Coveberry Limited

Cedar House

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Cedar House is a specialist hospital managed by Coveberry Limited. The hospital provides assessment and treatment in a low secure environment for people with a diagnosis of learning disability and autistic people, including those who have a forensic history, challenging behaviour and complex mental health needs. At the time of the inspection they had 32 people at the service. The service has six wards, along with three purpose-built annexes. These included Folkestone ward – a nine-bed ward for males, Enhanced Low Secure (ELS) which provides five beds for males and includes one annexe, Maidstone ward – an eight-bed ward for females, Tonbridge ward – an eight-bed ward for males, Rochester ward – a six-bed ward for males, two of which are contained within annexes and Poplar ward – a locked rehabilitation ward for five males. This ward was outside the secure perimeter fence.

On 18, 19, 20 and 25 January 2022 we carried out an unannounced comprehensive inspection at Cedar House. This was in response to concerns we received about the care and treatment being provided, as well as information we had around governance changes and staffing issues. During the inspection we found a number of areas of concern.

On 27 January 2022, following our inspection visits, we served the provider with a letter of intent telling the provider that we required them to provide us with assurance that they would make immediate and ongoing improvements to address the concerns, otherwise we would use our powers under Section 31 of the Health and Social Care Act 2008. This letter outlined concerns that people were not being provided with safe care and treatment. This included insufficient levels of interaction and observation from staff; a lack of cleanliness and poor maintenance across the hospital; the seclusion room not meeting the Mental Health Act (1983) Code of Practice and not being an environment to keep people safe; peoples' Positive Behaviour Support (PBS) plans not being delivered in an effective way and staff not being sufficiently trained, competent and supported in delivering the care needed for the people using the service. The provider was required to submit an action plan by 31 January 2022 that described how it was addressing our concerns.

The provider's response did not provide enough assurance that the actions the provider was taking addressed the immediate concerns. Due to the serious nature of the concerns, we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and imposed urgent additional conditions on the provider's registration on 2 February 2022. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns.

The condition prevented the provider from admitting any new people to Cedar House without the prior written agreement of the Care Quality Commission. The provider was also required to provide a detailed action plan to address the following: to improve systems of governance around reviews of incidents and observation levels; to ensure that care provided is therapeutic, person centered, proactive and takes a preventative approach using Positive Behaviour Support (PBS); to make improvements to the environment, including the seclusion room and one person's annexe, to ensure these are suitable environments to meet the needs of people with learning disabilities and autistic people; to ensure that staff are appropriately trained with the correct skills to deliver safe and effective care to people with learning disabilities or autism and that there is appropriate support and supervision. We also placed a condition requiring the service to provide fortnightly updates as to the progress, monitoring and audits of the implemented action plan.

We have progressed further enforcement action, but the outcome is still to be determined. CQC continues to closely monitor the hospital.

Summary of findings

We took this urgent action as we believed that people would or may be exposed to significant risk of harm if we did not do so. We expect providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, Right Care, Right Culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people.

Our rating of this service went down. This inspection rated Cedar House as inadequate and placed them into special measures.

We rated it as inadequate because:

- People could not always be observed in all parts of all wards, and observation levels were not always maintained as prescribed in care plans. During a review of CCTV footage, we saw that a person requiring continuous observation did not receive any for over an hour.
- People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment which were suitable for people's sensory and physical needs. Folkestone and Enhanced Low Secure (ELS) were both decorated with extremely bright colours and were also noisy which would be overwhelming for people with sensory processing difficulties. Some relatives told us that their loved ones found the ward environments noisy and the lighting very bright. All wards were tired, unclean and showed signs of disrepair including damaged flooring, boarded up windows, stained bathroom suites, broken external vents, rotten window frames, damaged curtains, damaged furniture, dirty doors, leaking baths and sewage issues, broken fixtures and perspex screens for TV units being marked and smeary.
- We found a range of concerns with the hospital environment which negatively affected care. People did not always have access to outside space as some wards did not have a secure outside area. Some people required staff assistance to access fresh air and exercise. The environment of one annexe did not uphold the basic rights of privacy, dignity or humane treatment. Food, drink and personal hygiene items were being passed through a side window adjacent to the main hospital entrance and main walkways and the environment lacked any comfort other than a bed. In addition, the hospital seclusion room bathroom could be directly observed by staff and provided no privacy and dignity for the person using these facilities.
- People did not always receive care and treatment that kept them safe or understood and met their needs and aspirations. Staff did not understand how to implement effective PBS plans. The PBS plans we reviewed were mostly used by staff to assist with the management of challenging behaviours, but not as an overall holistic approach to a person's care or for the day to day understanding of people's behaviour. Care plans were not consistent in quality and assessment of the persons physical, psychological and social care need. Most people did not have clear plans in place to support them to return home or move to a community setting. We were told that discharge planning started when a person was ready, rather than upon admission with care focused towards goals and outcomes.
- We observed staff engagement with people using the service, on the wards we inspected, and by a review of CCTV following incidents. We saw that staff were not always consistently and actively engaging with the people they were working with and assisting them with activities. On ELS, Folkestone and Rochester wards, we observed that interaction with people being cared for was infrequent. At the time of inspection, on the wards we visited there was little evidence of meaningful activity taking place with patients. Most people told us that they were just stuck on the ward. Relatives told us their loved ones spend all day watching TV and that they had no access to education or work opportunities.

Summary of findings

- Staff did not always provide a range of treatment and care for people based on national guidance and best practice. At the time of inspection, the service was reviewing how psychology services were delivered to people at the hospital. Staff reported a lack of psychology presence on the wards and felt that this had impacted people within the service. Although, the service had a speech and language therapist (SaLT) staff told us that they were only available two days per week which wasn't enough to meet the needs of people at the hospital.
- People did not always have access to information in appropriate formats. We saw that not all people had communication passports. These are practical tools about people with complex communication difficulties who cannot easily speak for themselves. In addition, the service did not consistently display information on complaints, advocacy and other local services within all communal areas.
- Staff were not comprehensively reviewing the use of restrictive practices to reduce them. For example, the hospital had a reducing restrictive interventions risk assessment and action plan, however some areas had not been reviewed since February or March 2021 and a revised draft policy and action plan supplied by the provider was due to be embedded by February 2022.
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. The service did not provide specific training on the Mental Health Act (MHA) and the Mental Health Act Code of Practice. The service provided a Mental Health Awareness e-learning course, however, this was not included within the mandatory training list and staff did not always keep up to date. People, relatives and staff told us that staff shortages often meant that Section 17 leave, which was permission granted to leave the hospital for those detained under the Mental Health Act (1983), and outdoor activities were cancelled and that there was a reduced ability for people to engage in activities. This included people's ability to take Section 17 leave to smoke off the hospital grounds.
- The service did not ensure care, support and treatment was delivered by trained staff and specialists able to meet people's needs. The service induction programme was offered to permanent and flexi/bank staff and was insufficient in providing staff with the necessary knowledge and skills to deliver effective care to those with a learning disability and autistic people. Staff also did not receive adequate training on other necessary areas including the Mental Health Act (MHA), Safeguarding, Safe Observations and Therapeutic Engagement. Most relatives told us they felt staff lacked training specific to learning difficulties and autism and did not understand their relatives' complex needs.
- Managers did not ensure that staff had regular supervision and appraisal. Not all staff received regular supervision, with some staff stating that they have supervision and others not. Some staff had to request their supervision, rather than there being a formal supervision process in place. Staff also did not understand who was responsible for facilitating their supervision. Managers told us that the supervision model within the hospital had recently been reviewed.
- Most relatives told us they were not involved in making decisions or planning of their relatives care and had not been asked for their views. Relatives we spoke with told us that staff also did not help families to give feedback on the service and that the complaints procedure had not been explained to them. Some relatives told us they would not feel comfortable raising concerns to the provider.
- The multidisciplinary team did not always support each other to make sure people had no gaps in their care. Some staff told us that information was not always communicated to them in a timely way from the multidisciplinary teams and ward managers, and between disciplines where records were not updated. This sometimes led to delays in delivery of care. We observed that team meeting documents were inconsistent and lacked any assurance that necessary information was being delivered between ward and senior levels.
- The service had incorporated Right Support, Right Care, Right Culture into their current quality improvement action plan, however this was still not embedded into the culture, environment and model of care within the service.
- Leadership was not always effective and governance processes did not always ensure the service kept people safe, protected their human rights and provided good care, support and treatment. Not all ward managers were based on

the wards in which they managed, making them less accessible to staff. Leaders did not recognise the necessity for staff to have consistent support and training to meet the needs of the people using the service. There were a lack of processes and systems in place to address concerns, including requirement notices issued previously. This meant that there had been little to no change in areas where improvement would have been expected.

- Managers did not always share lessons learned with the whole team and the wider service. The hospital held learning review meetings to explore any learning from incidents, safeguarding concerns and complaints. These were further discussed within the monthly internal clinical governance meetings and quarterly lesson sharing across the division. However, staff told us that there was a lack of information shared by managers. Systems in place, such as the audit schedule and incident reviews were not effective in identifying issues of performance and risk and ensuring these were managed and improved. The completed audit document did not identify actions required to improve in the areas where the audit indicated that improvements were needed. We saw that audits had identified previous issues with cleanliness and infection control compliance, but these issues were still current.

However:

- The service had some processes in place to safely administer and record medicines use. Medicines were stored safely and securely. Medicines for use in emergencies were easily accessible to staff. Staff reviewed each person's medicines regularly and provided advice on their medicines. Staff could access advice from a clinical pharmacist either during in person visits that occurred at least monthly or by telephone or email outside of these times. There was a weekly meeting where people's treatment including medicines were discussed by a multidisciplinary team of healthcare professionals. Staff were able to demonstrate the impact of people's medicines on their treatment and how care plans would be updated with new treatment plans if needed.
- People's risks were assessed, recorded and reviewed regularly by the multidisciplinary teams, including after any incident and at monthly multidisciplinary meetings. People were involved in managing their own risks whenever possible. People were engaged in developing their care and PBS plans to help them understand how they viewed their needs and communication styles and what helped them at times of upset or anger.
- We had feedback that from people we spoke with who said that staff treated them well and behaved kindly.
- Most staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, and the Mental Capacity Act 2005.
- When discharge was agreed, staff worked well with services that provide aftercare to ensure people received the right care and support in place they went home. They also held multidisciplinary discussing and planning meetings to support the person and keep them informed of plans and changes.
- People could give feedback on the service and their treatment and staff supported them to do this. We saw community meeting minutes for ELS, Folkestone, Maidstone, Poplar and Rochester wards and could see that regular community meetings took place on these wards which gave people the opportunity to develop and improve the service.

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 	

Summary of findings

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Background to Cedar House

Cedar House is registered to provide the following regulated activities;

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury

Coveberry Limited took over as provider of Cedar House on 30 November 2020, when the service was rated 'inadequate'. The first comprehensive inspection under this provider was carried out on the 8 and 9June 2021 where it was rated 'requires improvement'. At this previous inspection, the provider was given two requirement notices:

- The provider must ensure that they continue to make improvements in line with their improvement plan and in a timely manner. These must then be sustained to ensure safe care and treatment for people using the service. (Regulation 17)
- The provider must look to bring the built environment and model of care in line with right support, right care, right culture. In the meantime, it must ensure that current improvements to the environment are completed so that people are in an environment that is safe, well maintained, and meets their physical and sensory needs. (Regulation 15)

Upon reviewing the progress of these at this recent inspection (January 2022), we did not observe significant improvements that confirmed that the provider had fully addressed these breaches and areas of improvement. Therefore, these breaches remain in place.

There was no registered manager in post at the time of inspection, but an interim hospital director was in place who was assuming the responsibilities of the registered manager. The new registered manager was due to start in April 2022.

What people who use the service say:

People spoke positively of the physical healthcare provided, especially from the doctors at the hospital, the visiting GP and any external appointments that were facilitated.

People said that they could phone their relatives to keep in contact and that they facilitated visits in the visitors cabin.

All people spoke positively of most staff and felt they were respectful, kind and helpful.

Some people told us that they had bedroom keys and access to games and ward phones.

Although, people told us that the environment was not always comfortable. Some told us that it was too hot on the wards and that the mattresses were uncomfortable.

People told us that they did not always feel safe on the wards due to other people and when there was only one member of staff on the ward. One told us that they found restraint frightening.

Summary of this inspection

People said that there were often staff shortages and that this affected them taking leave and engaging in activities. One told us that they were often unclear on whether they were able to go out until the day as staff did not know who would be working. Another told us that they "cannot do any activities and were just stuck on the ward".

Some people we spoke with were critical of the food available saying that it was bland, and menus were repetitive. Some told us that they preferred to cook their own food and another told us that they sometimes did not get to choose from a menu and were just given what was there. They all said that the desserts were the same. One told us that staff catered to their personal dietary requirements of liquidising food.

What carers and relatives of people who use the service say:

Relatives we spoke with told us they would see their relative in the visitor's cabins or speak with their loved one on the telephone when staff were available to enable them to use a phone.

Although, relatives told us there was a lack of staff and heavy reliance on agency staff. They told us that staff shortages impacted escorted leave and outdoor activities which were regularly cancelled, and communication, with telephone calls and emails not followed up or responded to.

Four relatives we spoke with told us they felt staff lacked training specific to learning difficulties and autism and did not understand their relative's complex needs. Two relatives told us their loved ones had said that they found the ward environments noisy and the lighting very bright. They also told us that mealtimes were inflexible, and that the service provided unhealthy food options which were limited.

Four relatives we spoke with told us they felt their loved one was heavily or over medicated. Four relatives we spoke with had concerns for how their loved one's physical needs were being met.

Relatives told us they were not involved in care planning and had not been asked for their views. Four relatives told us they felt their loved ones were not encouraged to become more independent and staff did not support them to make independent choices.

Relatives that we spoke with told us the complaints procedure has not been explained to them. Two relatives told us they would not feel comfortable raising concerns to the provider. Four relatives we spoke with told us they have not been supported with a carer's assessment.

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?

Summary of this inspection

• Is it well-led?

The team that inspected the hospital comprised of five CQC mental health inspectors (two remotely), one CQC medicines inspector, one CQC adult social care inspector, one specialist advisor, and one expert by experience (remotely). The specialist advisor had professional experience of Occupational Therapy with people with learning disability and autism. The expert by experience had lived experience of caring for an adult relative who had a learning disability and complex needs and who had been detained in assessment and treatment units.

Before the inspection visit, we reviewed information that we held about the hospital.

During the inspection visit, the inspection team:

- Spoke with 22 people who use the service
- Spoke with five relatives
- Carried out five direct observations of care using the Short Observational Framework for inspection (SOFi). SOFi is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions
- Undertook tours of the hospital site including; the clinic rooms and ward environments for Folkestone Enhanced Low Secure (ELS), Folkestone, Rochester, Maidstone, Tonbridge and Poplar, the hospital seclusion room, the gym and the activity and education centre
- Looked at seventeen care records and administration charts for people using the service
- Looked at nurse and doctor reviews for a person in prolonged seclusion on ELS
- Looked at 11 positive behaviour support plans
- Reviewed the records around three instances of rapid tranquilisation
- Attended and observed My Aims and Goals (MAG) multidisciplinary review meeting for three people
- Spoke with 38 members of staff including: nurses, support workers, occupational therapists, occupational therapy assistants, an assistant psychologist, PBS support workers, a PBS lead, a speech and language therapist, activity coordinators, kitchen staff, mental health act administration, a social worker, health and safety lead, ward managers, a consultant psychiatrist, head of psychology, head of nursing and interim hospital director
- Reviewed a range of policies, procedures and other documents relating to the running of the service
- Reviewed the Closed Circuit Television (CCTV) of nine randomly selected incidents recorded on the hospital incident log over a recent four week period

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that staff are managing risk and safety through appropriate observations. (Regulation 12)

Summary of this inspection

- The service must ensure that it has effective systems and processes in place that appropriately identify compliance and performance issues and to take action as appropriate. This includes reviewing all incidents to ensure that recording is accurate, necessary actions are taken and that lessons learnt are identified. (Regulation 17)
- The provider must ensure that staff fully understand and are confident in delivering positive behaviour support (PBS) plans and that the effectiveness and quality of this is monitored. (Regulation 9)
- The provider must ensure that all people are receiving supportive and appropriate meaningful staff interaction in line with their care and support plans. (Regulation 9)
- The provider must ensure that all ward environments, especially one annexe, the Folkestone ward and ELS, and the seclusion room, meet the basic human rights of the people using these and the Mental Health Act (1983) Code of Practice. This includes ensuring safety, comfort, privacy, dignity, and free access to fresh air. (Regulation 13)
- The provider must ensure that all environmental risks, building maintenance, décor and issues with standards of cleanliness across the hospital are identified and acted upon in a timely way. (Regulation 15)
- The provider must ensure that all staff have sufficient training, competency and supervision to enable them to effectively support the people at Cedar House. (Regulation 17)
- The service must ensure it embeds effective governance processes that keep people safe, drive improvement activity, manage the performance and quality of care and support staff. (Regulation 17)
- The provider must ensure that people have regular access to necessary therapies, including psychology, occupational therapy and speech and language, activities and Section 17 leave and that these are not impacted by staffing. (Regulation 18)
- The provider must ensure that care plans are consistent in quality, that they are recovery orientated, goal and discharge focused, and that people are provided copies of these. Where this is not possible or refused, this rationale should be clearly identified. (Regulation 9)
- The provider must ensure that communication between senior staff and ward staff is improved and that information, such as learning from incidents and complaints or changes made from multidisciplinary decisions, are shared consistently with staff through regular team meetings and information sharing processes. (Regulation 17)
- The provider must ensure that it embeds the guidance from Right Support, Right Care, Right Culture into its environment and treatment for people with a learning disability or autistic people. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure that the policies and actions set out for reducing restrictive practices are embedded as proposed.
- The service should ensure that medicines administration records are completed accurately with no blank entries.
- The provider should consider making improvements to the environment to ensure these are appropriate and meet people's sensory needs.
- The service should ensure that relevant information is available and visible in all necessary formats for all people across the hospital.
- The provider should ensure that they are working proactively with carers/relatives to involve them in the care and treatment of their relatives and the wider improvement of the service.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. They did not always meet peoples sensory needs.

Safety of the ward layout

Staff could not always observe people in all parts of all wards. Due to the corridor layouts of most of the wards, not all areas were easily observable by staff. On Tonbridge, Maidstone, Rochester and Poplar wards, the wards had floors and staff were not always seen to be observing these areas. On the Enhanced Low Secure (ELS), although the main nursing office was at one end of the corridor and the communal areas at the opposite end, risk on this ward was mitigated as all people were on line of sight observations due to risk. However, observation levels were not always carried out as described in their care plans. Via CCTV, we observed a person on line of sight observation from staff at all times, receive no observation from staff over a one-hour review period.

CCTV was only available on ELS, Folkestone and Rochester wards. The remaining wards, activity centre and external communal spaces did not have any CCTV. The CCTV system available was of poor quality, did not cover all accessible areas and had incorrect time stamps which made reviews of any incidents inefficient.

Rochester, Tonbridge, Maidstone, Folkestone wards and the ELS were all based within a secure perimeter fence. However, people were only able to freely access the secure outdoor space allocated to their wards without staff assistance. ELS and Folkestone did not have a lockable gate on the allocated outside area and so people on these wards relied on staff if they wanted to access fresh air. This issue was noted in ward level clinical improvement minutes which was fed into the governance meeting in November 2021, yet this was still not resolved by the time of our inspection.

An annexe for one person was attached to these wards and this also did not have any secure outdoor space which the person could freely access to exercise and receive fresh air without staff assistance. This person's access to fresh air took

place once or twice a day via a walk, however we were told that when there was no access to fresh air this was due to the person's presenting risk and occasionally, due to insufficient staffing. Other people using the service were also unable to access the communal secure outdoor space whilst this walk was taking place. In addition, this person's food and drink were being given through windows or placed onto the floor by the entrance door whilst the person was to sit on the bed. Despite staff efforts to improve the living environment for this person and enable a robust and secure setting, we observed that it lacked any warmth or comfort other than a bed.

The hospital had ligature risk assessments on each ward which identified ligature risks. However, the actions on these did not display completion dates, for example actions often stated, "ongoing maintenance". On ELS, they did not have the recent version for reference within the staffing area.

Staff told us that daily checks were carried out on each ward to locate and check the emergency ligature cutting equipment. We saw in the hospital governance meeting minutes that these checks were frequently not completed. At the time of inspection, annexe A which had its own separate entrance and was not directly accessible from the adjacent ward, did not have the required emergency ligature equipment available. As such, this annexe did not have an emergency ligature equipment check. This was raised following an incident involving the person within the annexe, who had already been identified as having a ligature risk. Staff had to seek ligature cutters from the adjacent locked ward. Managers told us that they had ordered ligature cutters for the annexe.

The hospital had an alarm system which was seen in use during inspection. This signalled on all wards when an incident was taking place in order to request assistance. However, staff told us that the response was not always prompt, especially on weekends. Staff told us that this was mostly down to low staffing levels and being unable to leave the wards to assist when the alarm sounded. Staff also used personal radios for safety, and these were observed to be loud when signalling.

Maintenance, cleanliness and infection control

Whilst there had been some improvements made to the activity and education centre and some ward areas were being repainted, all wards we visited looked tired and showed signs of damage including damaged flooring, boarded up windows, stained bathroom suites, broken external vents, rotten window frames, damaged curtains, damaged furniture, dirty doors, leaking baths and sewage issues, broken fixtures and perspex screens for TV units being marked and smeary. We also observed fire doors being wedged open with paper and tissue on Maidstone ward. Maintenance issues were not identified and repaired in a timely way. This disrepair impacted on the overall wellbeing of people and the environmental damage we observed could cause physical harm to people using the service.

The wards were also visibly unclean. Three housekeeping staff were contracted to clean each ward twice a week. Ward staff, who were already strained, were responsible for the remainder of daily cleaning on the wards. Cleaning records were available and up to date, however within a recent hospital clinical governance meeting, it was documented that cleaning schedules had been signed by staff when cleaning had not actually taken place. A weekly cleaning book audit was completed by the health and safety lead to audit cleaning records however, the wards were still found to be unclean during inspection. In addition, a cleaning audit provided to us clearly identified issues with cleanliness and infection control compliance, yet failed to identify any improvement actions.

Staff did not always follow infection control policy. At the time of the inspection, the hospital was in a COVID-19 outbreak status due to staff, and a few people using the service, having contracted COVID-19. On inspection, we observed staff not wearing masks appropriately and in one case, observed to not be wearing a mask at all. We also observed staff not wearing masks appropriately within some of our CCTV reviews. Within clinical governance meeting from November

2021, it was stated that staff were breaching the requirement to wear face masks whilst at work and that they had emailed staff to remind them of this requirement. Given our observations on inspection, improvement was still needed following this communication. Care staff were also observed to be wearing nail varnish, nail enhancements and were not bare below the elbow. This was also identified within the last infection control audit in October 2021.

Seclusion room

The hospital had one seclusion room based on the ELS. This room was not fit for purpose and did not meet the Mental Health Act (1983) Code of Practice. There was no lockable gate for the external patio area which meant that someone under seclusion would not be able to access any fresh air or exercise. The room itself was small and there were concerns as to whether a person could be safely managed and restrained if necessary, within the space. The observation window from the staff office was marked and damaged which impacted the visibility into the room. There was no dimmable lighting within the room, therefore making it either brightly lit or not lit at all.

The seclusion room toilet and shower facilities could be observed through windows in both the staff observation area and the de-escalation area. Staff maintained the privacy and dignity of people using the bathroom facilities by ensuring that the blind was closed within the observation area, however, this did not prevent the viewing of staff situated within the de-escalation area. Following initial feedback, the hospital has installed a blind in the de-escalation room.

There was an intercom system which had recently been installed and a manual battery-operated clock which could be seen from the seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked every day. Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing staff. The staff employed by the service did not always know the people or receive basic training to keep people safe from avoidable harm.

Nursing staff

The service had significant issues recruiting and retaining both registered nurses and support staff. As a result, the service maintained staffing levels by use of regular agency staff. Managers told us that they were in the process of employing international nurses into support worker positions, in hope of reducing the reliance on agency staff.

The staffing levels differed between the wards depending on the observation levels of people however, staffing issues meant that observation levels were not always able to be maintained with people as described in their care plans. Staff told us that frequent need for restraint and rapid tranquilisation on ELS, as well as assaults and injuries on staff meant they struggled to fill the shifts. On the inspection, staff told us that there should have been 12 staff on shift on ELS, but they were operating with seven including one staff member from another ward. Whilst they maintained minimum numbers for observation requirements, this often required them borrowing staff members from other wards, but they would not have enough people to ensure breaks could be taken. We saw that observation levels were unable to be maintained in the instance where a staff member required a break.

Inadequate

Wards for people with learning disabilities or autism

Managers told us that 8.6% of shifts were below baseline nurse staffing. The service also told us that in the last three months, 32% of shifts were covered by agency staffing, 61.3% of shifts were covered by permanent staff and that there was a 6.7% shortfall of unfilled shifts.

However, staff told us that Tonbridge and Poplar wards were often left short due to staff being sent to higher priority wards. Staff also told us that there were not enough nurses employed across the hospital and that they felt they were unable to fulfil their roles properly due to undertaking multiple roles across wards. They told us that this meant people did not always get their needs met including delays in medication being administered, as well as increased sickness and stress for staff.

People had their escorted leave or activities cancelled due to the service being short staffed. People using the service and their relatives told us that staffing shortages often meant that leave and activities were cancelled. Staff also told us that the staffing issues often meant that people had postponed leave and reduced activity. The senior nurse on shift was responsible for allocating staff to wards dependent on need and any staff shortages. Ward staff told us that they could not access the ward rotas in a timely way and that these were not updated in real time to reflect staff changes. They told us that this impacted on handovers, where they were unable to ensure enough staffing would be available for leave and arranged activity.

Managers told us that they mostly used agency staff familiar with the service. The induction received by agency workers was a ward-based induction carried out by the senior member of staff on duty. Staff told us that agency staff often did not turn up for shifts, did not familiarise themselves with care plans and positive behaviour support (PBS) plans and that the high use of agency staff contributed to a lack of consistency and familiarity for people using the service, and staff, who often would not know who they were working with day to day.

However, people had the opportunity to have one- to-one sessions with a member of staff and there was always a staff handover on both day and night shifts to discuss key information and updates.

Medical staff

The service had two permanent and one locum consultant psychiatrists, each holding two wards each. All people were registered with a local GP practice. The GP would visit the service once a week to provide physical healthcare and monitoring for people using the service and the GP was also available for urgent issues in between their weekly visits. The consultant psychiatrists also provided out of hours medical cover for nights and weekends. Consultant psychiatrists gave examples of positive practice carried out by staff in the event of an emergency and we also observed an incident via CCTV where staff responded in a timely way to an emergency. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

We reviewed the mandatory training records both provided and embedded within governance meeting minutes. These showed that not all staff had completed their mandatory training to ensure they had the skills to carry out their roles to meet the needs of people. Staff told us that they were to have seconded days to complete training, but the lack of staff impacted on their ability to have these.

Whilst the overall compliance was 84%, we found that 46% of staff had completed face to face manual handling, 77% had completed face to face emergency first aid and basic life support training, 74% had completed fire safety at work e-learning and 68% had completed mental health awareness e-learning. The hospital told us that face to face training resource had been impacted by COVID-19.

The mandatory training offered to staff was not sufficiently tailored to work effectively with the needs of the people at the service. There was a half an hour mandatory input on the Mental Health Act (MHA) given at induction. There were no mandatory training courses for Learning Disability and Autism. Relatives told us they felt staff lacked training specific to learning difficulties and autism and did not understand their relative's complex needs.

Assessing and managing risk to people and staff

Staff assessed risks to people and themselves. However, they did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to support peoples' recovery. Staff did not have the skills to implement good positive behaviour support plans and did not always follow best practice in anticipating and de-escalating challenging behaviour, before it needed to be managed. On most wards, they used restraint and seclusion only after attempts at de-escalation had failed, however on some wards restrictive interventions were more frequent.

Assessment of people's risk

Staff completed risk assessments for each person on or prior to admission, using a recognised tool, and reviewed these regularly, including after any incident and at monthly multidisciplinary meetings. We reviewed seven risk assessments had been completed and were up to date.

Staff and managers told us that some people were inappropriately placed and that their presenting risk required alternative environments in order to suit their needs and care. Managers told us that these people's risk had increased since admission. Some staff expressed concern that the hospital was not meeting the needs of all people at the service.

Management of people's risk

The hospital had rolled out the use of positive behaviour support (PBS) plans across all but one ward. However, most staff we spoke with did not explain its purpose of identifying the triggers for people when behaviours showed an escalation of risk, what action would benefit the person in diffusing the situation before it became a more serious event and to aid in understanding a person's behaviour. These plans were also not linked in with people's care plans or risk assessments and were saved as a separate document on the internal computer system. Staff told us that often the latest information about risks discussed within multidisciplinary meetings were not always being shared in a timely way with staff.

Staff followed the service's policies and procedures when they needed to search people or their bedrooms to keep them safe from harm. Staff told us that they would search people's bedrooms only when necessary for security checks and would always seek consent and to explain to the person the need for this.

Use of restrictive interventions

From the most recent data provided to us, in October 2021, levels of restrictive interventions had increased overall for the hospital, although the increases had been on ELS and Rochester ward, with incidents on Maidstone and Folkestone

wards decreasing and Tonbridge and Poplar wards remaining the same. The numbers of recorded incidents for physical interventions were considerably higher on ELS, compared to all other wards and one person had contributed significantly to the figures. We saw that staff were using least restrictive practices before using physical intervention and some staff also told us that at times they often put themselves at risk in order to avoid using restraint.

Rapid tranquilisation was frequently used on the ELS. One person we reviewed had multiple daily uses of PRN medicines for the management of agitation and aggression, including 18 administrations of both oral and intramuscular rapid tranquilisation over the past month. PRN medicines are medicines administered as circumstances require and are not scheduled.

The hospital had a reducing restrictive interventions risk assessment and action plan; however, some areas had not been reviewed since February or March 2021. The service provided a revised draft policy which acknowledged areas of required action including communication of the new policy with staff and people using the service, governance and audits which would see any practices without rationale removed from the service, and training delivery for staff on restraint reduction practices. The policy was due to be shared with staff and service users by December 2022 however at the time of inspection we received a draft version. The rest of the plan was expected to be finalised by February 2022 therefore this had not been embedded at the time of the inspection.

The service had blanket restrictions including the possession of batteries following a previous incident. Blanket restrictions are restrictions which are routinely applied to all people within a service. Whilst the service had battery contracts to enable regular battery checks on any items, people using the service did not have access to a personal mobile phone because of this restriction. Governance minutes from November 2021 identified an internal proposal for this to be reviewed in line with the Code of Practice recommendations.

Safeguarding

The provider had training available for staff on how to recognise and report abuse. The compliance data showed that 88% of staff had completed safeguarding children and 87% of staff had completed safeguarding vulnerable adults. Managers told us that they had monthly meetings with local authority safeguarding teams to discuss safeguarding concerns.

There was, however, inconsistent knowledge and understanding from staff around safeguarding. Some staff were able to identify that it involved protecting people from harm and that this could involve other people and staff however, they only gave examples of physical abuse. Other staff we spoke with appeared very limited in their knowledge of safeguarding.

However, all staff did know how to escalate any concerns and told us that this would be to management and safeguarding leads within the service who then reported it directly to the local authority safeguarding team.

Staff access to essential information

All information relating to people using the service was stored electronically with a secure password for access. All notes could be electronically and securely transferred should the need arise. However, staff told us that the information shared between multidisciplinary teams was not always easily accessed as recording system was not always updated.

Medicines management

Wards for people with learning disabilities or autism

Staff used an electronic system to prescribe and record the administration of medicines. The person's GP and consultant psychiatrist had access to the prescribing system, meaning there was no delay between a decision being made to prescribe and the prescription being available to be dispensed and administered. The clinical pharmacist was able to provide clinical input and advice. They could leave comments on people's records which would then be seen and actioned by the prescriber. Medicines were dispensed by an external pharmacy. Each ward held an amount of stock medicines to meet people's needs, but anything that was unavailable could usually be delivered within a day or obtained from a local community pharmacy if needed sooner. The electronic system reminded staff when medicines were due and ensured that there was an appropriate gap between doses. Consent to treatment documents were in place and adhered to for all people at the service.

Staff reviewed each person's medicines regularly and provided advice on their medicines. Staff could access advice from a clinical pharmacist either during in person visits that occurred at least monthly or by telephone or email outside of these times. There was a weekly meeting where people's treatment including medicines were discussed by a multidisciplinary team of healthcare professionals. At least two people were reviewed each week and they were able to input into these meetings to ask for increase or reductions in dose or changes to prescribed medicines to meet their needs. Staff were able to demonstrate the impact of people's medicines on their treatment and how care plans would be updated with new treatment plans if needed.

Staff usually ensured that medicine records were accurate and up to date. However, on two wards we saw people with missed doses. Staff believed this was a computer recording error rather than a missed dose of a medicine. The provider told us that the external pharmacy undertook regular audits of omissions and sent the reports to the hospital. However, staff did not appear to be aware of any process outside of this audit to ensure that medicines were given and that the records were updated accordingly. We asked the provider to review these and ensure staff were properly recording information when a dose was administered or omitted so the records reflected what happened.

Staff stored and managed all medicines and prescribing documents safely. Access to medicine storage areas and cupboards were appropriately restricted. Medicines were stored appropriately so that they remained safe and effective for use. The service used temperature probes to monitor fridge and ambient room temperatures. They continually record the temperatures of the environment. There was a remote system which would alert staff to temperature excursions as they happened.

Staff learned from safety alerts and incidents to improve practice. Medicines audits were carried out by the external pharmacy provider as well as 'informal' audits being conducted more frequently by the nursing associates who administered medicines. Staff had systems to review medicine incidents and ensure that learning was shared with the other wards on site.

Most relatives told us they felt their loved ones were heavily or over-medicated due to confusion and slurred speech when they were in contact. We reviewed the full documentation for three instances of rapid tranquilisation and found the correct monitoring had been completed after its use to ensure the safety of the people. When rapid tranquilisation was given, an incident form was completed. Debriefs were held with people to find ways to prevent its use in future. Use of 'when required' (PRN) medicines and rapid tranquilisation to manage agitation and aggression was also low on all wards except ELS, where these were used frequently. If a medicine was used, it was at the lowest available dose. Records were completed showing why it was needed and if it was successful in achieving the desired outcome.

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). The consultant psychiatrists on the wards worked towards reducing doses of people's medicines to ensure they maintained the correct therapeutic response at the minimum possible dose. Staff were able to provide examples of people whose medicines had been reviewed and altered in line with STOMP principles.

Staff reviewed the effects of each person's medication on their physical health according to the National Institute for Health and Care Excellence (NICE) guidance. Staff ensured that each person's physical health was monitored regularly. Nursing associates were responsible for much of the routine physical health monitoring of people, but a GP also visited the service each week. A full physical health check was carried out every month. Any medicines or treatment regimens that required additional monitoring had these carried out within the required timeframe. The service was aware of which people were on high dose anti-psychotic treatments and had increased physical health monitoring in place for these people.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff did not always report incidents appropriately. Managers did not always investigate incidents and share lessons learned with the whole team and the wider service. We could not identify that when things went wrong, staff apologised and gave people honest information and suitable support.

The hospital held learning review meetings to explore any learning from incidents, safeguarding concerns and complaints. These were further discussed within the monthly internal clinical governance meetings and quarterly lesson sharing across the division. However, some staff told us that there was a lack of information shared by managers. We reviewed team meeting documents from the service for four of the six wards. There was no consistency with these minutes, or the information contained within them, and no agenda for shared learning or incidents to assure that the information discussed on this at the higher governance meetings was then shared.

Staff knew what incidents to report and how to report them. We reviewed nine CCTV incidents to check that the recording of these incidents was accurate. The majority were as described; however, we did review an incident where this had not been accurately recorded and indicated that the person involved had been antagonistic when we actually observed omissions of care by the staff in place to support this person. We informed the provider of our findings and they informed us that they would investigate further

The hospital had an audit schedule in place which reviewed incident records, complaints and duty of candour. The last audit in November 2021 reviewed four cases. This audit also identified that incidents were reviewed at daily handover to ensure that they were accurately reported and that appropriate actions were taken. However, as evidenced from our review of CCTV above, the accuracy of recording and appropriate actions taken, were not always verified by managers.

The service provided a complaints and compliments document which identified the details of complaints raised and the status and outcomes of these. However, they did not identify any actions taken in instances where they were upheld. Managers did not always debrief and support staff after any serious incident. Clinical governance minutes show debriefs and reflective practice as a working agenda, however staff told us that they felt there was not enough support provided to debrief following incidents. Managers told us that this process was being formalised although this had not been embedded.

Inadequate

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not always work with families and carers to develop care and support plans. Some care plans reflected the assessed needs, were personalised, holistic and strengths based, though these were not always consistent in quality and these were not always recovery orientated or goal focused.

Staff completed a mental health assessment of each person either on admission or soon after. People had their physical health assessed and regularly reviewed during their time on the wards. Changes in peoples physical health were identified through National Early Warning Score (NEWS2) monitoring tool which then indicated a score for action to be taken to treat the individual. Where there was identified deterioration in physical or mental health multidisciplinary team crisis meetings were held.

We saw evidence of four care plans on Poplar ward which were thorough, and addressed aspects of the persons physical, psychological and social care needs. However, this was not always consistent, and we saw that three care plans on Rochester ward, for example, did not appear to be holistic and were not of the same quality. Five out of seven care plans were not recovery orientated or goal focused. Some relatives told us that they were not involved in care planning and had not been asked for their views. Most relatives had concerns for how their relatives needs were being met and told us that staff did not communicate this information to them.

Not all people had discharge plans with clear timeframes in place to support them to return home or move to a community setting. We saw evidence of discharge planning in care plans on Poplar ward, but this was not seen in other wards. We were told that discharge planning started when a person was ready, rather than upon admission with goal orientated care focused towards this outcome. This could lead to delays in discharge because people's care was not necessarily focused on this outcome.

Positive behaviour support (PBS) plans were present on five out of six wards and were supported by a comprehensive assessment. The service had introduced monthly positive behaviour support review meetings to discuss and review the plans in place. These were then reviewed by PBS leads. However, staff had limited understanding of PBS plans and were not able to identify their role in providing the identified care and support, and how to use PBS plans effectively. Staff were also inconsistent in their knowledge of who was responsible for ensuring these were being used. We observed that the PBS plans in place were being used for behaviour management for violence and aggression, but not as an overall holistic model of care or with the day to day understanding of people's behaviour.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for people based on national guidance and best practice. They did not have regular access to psychological therapies, support for self-care and the

development of everyday living skills and meaningful occupation. However, staff did support people with their physical health and encouraged them to live healthier lives. Staff did use recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The service had an activity and education centre which had a range of facilities including a sensory room, IT suite, kitchen and gym. We were given examples of some of the activities available both on and offsite including camping, music, swimming, trampolining, gardening projects, working with animals, cooking, art and shopping. Whilst these appeared available, not all were observed taking place at the time of inspection.

People using the service, relatives and staff told us that staff shortages affected outdoor activities and meant that there was less opportunity to engage in activities. One person told us that they were unable to do any activities due to staff shortages and that they just stayed on the wards. Relatives told us their loved ones spend all day watching TV and that they had no access to education or work opportunities. We observed little meaningful activity taking place on the wards with people.

Staff did not always provide a range of treatment and care for people based on national guidance and best practice. At the time of inspection, the service was reviewing how psychology services were delivered to people at the hospital. This was being supported by a contracted external psychologist who had previously worked at the service before leaving in August 2021. There was a forensic psychologist employed at the service two days a week, as well as assistant psychologists, with further recruitment currently underway to fulfil the in-house psychology team. Managers told us that psychology had more availability to meet the people's needs, however, staff reported a lack of psychology presence on the wards and felt that this had impacted people within the service. One person had complained at the length of time it was taking to be able to engage in therapy that they wanted to do.

The service employed occupational therapists (OT), occupational therapy assistants (OTA), and activity coordinators (AC). Managers told us that there had been an increase in OTA's and AC's and that they had undergone a workforce consultation to base these within ward teams to enable increased ward-based activities. However, staff told us that AC's were now being used to backfill support worker numbers on the wards and that this was impacting them being able to fulfil their role and deliver activities. The service also had a speech and language therapist (SaLT) however staff told us that they felt this provision needed increasing as currently the SaLT was only available two days a week across all six wards.

The service employed a physical health nurse whose role was to ensure that people's physical healthcare needs were identified and addressed. The service had regular access to a local GP service who attended the service weekly and people told us that they could request to see them. People also told us that the service also enabled access to community specialists including dentists, opticians and emergency services when required and appropriate. Although, it was noted in advocacy feedback within October 2021 governance minutes that some people's medical appointments had been missed due to staff shortages.

Staff met people's dietary needs and assessed those needing specialist care for nutrition and hydration. One person told us that they required liquidised food due to dental issues and this was accommodated by the hospital.

Some staff helped people live healthier lives by supporting them to take part in programmes or giving advice. We saw evidence on some wards of healthy eating posters and some staff told us that they encouraged people to adhere to a healthy lifestyle through healthy eating and exercise.

Staff used the recognised rating scale of National Early Warning Score (NEWS2) to assess and record the severity of people's conditions and care and treatment outcomes. Managers told us that they completed outcome monitoring and tracked the progress of each person to ensure discharge. However, we did not see evidence of discharge planning in all people's records.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service provided a self and peer review from November 2020 undertaken by Quality Network for Forensic Mental Health Services. Managers also told us that they had a positive peer relationship and shared good practice with a local sister NHS unit.

Managers told us that the current audit schedule was under review and that this was being revised as part of the new governance structure being introduced. The current audit schedule included audits on care plans and risk assessments, infection control, health and safety, service user and family engagement and restrictive practice. However, the provided completed audit document did not identify actions required to improve in the areas where the audit indicated that improvements were needed. For example, the cleaning audit had identified previous issues with cleanliness and infection control compliance, however there were no improvement actions identified and these issues were still found to be present during inspection.

Skilled staff to deliver care

The ward teams did not have access to the full range of specialists required to meet the needs of people on the ward. Managers did not make sure that they had staff with the range of skills needed to provide high quality care. They did not always support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new permanent and flexi/bank staff, however this was considered insufficient for the needs of people using the service.

Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. Although managers provided an induction to new starters at the service before they started work, this was insufficient and did not meet the needs of people using the service or staff. Staff received one-hour training on understanding learning disabilities, three hours on effective communications and introduction to autistic spectrum conditions, half hour on Mental Health Act (MHA), three hours on safeguarding, and one hour 15 minutes on safe observations and therapeutic engagement. This was not adequate time to provide staff with the necessary skills to provide effective care to the people at the hospital.

Relatives told us they felt staff lacked training specific to learning difficulties and autism and did not understand their relatives' complex needs. Staff we spoke with told us that they did not get any specific training around learning disabilities and autism and some staff told us that they were unsure if they had enough training to do their role competently. Bank and agency staff were provided a ward-based induction carried out by the senior staff member on the ward at the start of a shift however, staff told us that agency workers did not familiarise themselves with PBS and care plans.

Managers did not always support staff through regular, constructive clinical supervision or appraisals of their work. Some staff told us that they had had supervision, whereas others had not. Some staff we spoke with identified that they had requested supervision, rather than there being a formal supervision process in place and most staff told us they would like frequent supervision. Staff also did not understand who was responsible for facilitating their supervision. The compliance data provided for hospital wide supervision was 83.6% for November and 60.7% for December. The provider told us that December's figures were impacted by the COVID outbreak at the time. Managers told us that the supervision

model within the hospital had recently been reviewed and a new process had only recently been implemented as the previous model which involved one person carrying out all supervisions had been unsustainable and was affecting quality. They were in the process of collating the data for the new structure at the time of inspection and hoped to have all supervision completed by the end of February.

Staff told us that they were supposed to have seconded days to give them the time and opportunity to develop their skills and knowledge with mandatory training, however the lack of staff impacted on their ability to do this.

We reviewed team meeting minutes for all wards for the last three months. We saw that team meetings were happening on most wards. However, the intervals between meetings and the agenda and minutes for these meetings were inconsistent across the hospital, with the minutes of meetings for Tonbridge and Folkstone wards not being found. This meant that actions taken at the meetings may not have been shared and understood by all staff.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. However, they did not always support each other to make sure people had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the person's discharge, however they did not engage with them from a person's admission to plan discharge.

Staff held regular multidisciplinary meetings referred to as My Aims and Goals (MAG) to discuss people and their care, and the individuals that were involved were also invited to be present. They also held fortnightly PBS review meetings which all ward staff were encouraged to attend. Most staff made sure they shared clear information about people and any changes in their care and staff told us that there was always a daily handover for staff on both day and night shifts in order to discuss key information and updates in relation to people.

However, some staff did tell us that information was not always communicated to them in a timely way from multidisciplinary teams and ward managers, and between disciplines where records were not updated. We observed delays with individuals waiting to go on leave or to arranged visits as staff were unclear on whether they were able to go and who would be taking them. Staff told us that they were unaware of who would be working on the shift and whether there would be enough staff to enable people to have their leave, which often led to delays and impacted handover. This was due to staff working on the shift not being provided all the information about sickness and absences that would impact the running of their shift.

The service had effective working relationships with local authority safeguarding teams who they held monthly meetings with. There was also regular input and joined up working with commissioners who funded people's care at the hospital. Case managers attended the hospital regularly.

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

Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

The service did not provide regular mandatory training on the Mental Health Act (MHA) and the Mental Health Act Code of Practice. The service provided half an hour of mandatory training for the Mental Health Act (MHA) upon induction and

they provided a Mental Health Awareness e-learning course, however, this was not included within the mandatory training list and staff did not always keep up to date as in the data we received, only 68% of staff completed this training. Staff had inconsistent awareness of the MHA and its guiding principles, with some staff showing understanding, and others very limited understanding.

The service had an MHA administrator and staff were aware that they could go to them for support and advice on policies, procedures and current MHA practice within the hospital. The MHA admin stored copies of people's detention papers and associated records correctly and staff could access them when needed. We saw that these were kept updated and saw evidence that these were audited.

We saw evidence of peoples' rights forms and these identified who did not want them read out, as well as those who did. There was also an accessible rights leaflet that could be printed out to help people understand. However, staff told us that whilst this should happen every three months, sometimes there was a delay in this being done due to short staffing. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to, and people were also encouraged to seek legal advice if they do not agree with their detention.

The service had employed a Mental Health Advocate at the service who attended each ward once a week to speak with people. However, there was a lack of information displayed on the wards for people to be able to access independent mental health advocacy outside of these ward visits. Staff told us that this information had been taken down a few weeks prior to be redone in easy read format.

People could take Section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. However, staff, people using the service and relatives told us that staff shortages often meant that Section 17 leave was cancelled. Section 17 leave is special permission for a person to leave hospital. One person told us that there was not enough staff to take them out for a cigarette which Section 17 leave was required for. This therefore impacted upon the choices of people.

Good practice in applying the Mental Capacity Act

Some staff supported people to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS), however they did not always keep up to date with training, with only 83% having completed it. Some staff told us that this training was "voluntary" however, it was on the mandatory training list.

Staff told us that they were not directly involved with mental capacity assessments and that these were completed by the multidisciplinary teams. They told us that they would escalate to a nurse or ward manager for advice if they were unsure if someone's capacity had fluctuated or changed. Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision and when staff assessed a person as not having capacity, they made decisions in the best interest of people and considered the person's wishes, feelings, and culture.

Are Wards for people with learning disabilities or autism caring?

Inadequate

Wards for people with learning disabilities or autism

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

People told us that most staff treated them with kindness, compassion and respect. Most staff respected peoples' privacy and dignity and enabled them to understand and manage their care, treatment or condition. However, they did not always engage supportively with people.

Staff were discreet and respectful when engaging with people. Staff told us that they provided people a private space to talk. People were not aware and could not tell us who their keyworkers were. We observed some positive interaction between staff and people on Poplar and Tonbridge wards. Most people we spoke with said staff treated them well and behaved kindly, though one person said that some staff did not have the time to engage with them.

Whilst most staff we observed were respectful, we did also see that not all staff engaged meaningfully with people, by encouraging activity or therapeutic engagement. We observed that some staff were not actively engaging with people or assisting them with meaningful activities. On ELS, Folkestone and Rochester wards, staff were observed to be engaging with each other, with infrequent interaction with people they were working with. Whilst carrying out CCTV reviews, we observed staff eating and interacting with laptops instead of interacting with the people they were supporting.

We did not observe meaningful interaction or therapeutic engagement from staff with one person whilst they were in their annexe on prolonged seclusion. Most interaction observed being given to this person whilst in the annexe was music and videos played through a laptop which staff operated from the observation area. This involved the person standing up at the staff observation area. Within a CCTV review we observed another person receive no engagement or observation from two staff members who were responsible for ensuring the person was within their line of sight at all times. These staff members were instead laid down on the person's sofa in a different room and only engaged when the person came to the room the staff were in.

Most staff respected people's privacy and dignity. Staff were able to give examples of how they maintained the privacy and dignity of people. We observed most members of staff knocking on people's bedroom doors and seeking their consent before entering, although there had been an instance on ELS where this was not observed.

The seclusion room toilet and shower facilities could be observed through windows in both the staff observation area and the de-escalation area. Staff maintained the privacy and dignity of people using the bathroom facilities by closing the blind within the observation area, however, this did not prevent the viewing of staff situated within the de-escalation area. Following initial feedback, the hospital has installed a blind in the de-escalation room.

Involvement in care

Staff involved people in care planning and risk assessment and sought their feedback on the quality of care provided. However, they did not always ensure that all people had easy access to independent advocates or involve families in care and decision making where appropriate.

Involvement of people

Inadequate

Wards for people with learning disabilities or autism

Staff introduced people to the wards and the services as part of their admission. Staff gave people a welcome booklet upon admission and told us that staff from cedar house visited the transferring service prior to admission to reassure the person.

There was evidence in some care plans that peoples wishes, feelings, culture and needs had been referred to. However, this was not always consistent across care plans we saw. We did not always see evidence that care plans and risk assessments were always given to people or where people did not want a copy, this was not always clearly identified within care plans.

Staff supported people to understand and make choices for themselves and their own care treatment or condition. For example, staff told us that in developing PBS plans, they engaged people to help them understand how they viewed their needs and communication styles and what helped them at times of upset and anger. We also observed in a multidisciplinary meeting that people were given opportunities to express themselves, and the psychologist and OT's checked the person understood the information contained in the meeting. Managers told us that one person had input into their own bespoke food menu which was seen. However, relatives told us they felt their loved ones were not encouraged to become more independent and that staff did not support them to make independent choices.

People did not always have access to information in appropriate formats. We saw that not all people had communication passports. These are practical tools about people with complex communication difficulties who cannot easily speak for themselves. In addition, the service did not consistently display information on complaints, advocacy and other local services within all communal areas. Staff told us that this was due to the lack of SaLT support and that accessible information was not produced as standard, but rather at the request or need of an individual.

People could give feedback on the service and their treatment and staff supported them to do this. Staff told us that the service held community meetings weekly on each ward. We were provided community meeting minutes for ELS, Folkestone, Maidstone, Poplar and Rochester wards and could see that regular community meetings took place on these wards. These enabled people using the service the opportunity to feedback. However, we did not receive any community minutes for Tonbridge ward.

Some people had easy access to independent advocacy. The hospital had an advocate who visited each ward on a weekly basis to speak with people. However, whilst some wards provided details of advocacy services within communal areas, this was not consistent across all wards, such as ELS, Folkestone and Rochester, where no information was shown. If people were not present on these wards during the weekly visits, then there was little assurance as to how people would know to make contact outside of these visits.

Involvement of families and carers

Staff did not support, inform and involve families and carers appropriately.

Most relatives told us they were not involved in making decisions or planning of their relatives care and had not been asked for their views. Staff did not maintain contact and share information with those involved in supporting people, as appropriate. Relatives had concerns for how their relatives physical needs were being met and told us staff did not communicate this information and had to be chased. All relatives told us that communication from staff was poor and that telephone calls and emails were not followed up or responded to.

Inadequate

Wards for people with learning disabilities or autism

One relative told us that the high number of agency staff contributed to a lack of consistency in what staff were available to speak with. Staff and relatives told us that there was previously a family liaison worker but at present, it was ward managers who were responsible for keeping relatives up to date. A relative told us they felt the ward manager was too busy to cover this job properly.

Staff did not help families to give feedback on the service. All relatives told us the complaints procedure had not been explained to them. A relative told us staff did not inform them of actions or outcomes when issues were raised. Some relatives we spoke with told us they would not feel comfortable raising concerns to the provider.

Staff did not give relatives/ carers information on how to find the carer's assessment. Most relatives that we spoke with told us they have not been supported with a carer's assessment.

Are Wards for people with learning disabilities or autism responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff did not always plan discharge well. Some people had excessive lengths of stay and delayed discharges. However, when discharge was agreed, they liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

Bed management

Managers made sure bed occupancy did not go above 85%. At the time of the inspection, the service had 32 people at the service, out of a potential capacity of 39 and there had been a pause on admissions prior to the inspection. The service had some patients with long lengths of stay, with one patient with a length of stay over 20 years. The shortest length of stay at the time of inspection was 10 months.

The service had a low number of out-of-area placements. An out-of-area placement is when a patient is placed in a service which is far away from their normal home. The service had four out of 32 people from referrers outside of the Kent, Surrey and Sussex commissioning area serviced by the hospital. This ensured people were able to stay close to relatives.

People were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the person. We were aware that some people had been moved due to increases in risk or where wards were not deemed suitable and conducive.

Discharge and transfers of care

The service had three delayed discharges. One person had their discharge delayed for over 10 years. We were told that discharge planning started when a person was ready, rather than upon admission with goal orientated care focused towards this outcome. Managers told us that discharges that were delayed were due to lack of appropriate supported living environments with safe staffing in the community.

People did not always have discharge plans with clear timeframes in place to support them to return home or move to a community setting. Managers told us that they tracked the progress of every person to ensure discharge, however staff told us that discharge planning only started once the person was assessed as suitable. We only observed discharge planning in the records of people on the Poplar ward who had already been on this ward for a long time. With these discharges taking place, this created more ability for the progression of people on other wards who told us that they were looking to move onto Poplar ward.

Within discharge plans, staff worked with community care managers and coordinators. They also held multidisciplinary discussing and planning meetings to support the person and keep them informed of plans and changes.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards did not always support people's treatment, privacy and dignity. Each person had their own bedroom and they could keep their personal belongings safe. There were quiet areas for privacy. The food was not of good quality and people could not always make hot drinks and snacks at any time.

Each person had their own bedroom, which they could personalise. We saw that some people had personalised bedrooms with pictures, posters and artwork. Other people using the service did not have personalised bedrooms and we were told that this was due to risk or personal choice. They shared bathroom facilities.

People could keep their personal belongings safe. Some people had cupboards within their bedrooms, and the service had lockers to secure people's valuable belongings in. One person told us that they hide away their belongings in their wardrobe as people entered their room due to staff not locking this. Some people had their own keys to their bedrooms, whereas others were not given keys due to the outcome of an individual risk assessment.

There was limited space on the wards for additional rooms to support treatment and care, though the service's activity and education centre provided a range of rooms and equipment. However, during inspection we did not always see this space being used and were told that due to COVID-19, wards had allocated slots when they were able to use this building.

The wards were not always appropriate for promoting comfort and meeting the sensory needs of people. For example, Folkestone ward and ELS were both decorated with extremely bright colours and were also considerably noisy which would be overwhelming for people with sensory processing difficulties. Managers told us that former people on the wards had chosen the colour schemes. The noise was often staff radios, and banging coming the adjacent annexe. This banging was heard throughout the bedroom corridor of Folkestone ward and this could be overwhelming for someone with sensitivity to noise, especially at night-time. Some relatives told us their loved ones found the ward environments noisy and the lighting very bright. The service was developing sensory rooms on each ward; however, these were sparse at the time of the inspection.

The service had quiet areas on each ward where people could go for private conversations and private phonecalls. Relatives that we spoke with told us it was not always easy to speak to their loved one on the telephone as it required staff to be available to assist them. A relative also told us they had overheard staff laughing in the background whilst on the phone to their loved one and were unsure whether these were private conversations.

Inadequate

Wards for people with learning disabilities or autism

The service had rooms where people could meet with visitors in private and these were outside of the secure wards and in a portacabin within the main car park. Relatives visited their loved ones in the visitor's room although for two people, individual arrangements were in place to enable visitors into the secure site to see their relative.

We also observed one person in an annexe being given drinks and personal hygiene products through external windows and staff told us that their food was placed onto the floor by the entrance door whilst the person in the annexe was to sit on the bed as there was no other means of passing this to them. Staff were also observed to be communicating with this person through the external side window directly adjacent to the main hospital entrance even though an intercom system had been recently installed. We observed several other staff walking directly past this window to access the rear entrances of Folkestone and ELS and so there was no privacy for this person when these conversations were taking place like this.

On most wards, the service had an outside space that people could access easily. However, on Folkestone and ELS, including the individual annexe, people did not have free access to outdoor space and fresh air and were reliant upon staff to assist with this.

People could make their own hot drinks and snacks; however, they were dependent on staff being available to support with this by unlocking the areas to do this, which may be impacted when there were staff shortages.

The service did not always provide people with a choice of good quality food. We saw four weekly menus for Autumn and Winter which showed a variety of meals for both lunches and dinners. However, most people we spoke with said that the food was bland and not enjoyable. Some told us that they preferred to get their own food. Some told us that they sometimes got to choose main meals, though they never had choice with desserts which were always the same and one also said that they were not shown the menu to make a choice. All relatives told us the service provides unhealthy food options which are limited, and some told us that often their loved ones had a lot of takeaways.

Peoples' engagement with the wider community

Staff did not always support people with activities outside the service, such as work, education, however they did support with family relationships.

Whilst we saw some positive community activities, these were more for social rather than education and work. We were told that before COVID-19, people were offered work experience in the café at Cedar House admin block and that this had been popular. However, due to COVID-19 this had stopped.

Relatives told us escorted leave and outside activities were regularly cancelled as a result of staff shortages and that their loved one had no access to education or work opportunities.

Staff did help people to stay in contact with families and carers. Most relatives told us they could speak with their loved ones on the telephone when staff were available to enable them to use a phone.

Meeting the needs of all people who use the service

The service met some needs of people – including those with a protected characteristic.

The service could support disabled people. The service also provided food to meet the dietary needs of individual people. For example, one person told us that they were given liquidised food due to dental issues. Another person had input into designing a bespoke food menu.

However, staff did not always meet people's communication needs as people did not always have access to information in appropriate formats which staff told us was due to the lack of SALT support.

Staff also did not always make sure people could access information on treatment and services. Some wards provided details of advocacy services and CQC within communal areas, however, this was not consistent across all wards, such as ELS, Folkestone and Rochester, where this information was not on display.

Listening to and learning from concerns and complaints

People could raise concerns and complaints. The service investigated all concerns and complaints. However, lessons learnt and outcomes from these investigations were not always shared with the whole team, wider service and carer/relatives.

The service did not clearly display information about how to raise a concern in all communal areas. However, people using the service were aware of how to make a complaint internally and one person we spoke with was able to detail how they would do this. Staff protected people who raised concerns or complaints from discrimination and harassment. Staff told us that anonymity was maintained for those who make complaints to protect them.

However, relatives did not know how to complain or raise concerns. Relatives told us the complaints procedure has not been explained to them and some relatives told us that they would not feel comfortable raising a complaint with the service. One relative told us staff did not inform them of actions or outcomes when issues had been raised.

Learning was reviewed however, managers did not always share feedback with staff. The hospital held learning review meetings to explore any learning from incidents, safeguarding and complaints. This was then further discussed within the monthly clinical governance meetings, where there were also quarterly agendas for lesson sharing across the division. However, staff told us that there was a lack of communication from ward managers, and each ward did not have consistent team meeting agendas and minutes where this information could be discussed and shared with any team members who were unable to attend. Staff also told us that there was inconsistent supervision, therefore there was no identified process to ensure that feedback was always being shared with ward staff. In addition, staff told us that debriefs were not always provided and that there was not always enough support provided following incidents, including complaints.

We expect those that provide services to people with a learning disability and autistic to be able to demonstrate how their service meets the needs of people in line with current guidance and best practice. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people. This guidance requires that people with a learning disability are guaranteed the choices, dignity, independence and good access to local communities that most people take for granted. The service had incorporated Right Support, Right Care, Right Culture into their current quality improvement action plan, however this was still not currently embedded into the culture and model of care within the service. Leaders did however recognise a future strategy for the hospital to be in line with Transforming Care, an NHS programme aiming to improve the lives of adult with a learning disability and/or autism who display behaviours that challenge including mental health conditions.

Inadequate

Wards for people with learning disabilities or autism

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Some leaders had the skills, knowledge and experience to perform their roles. However, leaders and staff told us that some promotions within the service happened very quickly and that because of this, the confidence, experience and competency of some senior staff needed to be looked at. Leaders did demonstrate understanding of some of the issues present within the service however, actions being taken to address these were still not embedded and they did not have necessary oversight of the entirety of the issues within the service. For example, leaders did not recognise the necessity for staff to have increased support and training to meet the needs of the people using the service. Managers and staff told us that senior leaders had been more visible on the wards but not all ward managers were based on the wards in which they managed.

Vision and strategy

Staff were not aware of the provider's vision and values. Leaders told us that the vision, values and strategies of the service were undergoing development. However, there had been a recognition of positive change felt by staff from all levels with the new leadership structure that was in place. Leaders also told us that they wanted the hospital to continue to move in the direction of Transforming Care. The Transforming Care programme is a service model designed to improve the lives of children, young people and adults with a learning disability and/or autistic people who display behaviours that challenge, including those with a mental health condition. The programme aims to improve quality of care for people with a learning disability and/or autism, to improve quality of life for people with a learning disability and/or autism and to enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay. As part of this, leaders told us that they wanted to ensure that they provided the least restrictive environment for the shortest period and that they led a professional and open service that focused on person care.

Culture

Staff felt respected and valued, and most staff we spoke with had recognised a recent secure service pay increase as a positive. However, they varied in their responses of feeling supported by managers. There was a consensus that staff managed because it was what they had become used to. For example, a staff member told us that the staffing issues were regularly escalated to senior leaders but that they saw no change from this feedback. Managers told us that plans were in place for improving staffing and therefore, there were clear gaps in the communication and reassurance given to ward staff who were impacted by staffing shortages.

The service provided good prospects for professional development and career progression. Managers and staff told us of plenty of workforce development opportunities including graduate and post graduate degree funding, care staff being supported into nurse training, nursing associate roles and promotions into senior roles.

Managers told us that staff had access to the providers whistleblowing policies and could escalate concerns through line management. Staff varied in their responses around whether they felt able to raise concerns without fear of retribution. Some staff said that they would feel confident to do this.

Inadequate

Wards for people with learning disabilities or autism

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not always managed well.

There were a lack of processes and systems in place to address concerns, including those that had previously been brought to the attention of the service through inspection activity. This meant that there had been little to no change in areas where improvement would have been expected.

Leaders did acknowledge that the former governance arrangements within the service were not always efficient or effective both at senior level and ward level, and they had implemented a new governance strategy to address this. The new arrangements planned to increase the empowerment and agency of the hospital governance by sharing parts of this amongst senior leaders. At the time of the inspection, this was in its infancy of being implemented.

Management of risk, issues and performance

The service had systems in place such as the audit schedule and incident reviews, however these were not effective in identifying issues of performance and risk and ensuring these were managed and improved. The provided completed audit document did not identify actions required to improve in the areas where the audit indicated that improvements were needed, for example previous issues with standards of cleanliness and infection control compliance had been identified, however these issues were still present and upon review of an incident we observed that this had not been accurately recorded and there had been evident omissions of care by the staff in place to support this person, yet the review process had not identified this.

The audit schedule did not cover all areas of performance and risk. At the time of inspection, the hospital did not have any audit or data in place that ensured PBS plans were being implemented effectively, and therefore although they had made improvements to have these in place for the majority of people using the service, there was not a process in place to allow them to review practice for assurance and to improve quality. Managers told us that the current audit schedule was under review and that this was being revised as part of the new governance structure being introduced, including plans for the lead of a national PBS organisation to assist the service in audits of PBS delivery.

The service had an overall risk register, which covered high risk areas of the hospital and described controls and mitigations to manage the risks. However, it did not appropriately identify all the concerns found at this inspection.

Information management

Staff collected data about performance and engaged in local and national quality improvement activities. However, they did not always utilise the feedback to make necessary improvements.

Engagement

The hospital senior leadership team had strong relationships with the local authority safeguarding team and had made connections with a similar service run by a local NHS trust.

Learning, continuous improvement and innovation

Inadequate

Wards for people with learning disabilities or autism

Managers also told us that they had a positive peer relationship and shared good practice with a local sister NHS unit. The service also provided a self and peer review from November 2020 undertaken by Quality Network for Forensic Mental Health Services. This identified positive aspects of the service including the increased implementation of PBS plans, family and carer feedback including staffs receptiveness to feedback and their communication, as well as the range of activities available at the service. However, this also identified similar issues found on this inspection including a lack of staffing, lack of supervision and appraisals, people having unrealistic goals or an unawareness as to what they needed to do to achieve discharge and a lack of communication between multidisciplinary teams and ward staff.

The service had not made adequate progress to address the findings of the last CQC inspection, especially in relation to the built environment, staffing and staff supervision, and ensuring a consistent and robust model of care was being used across the site through the quality and effective delivery of PBS plans.

Feedback from people using the service was captured at the ward community meetings and the service also introduced praise boxes on wards which were used to celebrate positive behaviour of people using the service and any praise for staff.

We were not aware of any specific forums or channels in which staff were able to feedback to help develop and improve the service. Some staff told us that when they raised concerns and issues, they did not see any change from the feedback. There were ward level clinical improvement group meetings which identified issues to be escalated up to clinical integrated governance however, there did not appear to be any identification of this information being received and actioned at a senior level.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that staff fully understood and were confident in delivering positive behaviour support (PBS) plans and that the effectiveness and quality of these were monitored. (Regulation 9) The provider did not ensure that all people were receiving supportive and appropriate meaningful staff interaction in line with their care and support plans. (Regulation 9) The provider did not ensure that care plans were consistent in quality, that they were recovery orientated, goal and discharge focused, and that people were provided copies of these. Where this was not possible or refused, this rationale was not clearly identified. (Regulation 9)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that all environmental risks, building maintenance, décor and issues with standards of cleanliness across the hospital were identified and acted upon in a timely way. (Regulation 15)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	The provider did not ensure that people had regular access to necessary therapies, including psychology, occupational therapy and speech and language, activities and Section 17 leave and that these were not impacted by staffing. (Regulation 18)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that staff were managing risk and safety through appropriate observations. (Regulation 12)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure that it had effective systems and processes in place that appropriately identified compliance and performance issues and took action as appropriate. This included reviewing all incidents to ensure that recording was accurate, necessary actions were taken and that lessons learnt were identified. (Regulation 17) The provider did not ensure that all staff had sufficient training, competency and supervision to enable them to effectively support the people at Cedar House. (Regulation 17) The service did not ensure it embedded effective governance processes that kept people safe, drove improvement activity, and managed the performance and quality of care. (Regulation 17) The provider did not ensure communication between senior staff and ward staff and that information, such as

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that all ward environments, especially one annexe, Folkestone and ELS wards, and the seclusion room, met the basic human rights of the people using these and the Mental Health Act (1983) Code of Practice. This included ensuring safety, comfort, privacy, dignity, and free access to fresh air. (Regulation 13)

learning from incidents and complaints or changes made from multidisciplinary decisions, were shared consistently with staff through regular team meetings and information sharing processes. (Regulation 17)

The provider did not ensure that it embedded the guidance from Right Support, Right Care, Right Culture into its environment and treatment for people with a learning disability or autistic people. (Regulation 17)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Urgent action was taken because patients would or may be exposed to the risk of harm. On 27 January 2022, following our inspection visits, we served the provider with a letter of intent telling the provider that we required them to provide us with assurance that they would make immediate and ongoing improvements to address the concerns, otherwise we would use our powers under Section 31 of the Health and Social Care Act 2008. This letter outlined concerns that people were not being provided with safe care and treatment. This included insufficient levels of interaction and observation from staff; a lack of cleanliness and poor maintenance across the hospital; the seclusion room not meeting the Mental Health Act (1983) Code of Practice and not being an environment to keep people safe; peoples' Positive Behaviour Support (PBS) plans not being delivered in an effective way and staff not being sufficiently trained, competent and supported in delivering the care needed for the people using the service. The provider was required to submit an action plan by 31 January 2022 that described how it was addressing our concerns. The provider's response did not provide enough assurance that the actions the provider was taking addressed the immediate concerns. Due to the serious nature of the concerns, we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and imposed urgent additional conditions on the provider's registration on 2 February 2022. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. The condition prevented the provider from admitting any new people to Cedar House without the prior written

This section is primarily information for the provider

Enforcement actions

agreement of the Care Quality Commission. The provider was also required to provide a detailed action plan to address the following: to improve systems of governance around reviews of incidents and observation levels; to ensure that care provided is therapeutic, person centered, proactive and takes a preventative approach using Positive Behaviour Support (PBS); to make improvements to the environment, including the seclusion room and one person's annexe, to ensure these are suitable environments to meet the needs of people with learning disabilities and autistic people; to ensure that staff are appropriately trained with the correct skills to deliver safe and effective care to people with learning disabilities or autism and that there is appropriate support and supervision. We also placed a condition requiring the service to provide fortnightly updates as to the progress, monitoring and audits of the implemented action plan.

We have progressed further enforcement action, but the outcome is still to be determined. CQC continues to closely monitor the hospital.