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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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.

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

Overall summary

The Care Quality Commission inspected Jeesal Cawston Park Hospital in June and July 2019. Following that inspection, we rated the service as inadequate. Due to our concerns, we issued the hospital with a warning notice for a breach of regulation 17 of the Health and Social Care Act (2008) and placed it into special measures.

This inspection was an unannounced, focussed inspection to follow up on the warning notice and to assess whether the provider had made the required improvements. During the inspection period, we found significant concerns that required urgent action. We have taken further enforcement action against the provider to require that, with immediate effect, the Registered Provider must not admit any patients to any ward at Jeesal Cawston Park hospital without prior written agreement of the Care Quality Commission.

We found some areas of improvement. However, we found that further improvements were required, or it was too early to judge whether the measures the provider had put in place had an impact or were sustainable.

We did not re-rate this service at this inspection.

We found the following areas required improvement:

- There had not been a consistent senior leadership team in place since July 2019. 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 leadership team. The registered manager left in July 2019 and an interim appointment was made to cover this vacancy who unfortunately was on long term sick. This meant that other senior managers had to fulfil the role.There had been a restructure of the quality improvement team. We were not assured that there was the stable, robust leadership in place in order to embed and sustain the quality improvements necessary to ensure effective and safe patient care.
- The provider did not demonstrate that governance systems were sufficiently embedded to be assured of the impact and sustainability of these systems. For example, we were not assured that the quality of clinical observations was consistent and sustainable due to new staff not receiving observation training from March to September 2019. Managers had not prioritised the oversight of patient observations despite a high number of safeguarding incidents directly related to this concern in the six months prior to this inspection. Managers had not implemented recommendations made by an external nurse consultant relating to patients swallowing foreign objects as a matter of priority.
- Recruitment and retention of qualified nurses remained challenging and staff we spoke to described difficulties in meeting the demands of their roles. We spoke to 16 members of staff. Three members of staff told us that the wards could be short-staffed and sometimes staff were unable to escort patients on trips out of the hospital because of this. One member of staff told us that because of a high number of incidents the previous day, general observations had not been completed as per the observation and engagement policy. This could have an impact on patient safety.
- Staff did not have a co-ordinated approach to the completion of audits or the implementation of quality improvement work. We spoke to senior managers and four members of staff who were involved in quality improvements and audit and we observed staff working on separate projects without management oversight or actions being taken. For example, one person working on quality improvement had reviewed incidents relating to patients swallowing objects. However, managers had not discussed the review, drawn up an action plan or put into place any of the recommendations made. The provider had reported further incidents of patients swallowing objects since the time of the review. Managers were not acting on concerns and reviews with enough co-ordination and urgency which had an impact on improving patient safety.

Summary of findings

- Staff did not ensure care and treatment records contained information on the patients' capacity. We found no individualised assessments of capacity for specific decisions within patient records except for the use of medication.
- During the inspection we found an infection control issue on the Manor. We also found poorly written lessons learnt bulletins. Managers acknowledged our findings at the time of inspection. The provider's internal audits and governance processes had not identified these concerns. There were ineffective systems in place to assess and monitor the quality of care which was a concern at the last inspection.

However:

- Staff ensured that patients cared for within long term segregation were nursed in accordance with Mental Health Act Code of Practice guidelines. Staff completed daily, weekly, monthly and quarterly reviews and we did not find any gaps in recording in the two weeks prior to the inspection.
- The provider had improved discharge planning. Managers had reviewed the care planning structure to include a specific 'working towards discharge' care plan. We looked at six care plans and found that five out of six included a discharge plan with evidence of patient involvement.
- Staff had made regular checks of emergency equipment and all signatures were in place.
- Seclusion rooms met the standards required in the Mental Health Act Code of Practice and we saw evidence that staff were completing regular daily and weekly checks.

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		We did not rate the service at this inspection

Summary of findings

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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 or 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 35 patients in the hospital when we inspected. The hospital had an informal agreement with clinical commissioners to not admit new patients whilst it was in special measures, unless there were exceptional circumstances.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, three CQC inspectors, a specialist advisor (nurse) with experience working with patients with a learning disability and an expert by experience.

Why we carried out this inspection

We carried out this inspection to follow up on the warning notice issued in August 2019 to ensure that the improvements required had been made.

How we carried out this inspection

We have reported in the following domains:

- Safe
- Effective
- Caring
- Responsive
- Well led

This was a focussed inspection. We looked at specific key lines of enquiry in line with issues raised in the warning notice. Therefore, our report does not include all the headings and information usually found in a comprehensive report.

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and asked other organisations, including the local safeguarding authority, for information.

During the inspection visit, the inspection team:

- visited the clinic rooms, seclusion rooms and long term segregation areas at the hospital
- spoke with five patients who were using the service
- spoke with the hospital director, a turnaround consultant employed to work on quality improvement and two ward managers
- spoke with 16 other staff members including registered nurses, support workers, a consultant psychiatrist and quality improvement staff
- received feedback about the service from West Norfolk NHS Clinical Commissioning Group and the Norfolk safeguarding authority
- looked in detail at the care and treatment records of eight patients, including two patients being nursed in long term segregation
- looked in detail at the discharge planning for six patients
- examined in detail three incident forms
- attended a morning handover meeting
- reviewed CCTV footage to ensure observations were being completed correctly
- looked at a range of governance documents, internal audits, policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas requiring improvement:

- During the inspection we found an unbagged stool sample in the medication fridge on The Manor, which had been there since 9 September 2019. This was an infection control risk and also it was unclear why the sample had not been sent off for testing. We raised this during the inspection and the sample was disposed of immediately. We were reassured that the patient was unharmed and other tests had been carried out to determine their state of health.
- We were not assured that the quality of clinical observations was consistent and sustainable. New staff had not received supportive observation training from March to September 2019 as this had been removed from the induction programme. Managers had not prioritised the oversight of patient observations despite a high number of safeguarding incidents in the three months prior to this inspection.
- Recruitment and retention of qualified nurses remained challenging and staff we spoke to described difficulties in meeting the demands of their roles. We spoke to 16 members of staff. Three members of staff told us that the wards could be short-staffed and sometimes staff were unable to escort patients on trips out of the hospital because of this. One member of staff told us that because of a high number of incidents the previous day, general observations had not been completed as per the observation and engagement policy. This could have an impact on patient safety. An incident occurred during the inspection where a patient broke a toilet seat and swallowed a screw. Staff had reduced the patient's level of observations due to lack of staff. The provider told us this had been approved by the responsible clinician, however staff had not documented this decision anywhere in the patient's clinical notes.

However:

- Staff ensured that seclusion rooms complied with the Mental Health Act Code of Practice. Staff had ensured that the two-way communication system was working in The Lodge seclusion room and the temperature controls were accessible to staff in the Grange and The Lodge seclusion rooms.
- Staff ensured that patients nursed within long term segregation were nursed in accordance with the Mental Health Act Code of

Summary of this inspection

Practice guidelines. Staff were completing daily, weekly, monthly and quarterly reviews and we did not find any gaps in recording in the two weeks prior to inspection. However, staff were recording quarterly reviews on the hospital shared drive rather than the provider electronic record system which could make it more difficult for staff to find these records.

- Staff had made regular checks of emergency equipment and all appropriate equipment was present and in date and all signatures were in place on the weekly checklists.

Are services effective?

We found the following areas requiring improvement:

- Ward managers did not have a consistent approach to weekly audits. The provider had introduced a weekly audit, carried out by the ward managers, which included checking a random sample of three care plans and whether they were of the expected quality. On two of the wards, managers had identified which care records they had looked at and highlighted any areas that needed improvement. However, on one of the wards, managers had not identified which care records had been audited which would make it difficult for staff to ensure they reviewed a different sample the following week or ensure that any improvements had been made.
- Staff did not ensure that all care and treatment records contained information on the patients' capacity. We found references to patient capacity in various documents, but we did not always see formal capacity documentation or best interest decision-making. Staff recording of patient capacity had been a concern at the last two inspections.

However:

- We reviewed eight care and treatment records on the provider's electronic recording system, including two patients who were in long term segregation. Six of the care plans we looked at were in the new format and we could see evidence of improved care planning, including discharge planning and patient involvement.
- Since the last inspection, the provider had resolved the issue relating to the patient who had an invalid 'Do Not Attempt Resuscitation' form on his record. A best interest meeting had been held, involving the patient's nearest relative and the 'Do Not Attempt Resuscitation' had been rescinded. There were no patients at the hospital subject to a 'Do Not Attempt Resuscitation' plan at the time of the inspection.

Summary of this inspection

Are services caring?

We found the following areas of improvement:

- Staff involved patients in their care planning and ensured that they offered patients a copy of their care plan. This was an improvement since the last inspection. All the patients we spoke with were aware of their care plan and had been offered a copy, including an easy read version if appropriate.
- We observed staff being responsive to patient needs; for example, one patient asked if they could visit the local town using the hospital minibus and this was arranged for later that day. We saw a member of staff responding with care and compassion to a patient who wanted to see a family member.

Are services responsive?

- The provider had reviewed its approach to transition planning and had held regular fortnightly meetings since September 2019. The provider had begun to implement the NHS Transforming Care 12 Step Discharge Checklist in combination with a detailed easy-read discharge pathway document which was completed with the patient from the point of admission. Staff had begun to use this checklist and pathway document with patients.
- We looked in detail at the care records and discharge planning for six patients. Five out of the six records we looked at contained a discharge plan with staff setting achievable goals for the patient. This was an improvement since the last inspection.
- We looked at the discharge plans for two patients being cared for in long term segregation. Both patients had discharge plans which had been updated at the beginning of November 2019 and included plans for re-integration onto the wards. Planning for discharge featured in different aspects of care and we saw that discharge arrangements featured in long term segregation reviews and multi-disciplinary reviews.
- The provider was able to give us clear information regarding patients who were subject to delayed discharge, including the reasons for the delay. This was an improvement since the last inspection.

Are services well-led?

We found the following areas requiring improvement:

- There had not been a consistent senior leadership team in place since July 2019. Whilst some members of the leadership team had been with the organisation for some time, there was

Summary of this inspection

evidence of changes in roles which affected the stability of the leadership team. The registered manager left in July 2019 and an interim appointment was made to cover this vacancy who unfortunately was on long term sick. This meant that other senior managers had to fulfil the role. We were not assured that there was the stable, robust leadership in place in order to embed and sustain the quality improvements necessary to ensure effective and safe patient care.

- The provider did not demonstrate that governance systems were sufficiently embedded to be assured of the impact and sustainability of these systems. For example, we were not assured that the quality of clinical observations was consistent and sustainable due to new staff not receiving observation training from March to September 2019. Managers had not prioritised the oversight of patient observations despite a high number of safeguarding incidents in the six months prior to this inspection.
- Staff did not have a co-ordinated approach to quality improvements. We spoke to senior managers and four members of staff who were involved in quality improvements and we observed staff working on separate projects without management oversight or actions being taken. Managers were not acting on concerns and reviews with enough co-ordination and urgency, which could have an impact on patient safety.
- During the inspection we found an infection control issue on the Manor and poorly written lessons learnt bulletins. Managers acknowledged our findings at the time of inspection. The provider's internal audit and governance processes did not ensure all concerns were identified and addressed. We were not assured enough progress had been made and this was a concern at the last inspection.
- We reviewed the draft minutes from the October clinical governance meeting. Managers had introduced a new agenda and minutes template for these meetings which included columns identifying actions required, the owner of the action and the due date. However, these columns had not been completed fully in the draft minutes. This was resolved during the inspection and managers had added this information to the minutes. Managers needed to further embed the revised clinical governance meeting agenda to ensure that issues were identified and resolved in a sustainable manner.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We did not review the provider's adherence to the Mental Health Act during this inspection.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

Maintenance, cleanliness and infection control

During the inspection, we found an un-bagged stool sample in the medication fridge on The Manor, next to some intravenous medication, which had been there since 9 September 2019. This was an infection control risk. We raised this during the inspection and the sample was disposed of immediately by staff. Managers had carried out a quality and safety review, including a spot check of the medication fridge on 10 October 2019, but had not identified this issue. The audit system in place to assess and monitor the quality of care was not effective and therefore staff had not taken steps to rectify this issue. This was a concern at the last inspection.

Staff had introduced a new format for keeping cleaning records within the clinic rooms since the last inspection. Cleaning records were in date with no missing signatures since October when the new system was introduced. However, the un-bagged stool sample had not been identified or removed by staff who were responsible for cleaning of the clinic rooms.

Seclusion room

There were two seclusion rooms at the hospital on The Lodge and The Grange. Seclusion rooms allowed clear observation and had two-way communication. Staff had resolved the issue of the two-way communication system not working since the last inspection 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

Staff had made regular checks of emergency equipment and all appropriate equipment was present and in date, including ligature cutters on the Manor which had been missing at the last inspection. All signatures were in place on the weekly checklists. This was an improvement since the last inspection.

Safe staffing

Recruitment and retention of qualified nurses remained challenging and staff we spoke to described difficulties in meeting the demands of their roles. We spoke to 16 members of staff. Three members of staff told us that the wards could be short-staffed and sometimes staff were unable to escort patients on trips out of the hospital because of this. One member of staff told us that because of a high number of incidents the previous day, general observations had not been completed as per the observation and engagement policy. This could have an impact on patient safety.

Staff did not complete continuous enhanced observations for longer than two hours unless there were exceptional circumstances. This is an improvement since the last inspection.

Management of patient risk

We were not assured that improvements observed in clinical observations, for example, staff knowledge of patient risks, were consistent and sustainable because of the number of staff who had not received supportive observation training and the lack of clarity around the implementation of the recommendations made by the nurse consultant,

In the three months prior to the inspection, the Care Quality Commission and safeguarding authorities were notified of six incidents involving patients where staff had failed to carry out observations as prescribed in the patient

care plan. In response to these incidents, the provider had engaged a nurse consultant who had undertaken a review of staff observations which had been completed at the beginning of November. The consultant had identified that a training session on completing supportive observations had been removed from the new staff induction in March 2019 and had only just been re-instated. This meant that all new starters between March 2019 and November 2019 would not have undertaken this training before starting to complete observations with patients. At the time of inspection, 32 staff out of 105 were still required to attend training in supportive observations. Managers could not be assured that these staff were trained and competent to carry out observations safely and effectively.

The nurse consultant recommended that staff recording of patient observation levels on the provider electronic record keeping system should be improved to include the level of support required, for example if the patient should be observed at arm's length. They had also recommended that additional information was included, for example if the patient should have female only staff carrying out observations, or if staff should observe patients using their bathroom facilities. This information was available on the whiteboards in the ward offices, but while on the wards, staff used the electronic system accessed via tablet computers, so the information would be more readily accessible outside of the office if it was on the system. This recommendation had not yet been implemented and it was unclear whether managers planned to implement it and, if so, when.

We reviewed the observation levels for two patients being cared for in long term segregation. For one patient, it was unclear what their observations levels should be from their patient record and we saw conflicting information under the observation tab on the provider electronic record system and what was recorded in multidisciplinary team meeting notes. There were three gaps in the observation records for this patient in the two weeks prior to inspection. There is a risk to patient safety if observation levels are not made clear to all staff and observations are not being carried out according to the provider observation and engagement policy.

At the time of the inspection, all but one of the staff we spoke with were aware of patients' risks. This is an improvement since the last inspection. We spoke with 11 members of staff who were carrying out enhanced or general observations with patients. All but one of the staff we spoke with demonstrated good knowledge of the patients they were observing, their risks and what level of observations they should be on, as well as any additional information - bathroom privacy for example. One member of staff was aware that a newly admitted patient was on one to one observations and knew the patient risks but was unsure whether they should be observing the patient at arm's length or at a distance. They checked this with a manager following the interview.

Use of restrictive interventions

Staff ensured patients cared for within long term segregation were nursed in accordance with the Mental Health Act Code of Practice guidelines. Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, 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 or unit. Four patients were in long term segregation at the hospital at the time of our inspection. Staff completed daily, weekly and monthly reviews and we did not find any gaps in recording. The quality of the daily reviews was variable, but the quality of the weekly and monthly reviews was good and improving.

Medicines management

We reviewed 11 patient medication records. Medicines had been correctly administered and there were no missing signatures in the charts in the two weeks prior to inspection.

Reporting incidents and learning from when things go wrong

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. Senior managers discussed each incident at the morning management meeting and updated patients' care plans and risk assessments accordingly.

Managers sent a 'learning lessons' bulletin to all staff by e-mail and displayed them on the wards to aid learning, discussion and inform clinical practice. 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. For example, in two bulletins the description of the incident was confusing, and it was difficult to understand exactly what had happened and who was involved. In two other bulletins, the description of the incident was very brief and did not contain enough information to understand fully what had happened; for example, one bulletin reported that a patient had been left on their own for six minutes but gave no further detail about what observation level the patient should have been on or what the consequences were. Staff would not be able to fully understand and learn from incidents if the details and lessons learnt were lacking clarity. Governance meeting minutes from October stated that the lessons learnt bulletin was clear and highlighted important areas. However, when we raised our concerns at the inspection, managers acknowledged that the information was not clear, and the bulletins could be improved. We were concerned that the governance system in place did not identify where quality and safety were being compromised. This was a concern at the last inspection.

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

Assessment of needs and planning of care

The provider told us that staff had revised 31 out of 35 patient care records and put them into a new format which reduced the amount of information contained within to make them less time-consuming to read and easier to understand. We reviewed eight care and treatment records on the provider's electronic recording system, including two patients who were in long term segregation. Six of the care plans we looked at were in the new format and we could see evidence of improved care planning, including discharge planning and patient involvement. Two of the care plans we looked at were still in the old format. Staff told us that these were due to be updated.

The provider had introduced a weekly audit, carried out by the ward managers, which included checking a random sample of three care plans and whether they were of the expected quality. The ward managers reports were forwarded to the clinical governance folder, which was shared with the board and reviewed as part of the new clinical governance meeting. We looked at a weekly report for each ward and saw evidence of care plan audit. On two of the wards, managers had identified which care records they had looked at and highlighted any areas that needed improvement. On one of the wards, managers had not identified which care records had been audited. This would make it difficult for staff to ensure they reviewed a different sample the following week or ensure that any improvements had been made.

Skilled staff to deliver care

Managers had increased the induction period for new staff to two weeks as of November 2019 and reintroduced a session on completing supportive observations. The induction programme also included face to face training in autistic spectrum disorders and mental health and learning disabilities.

Good practice in applying the Mental Capacity Act

Staff did not ensure that all care and treatment records contained information on the patients' capacity. We found references to patient capacity in various documents, but we did not always see formal capacity documentation or recording of best interests meetings. There was a capacity tab on the provider's electronic recording system, but this was blank in the records that we looked at. Staff recording of patient capacity had been a concern at the previous two inspections.

Since the last inspection, the provider had resolved the issue relating to the patient who had an invalid 'Do Not Attempt Resuscitation' form on his record. A best interests meeting had been held, involving the patient's nearest relative and the 'Do Not Attempt Resuscitation had been rescinded. There were no patients at the hospital subject to a 'Do Not Attempt Resuscitation' plan at the time of the inspection.

Are wards for people with learning disabilities or autism caring?

Kindness, privacy, dignity, respect, compassion and support

Wards for people with learning disabilities or autism

We spoke with five patients. Four patients spoke positively about staff and that they cared for their wellbeing. However, one patient told us they felt staff did not understand their difficulties.

All the patients we spoke with told us that they understood why staff were supporting them with observations and that it was to keep them safe.

During the inspection, we observed staff treating patients kindly and with compassion. We observed staff using appropriate humour with patients and relaxed and good-natured interactions between staff and patients.

We observed staff being responsive to patient needs; for example, one patient asked if they could visit the local town using the hospital minibus and this was arranged for later that day.

Involvement of patients

Staff involved patients in their care planning and offered them a copy of their care plans. This was an improvement since the last inspection. All the patients we spoke with were aware of their care plan and had been offered a copy, including an easy read version if appropriate.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Access and discharge

Discharge and transfer of care

Staff had improved discharge planning for patients since the last inspection. However, there were areas that required embedding. The Mental Health Act Code of Practice states "discharge planning for people with autism should begin when the person is admitted". Transforming Care for People with Learning Disabilities states patients "have an agreed discharge plan from the point of admission". The provider had voluntarily agreed not to admit new patients. However, one new patient had been admitted due to exceptional circumstances. We reviewed the care and treatment plans for this patient and a discharge planning support plan had been initiated with outcomes and success measures in place.

The provider had reviewed its approach to transition planning and had held regular fortnightly meetings since September 2019. The initial meetings focussed on reviewing the provider policy and protocols and confirming the list of patients who had a delayed discharge. Subsequent meetings involved discussion of individual patients and their transition and discharge plans. The provider had begun to implement the NHS Transforming Care 12 Step Discharge Checklist in combination with a detailed easy-read discharge pathway document which was completed with the patient from the point of admission. Staff had begun to use this checklist and pathway document with patients, but it was not yet fully embedded.

We looked in detail at the care records and discharge planning for six patients. Five out of the six records we looked at contained a discharge plan with staff setting achievable goals with the patient. This was an improvement since the last inspection. Within the plans there was some evidence of patient voice, however this was not clearly evident in one of the plans.

We looked at the discharge plans for two patients being cared for in long term segregation. Both patients had discharge plans which had been updated at the beginning of November 2019 and included plans for re-integration onto the wards. Planning for discharge featured in different aspects of care and we saw that discharge arrangements featured in long term segregation reviews and multi-disciplinary reviews.

The provider was able to give us clear information regarding patients who were subject to delayed discharge, including the reasons for the delay. This was an improvement since the last inspection.

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

Leadership

There had not been a consistent senior leadership team in place since July 2019. 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 leadership team. The registered manager left in July 2019 and an interim appointment was made to cover this vacancy who unfortunately was on long

term sick. This meant that other senior managers had to fulfil the role. We were not assured that there was the stable, robust leadership in place in order to embed and sustain the quality improvements necessary to ensure effective and safe patient care.

The hospital had a number of staff engaged, or employed, to carry out quality improvements. However, we observed that staff did not always work together, and actions recommended by consultants were not acted on in a timely manner

Culture

During the inspection, we observed some behaviours that caused concern about the welfare of some key staff and the overall culture. We observed incidences of staff being spoken to abruptly by managers and two members of staff we spoke to expressed concern about the culture.

Staff knew how to use the whistleblowing process and felt they could raise concerns without fear of victimisation.

Governance

The provider had not demonstrated that governance systems were sufficiently embedded to be assured of the impact and sustainability of these systems. For example, we were not assured that the quality of clinical observations was consistent and sustainable due to new staff not receiving observation training from March to September 2019. Managers had not prioritised the oversight of patient observations despite a high number of safeguarding incidents in the six months prior to this inspection. Managers had not implemented recommendations made by an external nurse consultant as a matter of priority.

During the inspection we found an infection control issue on the Manor and poorly written lessons learnt bulletins. Managers acknowledged our findings at the time of inspection. The provider's internal audits and governance processes had not identified these concerns. This was a concern at the last inspection.

We reviewed the draft minutes from the October clinical governance meeting. Managers had introduced a new agenda and minutes template for these meetings which included columns identifying actions required, the owner of the action and the due date. However, these columns had not been completed fully in the draft minutes. This was resolved during the inspection and managers had added this information to the minutes. The use of this template, alongside the use of the provider task engine, needed further embedding before we could be assured that managers would identify and resolve actions in a robust and sustainable manner.

The provider had introduced a number of quality improvement processes and audits, including daily, weekly and monthly ward audits, improvements to the agenda of clinical governance meetings and an audit schedule for the upcoming year. The provider had also introduced a new audit template which used a RAG rating system to rate each area as red, amber or green to indicate whether an area was complete or needed further improvements. Areas rated amber or green had actions noted with a date for completion and nominated member of staff who was responsible for that action. Staff had carried out recent audits in staff training, environmental cleanliness, hand hygiene and the Mental Health Act. However, managers could not provide evidence that staff were working cohesively together to ensure 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. For example, one person working on quality improvement had reviewed incidents relating to patients swallowing objects. They had identified this as a priority due to the risks such incidents posed to patient safety and concerns raised by the safeguarding authority regarding one particular patient with known risks of swallowing foreign objects. This report had been completed in August 2019 and presented to senior managers with a recommendation that an action plan was written by 20 August 2019. However, managers had not discussed the review, drawn up an action plan or put into place any of the recommendations made. The provider had reported further incidents of patients swallowing objects since the time of the review. Managers were not acting on concerns and reviews with sufficient co-ordination and urgency which had an impact on patient safety

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We had taken enforcement action and we issued a warning notice for a breach of regulation 17 in August 2019. At this inspection, to follow up on the warning notice, we have taken further enforcement action to require that, with immediate effect, the Registered Provider must not admit any patients to any ward at Jeesal Cawston Park hospital without prior written agreement of the Care Quality Commission.

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 Decision served under Section 31 of the Health and Social Care Act 2008. With immediate effect, the Registered Provider must not admit any patients to any ward at Jeesal Cawston Park hospital without prior written agreement of the Care Quality Commission. The provider must: Ensure that all observations are carried out correctly as per the patients care plan, and the provider engagement and observation policy, at all times. Ensure that all staff, including bank and agency staff, have received training and have the appropriate skills and knowledge to implement all patient observation levels and manage risks safely whilst they are carrying out supportive observations. Ensure that there is enough staff on all the wards with the relevant competence and skills to ensure patient safety. This is to include appropriate training for all staff in the management of risk, including risks posed by the environment. Ensure all incidents are reported to the Care Quality Commission as soon as practicable after the event. Ensure there are robust systems of governance in place which demonstrate that there is a culture of safety throughout the organization which will effectively manage the risk of preventable safeguarding incidents.