship programmes for staff members looking to take a different route in their careers.

Managers had introduced coaching for staff. At the time of inspection, 40 supervisors and line managers had completed a two day GROW coaching session and a further 15 people were booked to attend this course.

Multi-disciplinary and interagency team work

Staff worked as part of a multi-disciplinary team, which included doctors, nurses, support workers, occupational therapists, speech and language therapists, social workers, assistant psychologists and members of the educational skills development team. The post of senior clinical psychologist is currently vacant, and the hospital was actively recruiting to fill this post.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff provided patients with written information and a verbal explanation of their legal position and rights at the time of their detention/admission and every three months. They provided a fresh explanation at key times as recommended in the Code of Practice (4.29). For example, we saw evidence of this at the time of renewal of detention.

The Mental Health Act administrator and the speech and language therapist developed easy read Mental Health Act leaflets in two formats, one of which they called 'super easy read'. There was extra information in the Mental Health Act leaflets for patients who were in long-term segregation.

The Mental Health Act administrator completed an audit of Mental Health Act processes on each ward every three months including audits of Mental Health Act section papers, section 132 information, consent to treatment and section 17 leave.

The legal advisors for the hospital were due to complete a full audit of Mental Health Act processes.

There was a new recording form for section 17 leave which we saw being used at the time of inspection. The form recorded the risk assessment prior to the patient leaving the ward and the outcome of the leave to enable evaluation. However, the form did not state what the patient risks were. We raised this with managers at the time of inspection and they advised they would add this information to the form.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Inadequate

Wards for people with learning disabilities or autism

As of the time of inspection, 89% of staff in this service had received training in the Mental Health Act. The training compliance reported during this inspection was higher than the 78% reported at the last inspection.

An advocacy service was available for patients. Advocates attended the ward on a weekly basis and were available to give support and advice to patients and their families, including support with Mental Health Act tribunals and making complaints.

Good practice in applying the Mental Capacity Act

Staff had improved recording of mental capacity, which had been a concern at the last three inspections. The speech and language therapy team had conducted an audit to review the standards of how mental capacity was assessed and documented. Following this, a capacity assessment tab had been added to the provider electronic recording system and all staff members had been reminded of the need to upload all capacity assessments completed to the correct location in the electronic recording system.

Capacity assessments for specific decisions (not consent to treatment) completed in January and February 2020 were carried out in accordance with the Mental Capacity Act. There were two particularly good examples by the speech and language therapist which showed the patient's communication difficulties were taken into account and strategies used, for example talking mat and symbols to assist the patient to understand.

Two patients were assessed as lacking capacity to consent to sharing information in a care and treatment review. Their responsible clinician's recorded that a best interests decision was made by the multi-disciplinary meeting with no indication of who was involved in making the decision.

An advocate was involved in a best interests decision about one patient's use of social media.

The responsible clinicians assessed patients' capacity to consent when there were changes in the treatment plan.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of inspection, 86.2% of staff had received training in the Mental Capacity Act.

There were six deprivation of liberty safeguards (DoLS) applications in the last six months to protect people without capacity to make decisions about their own care. DoLS applications were stored in the electronic patient record system which all staff had access to.

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

Are wards for people with learning disabilities or autism caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff did not always use appropriate communication methods to support patients. At the time of inspection, only eight members of staff were trained in Makaton or Signalong. Autism and communication training was not mandatory beyond induction and did not form part of the refresher training for staff. Therefore, there was no organisational expectation for staff to refresh themselves on autism and communication. This could have an impact on patients who had communication difficulties as staff may not be able to fully understand them or meet their needs. An audit carried out the by the speech and language therapy department identified that an ongoing need for the service was for front-line staff to become consistent in implementing the recommendations made by the speech and language therapy department. There was no target date set for this action or a plan as to how this was to be implemented.

Staff did not always respect patients privacy and dignity. Staff left patients in long term segregation in undignified situations. One patient in long term segregation had a care plan which stated that they should wear anti-rip clothing at all times due to ligature risks. There was a lack of documented reviews or attempts to use alternative strategies. We looked at the care and treatment records for the patient and they did not show a care plan or risk management plan to reintroduce ordinary clothing. A multi-disciplinary team review held on 10 February 2020 recorded that the patient could be in usual clothing when settled. At the time of the inspection the patient presented as settled but was wearing anti-tear clothing. External

stakeholders raised concern that another patient was sleeping in unsuitable surroundings. These circumstances were a breach of both patient's dignity and we were concerned that staff had accepted these conditions for patients, and it was only during inspection or when external stakeholders visited that these issues had been raised as concerns.

We spoke with 16 patients. Most patients told us that staff were kind and caring and they were happy at the hospital. However, two patients told us that sometimes certain members of staff spoke to them in a rude manner.

During the inspection, we observed some kind and positive interactions between staff and patients on the wards

Staff followed policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

We reviewed 10 care and treatment records for patients and saw evidence of staff recording of patient views in each domain. However, only patients on The Grange had access to easy read care plans.

Patients knew how to access an advocate; they said that staff would help make a referral. We saw information displayed on the wards about the advocacy service, their staff, and other services.

Staff enabled patients to give feedback on the service they received via patient snapshot surveys. Patient snapshot surveys were carried out each month with patients being asked about a different topic each month, for example about their feelings of being safe and understanding their care plans . All the snapshot surveys were produced in 'easy read' versions which had been supported by the Speech & Language Therapy team and patients were assisted to complete them by a member of staff if necessary. Where patients were unable to complete them, the advocate offered assistance so that all patients had an opportunity to participate. During the inspection, we saw an example of a patient snapshot survey which asked patients for their views on their bedrooms. Following the surveys, staff produced a 'you said, we did' board which demonstrated what they would do in response to the survey results.

Involvement of families and carers

Staff mostly informed and involved families and carers appropriately. We spoke with five patients' family members or carers. Four of the carers we spoke with felt they were involved appropriately with the care of their family member and were invited to meetings and care reviews as appropriate. One carer felt that they did not always get the information that they needed from staff.

The service held two Family Involvement Days in 2019. The first one in October was attended by families and colleagues and included host NHS Commissioners. The day also included activities which involved patients as well as a play put on by patients for visitors on the day. The second Family Involvement Day was combined with the Christmas Carol Service and Christmas Pantomime which was performed by the patients.

Staff sent 'friends & family' cards to parents/carers of patients twice a year to allow parents and carers to offer recommendations for the hospital to improve services.

Four of the five carers we spoke with were happy with the care that was given to their family members and told us that staff were friendly, caring and approachable. One carer told us that there were not enough activities provided for their family member and they were often bored and rarely left the hospital.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

Between 1 December 2018 and 30 November 2019, the average bed occupancy was 82%. The Manor had the lowest bed occupancy of 54% as this ward was the most affected by the pause on admissions. The average length of stay for patients was 814 days.

Staff had improved discharge planning for patients since the last inspection. We looked at 10 patient discharge plans and saw completed plans with evidence of discharge

checklists and discharge goals. Two of the discharge plans had less detail but it was clear from those plans that the patient was not yet ready for discharge. We saw evidence of patient and carer involvement in the discharge plans.

Discharge plans for patients were discussed at multi-disciplinary meetings every five weeks and managers were able to provide information regarding the discharge status for patients at the hospital, i.e. if they had a projected date for discharge or they were searching for a placement etc. Four patients had a projected date for discharge by the end of March 2020.

The service had introduced a new recording form for section 17 leave. The form recorded the risk assessment prior to the patient leaving the ward and greater detail regarding the outcome of the leave in to assist staff to evaluate a patient's readiness for discharge.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of long term segregation environments did not create a therapeutic environment. This had previously been raised as a concern. Long-term segregation environments were bare and sterile and did not meet patients' needs. We observed a patient in the Bungalows had an environment that lacked appropriate decoration and furnishings. The patient had chosen a chair but was still in need of an appropriate table to eat from and to use during activities. A manager told us they were trying to source some "therapeutic equipment" but they were unable to provide details as to what this equipment would consist of.

The environment for another patient was very bare with all their personal possessions locked away.

Staff did not provide enough activities for patients. There was a lack of activities provided for patients, particularly at weekends and evenings. We looked at some activity plans and saw that four patients in The Manor Flats were offered less than 15 hours of activities per week. Five patients in the Manor and Manor Lodge were offered less than 15 hours of activities per week. The service held a 'Our Voice' patient meeting on 13 February 2020. Patients on both the Manor Flats and The Lodge said that off-site trips got cancelled, some at short notice, due to not enough staff or drivers. One carer told us that her family member did very little activities, did not have a weekly activity plan and had not left the hospital site for over a year. As a result, they often told expressed that they were bored and spent a lot of time in their room.

Staff did not provide enough activities and opportunities for a gradual introduction to the main ward environment and the community to patients in long term segregation. The three patients in long term segregation had access to secure outdoor space. However, the range of activities for all three patients was limited. Concern was raised by external stakeholders at a care and treatment review that one patient had no plan for graded exposure to the community and no plan to increase daily living skills. Concern was raised by an external stakeholder that short staffing was limiting the activities available to another patient in long term segregation. Staff confirmed that for one patient in long term segregation during the month of January only seven activities were recorded where the patient accessed the courtyard and played football or went on a bus ride to Norwich.

There was a full range of rooms available at the hospital, including clinic rooms, an activity centre, classrooms, gymnasium, art therapy and woodwork rooms.

Each patient had their own bedroom, which they could personalise. We saw evidence that patients had personalised their rooms during the inspection. Patients had a secure place to store personal possessions.

Since the last inspection, the service had made improvements to the ward environments to better meet the needs of patients with autism. The service had created two new sensory rooms for patients and provided training for 22 members of staff to enable them to support patients effectively to use the sensory rooms and sensory equipment. During the inspection, we saw evidence that patients were using the sensory rooms.

Managers had improved visual information on the wards by providing easy read activity timetables, easy read calendar boards and photo boards of staff.

Since the last inspection, the service had engaged with the National Autistic Society and had participated in a pre-audit to consider the ward environments and to ensure they could evidence the environment met the needs of patients with autism once this work had been completed.

Inadequate

Wards for people with learning disabilities or autism

The service had quiet areas and a room where patients could meet with visitors in private and patients could make phone calls in private.

The service had an outside space that patients could access easily. The hospital is set in spacious, pleasant grounds, so patients were able to access outside areas including a small farm and take part in gardening and horticultural activities.

The service offered a variety of good quality food. Patients we spoke with told us that they had a choice of food and they liked the food.

Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients' engagement with the wider community

Some patients had access to opportunities for education and work. There were opportunities for patients to engage with productive tasks around the hospital such as delivering post and working with the groundskeeping team. One patient attended a history club in the local town and another patient attended work experience at a local woodworking workshop. However, not all patients had these opportunities. An audit carried out by multi-disciplinary team staff titled 'Enabling the Autistic Person' acknowledged that there are many more ways which patients can be meaningfully engaged but these were not happening in practice.

Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

There were adapted bedrooms in the hospital for patients needing disability support. These rooms had suitable en-suite facilities. The Manor had bedrooms upstairs. There was a lift available for patients in wheelchairs, although this was not currently being used as it was not needed.

Wards had information leaflets available including in easy read formats and the service had improved the information available on the wards to make it more accessible, e.g. provided easy read activity and calendar boards.

The hospital provided a menu for patients to choose a variety of meals, which met their individual religious and cultural needs.

Staff told us that all patients had access to spiritual support. We saw an area of the lounge that was suitable for Christian worship and a chaplain visited regularly. Staff told us that if patients from other faiths wanted spiritual support, they would arrange this with community faith groups.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Independent advocates were available to assist patients with making complaints if required.

The hospital received 34 formal complaints in the last 12 months, five were upheld and no complaints were referred to the Ombudsman.

The service received eight formal compliments during the last 12 months. Managers told us they were not capturing all the informal compliments they received on a daily basis and had set a goal to achieve more compliments in 2020, and to reward staff members for compliments they received to encourage them to ensure the compliments are captured appropriately and recorded centrally.

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

Inadequate

Leadership

There had not been a consistent senior leadership team in place at the hospital since July 2019. Since the last inspection in November 2019, there had been further changes in the senior team as the Hospital Director had retired, and a new Chief Operating Officer (COO) had been appointed. The COO had also applied for the vacant post of Registered Manager. The owner of the service had applied for the vacant post of Nominated Individual. At the time of inspection, the COO had been in post for four weeks. We spoke with the COO during the inspection and they

demonstrated a good understanding of the challenges that the service faced and had begun to make a plan to manage them. However, it was too early to say whether these changes would be effective and sustainable.

Whilst some members of the leadership team had been with the organisation for some time, there was evidence of changes in roles which affected the stability of the team. There had been changes at ward manager level due to unforeseen circumstances. Staff told us they were not always clear about their roles and accountabilities and changes in leadership made it difficult to be confident about processes and procedures and their responsibilities in relation to these. The service carried out an employee engagement survey during August 2019. Within this survey, staff expressed concerns that they did not always feel communication and directives were clear. If staff are not clear about their roles and responsibilities, this can have an impact on patients as it is not clear who has responsibility for tasks and actions that are important for patient safety and quality of care.

During the inspection, we saw evidence where leaders had not taken action to address a concern and where it was not clear who was responsible for this action. For example, the service had not addressed the risk of fire. We saw fire risk assessments for the hospital dated 16 April 2019 which indicated there was a moderate to substantial risk to life from fire. We requested evidence of any actions that had been taken to address these risks, but managers were unable to provide these. This meant that patients were at potentially serious risk of harm from fire without any mitigation in place.

Vision and Strategy

The provider vision statement is: 'Our vision is for people with a learning disability to live a happy, meaningful and fulfilling life'. The provider states its values as: 1. Patients Voice 2. Coaching and Support 3. Employee Engagement 4. Family Involvement 5. Employee Development. The provider took a number of actions to embed the vision and values within the organisation, for example assigning two members of staff as employee engagement representatives and facilitating patient meetings and advocacy. Staff we spoke with told us that the senior managers had an 'open door' policy to encourage staff to raise concerns and contribute to service development. The provider does not currently have a patient representative at governance meetings, however managers have engaged with the advocacy service to work towards patients being able to contribute towards clinical governance in a meaningful way.

Culture

Many staff were not satisfied with the culture of the organisation. The results of the August 2019 employee engagement survey reported that only 52% of respondents either agreed or strongly agreed that they were satisfied with the culture in their workplace and 29% of respondents said that they neither agreed or disagreed with this statement. Staff expressed dissatisfaction with communication from managers and that they lacked direction. Staff also expressed concern that managers did not address the issue of colleagues, particularly agency staff, calling in sick at the last minute. Staff were worried about the future of hospital and their roles due to the inadequate rating given to the hospital by the Care Quality Commission. During the inspection, staff we spoke with told us they were concerned about staffing and not having the time to carry out the requirements of their role. Managers told us they had run open sessions on the ward to give staff the opportunity to express their concerns and would continue to do so.

Staff we spoke with mostly felt personally respected and valued. Staff told us that colleagues supported each other, and managers were visible and approachable. The results of the August 2019 employee engagement survey reported that 91% of staff stated that they either strongly agreed or agreed that they have a good working relationship with their colleagues and 75% of respondents stated that they either strongly agreed or agreed that they have a good working relationship with their line manager. Staff told us that the new Chief Operating Officer had been visible and had an open door policy so staff could approach them with their concerns.

Staff felt able to raise concerns without fear of retribution and were aware of the whistleblowing process.

Governance

Leaders did not ensure there were effective governance structures, processes and systems of accountability for the performance of the service.

Managers told us that the membership of clinical governance meetings had been narrow and did not include key staff such as ward managers. Staff told us that this had

led to a disconnect between senior managers and staff working on the wards. Staff were not clear about their roles and accountabilities and did not have regular opportunities, for example staff meetings, to meet, discuss and learn from the performance of the service and raise issues to feed back into clinical governance. At the time of the inspection, the Chief Operating Officer had made changes to the membership of clinical governance meetings to include the ward managers and the independent advocates. Staff we spoke with felt positive about these changes, however, it was too early to say whether these changes would be effective.

The service did not have effective systems and processes, such as regular audits of the service provided, to assess, monitor and improve the quality and safety of the at the hospital. At the November 2019 inspection, we reported that staff did not have a co-ordinated approach to quality improvement and audit across the hospital. Staff had not fully discussed what audits and reviews needed to be prioritised and we observed staff working on separate projects without management oversight or actions being taken. During this inspection, we saw evidence that managers were undertaking quality and safety reviews at ward level, but it was unclear how these fed into the overall governance processes as the reviews had been returned to the Director of Nursing who was no longer in post. These reviews identified actions required but not who was responsible for the action or a timescale for completion. Senior managers acknowledged that there was a disconnect between audit and governance and told us that the hospital audit process was being reviewed to ensure that this was aligned with priorities identified at governance meetings. Managers did not state a timescale for this review. Whilst the review was undertaken, managers and staff did not have up to date information from audits to enable them to analyse and escalate issues and take appropriate actions to ensure patient safety and quality.

Management of risk, issues and performance

The service did not have effective systems and processes in place to enable staff to identify and manage risks to the health, safety and/or welfare of patients. For example, the service had not addressed the risk of fire. We saw fire risk assessments for hospital dated 16 April 2019 which indicated there was a moderate to substantial risk to life from fire. We requested evidence of any actions that had been taken to address these risks, however managers were unable to provide these. This meant that patients were at potentially serious risk of harm from fire without any mitigation in place.

Manager did not have effective oversight of staff management of patient risk and the implementation of the supportive observation policy. Managers had reviewed the supportive observation policy and provided some additional training, in the form of workbooks, for staff to complete. However, in the month prior to inspection, and the two weeks following inspection, the service reported five further incidents where a patient was caused harm, or was exposed to the risk of harm, due to observations either not being completed as per the patient's support plan or where staff did not have the sufficient skills and experience to understand the meaning behind a patient's behaviour. These incidents involved staff who had completed the workbook in supportive observations.

Managers did not manage performance effectively and did not have effective systems in place to identify, monitor and reduce risks relating to performance. For example, the service had high sickness rates, staff phoning in sick at the last minute and difficulties with staff not turning up for work with no reason. Managers had not addressed this in a robust way. This had an impact on staffing levels on the wards and caused resentment for staff for who were at work as this impacted on their workload.

Managers did not have sufficient oversight of recruitment processes and procedures. We looked at five personnel (HR) files and four out of five were incomplete. There was no evidence of staff supervision or training within two out of five HR files. There were missing references in two out of five HR files. Managers could not be assured that fit and proper persons were employed if HR records were not complete and important information, such as references, were missing.

Managers had not ensured the safety of patients in long term segregation. External stakeholders raised concerns about the over-use of anti-psychotic and PRN medicine for patients in long term segregation. Stakeholders raised concerns that a patient was on a maximum weekly dose of an anti-psychotic medicine despite not having been diagnosed with a psychotic illness. Another patient was prescribed a sedative medicine to be given as required with a maximum dose within BNF limits. The patient had been

receiving 1mg of this medicine for several weeks at the discretion of the nurses in charge. From 20 January staff increased the dose more often to 2mg without a rationale for this being recorded.

Managers had not ensured the dignity of patients in long term segregation. A patient in long term segregation experienced deprivation of access to normal daytime clothing. The patient had a care plan which stated that they should wear anti-rip clothing at all times due to ligature risks. There was a lack of documented reviews or attempts to use alternative strategies. Another patient in long term segregation had a leather settee which they often slept on. As this patient experienced night-time urinary incontinence at times, it was observed that the settee was urine-sodden, and the lounge and entrance smelled strongly of urine. Managers responded to issues when identified by external stakeholders, however, were not proactive in identifying and responding to issues within the service. This was a concern at previous inspections.

Managers acknowledged that the hospital could improve the way that lessons were learnt across the hospital.

Information Management

Staff had access to the equipment and information technology needed to do their work. Staff had access to portable tablet computers where they could input observations and access patient care and treatment plans. However, some patients reported they found the tablet computers a barrier to staff communicating with them. We also saw evidence of staff using them for their own purposes which meant we could not be assured patients were being supported appropriately at all times

Learning, continuous improvement and innovation

Staff we spoke with were keen to improve the service, however, they told us that due to the current challenges faced by the service, in particular staffing and lack of leadership, it was difficult to find time to step back and consider improvements and innovation, or participate in research, that could be put in place to improve quality of services.

The hospital was participating in the Royal College of Psychiatrists quality network for inpatient learning disability services. This standard based quality external accreditation network facilitated good practice across similar services nationally.

Therapy staff told us they had the opportunity to be involved in research and development and to participate in external conferences. Occupational and speech and language therapy staff attended clinical excellence forums.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they deploy enough staff with the appropriate qualifications, skills and experience to meet patients' care and treatment needs and ensure patient safety.
- The provider must ensure all risks for each ward are identified on the environmental risk assessments, including addressing the risk of fire. In addition, the provider must ensure that the design, layout, and furnishings of long term segregation environments are suitable and create a therapeutic environment.
- The provider must ensure staff correctly carry out supportive observations correctly in accordance with the supportive observation policy and patient care plans.
- The provider must ensure that staff safely prescribe medicine to patients in long term segregation and record the rationale for prescribing maximum dose anti-psychotics and increased dosages of sedative medicine.
- The provider must ensure that lessons are learnt effectively across the hospital after incidents.
- The provider must ensure that patients in long term segregation have adequate physical health care.
- The provider must ensure all patients have a care plan which is accessible and in an easy read format.
- The provider must ensure that all patients have their dignity upheld.
- The provider must ensure they provide sufficient, meaningful activities for patients particularly at evenings and weekends.
- The provider must ensure that appropriate staff are trained in Makaton or Signalong to communicate with patients whose main form of communication is Makaton.
- The provider must ensure that they have robust recruitment processes and procedures in place and that human resources files are kept complete and in good order.
- The provider must ensure that audits are effective, comprehensive, robust, and contain the necessary detail to appropriately oversee the service to be able to make changes where required.
- The provider must ensure that robust governance systems and processes are sufficiently established and embedded to be identify, monitor and maintaining the quality and safety of care to patients and that improvements are made in a timely manner.

Action the provider SHOULD take to improve

- The provider should ensure that all staff can easily access the ligature cutters on The Manor.
- The provider should ensure that there is not a possibility of shadowing in the seclusion rooms if the light was on.
- The provider should monitor staff use of tablet computers to ensure they are not distracted by carrying out personal internet searches or playing games.

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 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **The provider had not ensured all risks were identified on environmental risk assessments.** **The provider had not addressed the risk of fire.** **The provider had not ensured staff were correctly carrying out supportive observations in accordance with the supportive observation policy and patient care plans.** **The Provider had not ensured that all patients in long term segregation had adequate physical healthcare.** **The provider had not ensured that medicine was safely prescribed for patients in long term segregation.** **The provider had not ensured that lessons were learnt effectively across the hospital.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not deploy enough nursing and support staff to meet patients care and treatment needs and ensure patient safety.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

The provider did not have robust recruitment processes and procedures in place to ensure the recruitment of fit and proper persons.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that appropriate staff were trained in Makaton and Signalong to communicate with patients whose main form of communication is Makaton. The provider had not ensured all patients had a care plans which was accessible and in an easy read format. The provider had not ensured they provided sufficient, meaningful activities for patients, including patients in long term segregation.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that the design, layout and furnishings of long term segregation environments were suitable and created a therapeutic environment.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured the dignity of patients in long term segregation

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not ensure they had effective systems in place to assess, monitor and improve the quality and safety of patients at the hospital.

The provider did not ensure they had effective systems in place to identify, monitor and reduce risks relating to staff performance

The provider did not ensure that audits are effective, comprehensive, robust and contained the necessary details to appropriately oversee the service to be able to make changes where required.

The provider did not ensure that governance systems and processes were sufficiently established and embedded to be effective in maintaining quality and safety.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Notice of Proposal served under Section 26 of the Health and Social Care Act 2008 to cancel the registration of the provider in respect of the regulated activities: 1. Treatment of disease, disorder and injury; and 2. Assessment or medical treatment for persons detained under the Mental Health Act 1983 Following an assessment of the evidence set out in this report, the Care Quality Commission is of the opinion that the most appropriate and proportionate response to the above cited failures is to propose to cancel the registration of the provider to carry on the regulated activities.