Cedar House

Quality Report

Dover Road
Barham
Canterbury
Kent
CT4 6PW
Tel: 01227 833700
Website: cedar.house@huntercombe.com

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

We rated Cedar House inadequate because:

• The hospital was not always able to adequately meet the complex needs of some of the patients. These patients had behaviours that were very challenging for staff to manage but the measures in place to manage their needs and risks (such as long-term segregation and use of physical restraint) had impacted negatively on their quality of life.

• There were high levels of restraint at the hospital. Staff who were unfamiliar with patients did not always follow de-escalation techniques before restraint was used.

• All wards we visited looked tired and showed signs of damage which could present a safety risk for patients. Four of the six wards were visibly unclean. We raised this at the time of the inspection and undertook a further visit five days later and found that short term repairs to the environment had been made. All the wards at the service still looked bare.

• The hospital had insufficient systems and processes in place to ensure all environmental risks were identified and mitigated. The ligature risk assessment did not identify how some of the identified risks should be mitigated.

• Whilst there were always enough staff on each shift, there was an increasing vacancy rate and increasing use of agency staff, many of whom were often unfamiliar with the patients. Therefore, some permanent staff members felt there were not enough staff who knew patients well enough to provide good quality care and meet patient needs at all times.

• We found blanket restrictions on all the secure wards. Button batteries were not allowed on the wards. Patients had not had individual risk assessments to decide whether this restriction was necessary.

• A small number of patients had been receiving care and treatment at the hospital for too long. Senior managers were working with commissioners to identify alternative placements and support the transfer of patients.

• Senior managers were not visible in the service and nursing staff felt they did not understand the daily challenges on the wards. Some nursing staff felt that the psychology team were rarely present on the wards. Staff from different disciplines appeared to work in isolation and there was a disconnect between the nursing team and the wide multi-disciplinary team. Whilst ward managers were felt to be supportive, they were not based on the ward which affected their availability to lead and oversee care. Feedback from staff was that they did not always have enough time, training or support to provide person centred care for people.

Summary of findings

• Support staff had a limited understanding of why some patients could have section 17 leave and others could not.

However:

• Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff recognised incidents and reported them appropriately. The senior management team had effective working relationships with stakeholders to review patient related incidents.

• The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

• Staff provided a range of treatment and care for patients based on national guidance and best practice; this included access to psychological therapies. Patients had access to occupational therapies. Staff supported patients with their physical health and encouraged them to live healthier lives.

• Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They supported patients to understand and manage their care, treatment or condition. Staff actively sought patient feedback on the quality of care provided and enabled them to contribute to decisions about how the hospital operated. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.

• Staff supported patients to access a range of therapeutic activities, opportunities for education and developing skills for employment within the hospital and local community.

Summary of findings

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Summary of this inspection

Background to Cedar House

Cedar House is a specialist hospital managed by The Huntercombe Group offering assessment and treatment in a low secure environment. The service has six wards and capacity for 39 patients. The hospital offers low secure inpatient services for people with a learning disability or autism who have offending or challenging behaviour and complex mental health needs.

The wards were as follows:

• Folkestone ward – eight-bed male patients

• Folkestone enhanced low secure (ELS) ward – six-bed male patients. This area of the ward had higher staffing levels and provided a service to patients who had particularly challenging behaviour.

• Folkestone ward – eight-bed male patients.

• Maidstone ward – six-bed female patients.

• Tonbridge ward – eight-bed male patients.

• Rochester ward had three male patients as well as single annexes for another three male patients.

• Poplar ward - locked rehabilitation ward for five male patients. This ward was outside the secure perimeter fence.

The CQC has inspected the services provided at Cedar House eight times between June 2011 and May 2019. Following the last comprehensive inspection in January 2019 Cedar House was rated as good overall with a rating of good in all the key question areas.

We carried out a focused unannounced inspection in May 2019, following concerns that had been raised about the use of long-term segregation and overall management of incidents. We found that:

• The provider did not ensure that staff use activity plans with patients to promote routine and structure whilst still promoting patient choice and preferences.

• The provider did not ensure that all notifiable incidents are reported fully and to relevant bodies in a timely way.

At the inspection in February 2020, we saw evidence that the provider had taken action to ensure patients had activity plans in place and that all notifiable incidents were being reported in a timely way to the relevant bodies.

Our inspection team

The team that inspected the service comprised an inspection manager, three inspectors, two specialist advisors who were nurses with expertise in forensic learning disability services and an expert by experience. The expert by experience had lived experience of caring for somebody with a learning disability.

Why we carried out this inspection

Whilst this inspection was carried out in response to information that raised some concerns about the services. We reviewed all aspects of each key question. We undertook this inspection due to concerns raised following a restraint, seclusion and segregation review and concerns raised around the culture and environment during a Mental Health Act monitoring visit in August 2019.

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 11 patients who were using the service;
- spoke with nine carers of patients;
- spoke with the registered manager of the service and the manager for each ward;
- spoke with 15 other staff members including doctors, nurses, support workers, occupational therapists, a forensic psychologist, a social worker and family and patient liaison nurse;
- attended and observed a clinical governance meeting, a senior clinical team hand-over meeting and a clinical improvement group;
- attended and observed two community meetings;
- looked at six care and treatment records of patients;
- carried out a specific check of the medicine management on all six wards;
- looked at medicine records for 13 patients;
- looked at incident records for all six wards; and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We spoke with 11 patients during this inspection. Five of the 11 patients we spoke with told us that there were not always enough staff. One patient told us that their time interacting with staff was often interrupted by other patients.
- Patients told us they could do a variety of activities on the hospital site. Patients told us that activities were not always possible on weekends due to there not being enough staff.
- Patients generally felt safe on the ward. One patient told us that they did not feel safe on the ward due to other patients acting inappropriately towards them. We asked the provider to raise a safeguarding concern on behalf of this patient.
- Two patients told us that staff were kind and respectful of patients. They said that staff took the time to listen to them. One patient told us that they felt bullied by the way staff spoke to them.
- Families told us that staff were friendly and good at communicating. They felt the service was open and honest. They felt their loved ones were receiving good care and that staff had the patient's best interests at heart.
- Patients on Poplar ward told us they had opportunities to make changes to the ward environment by choosing the colours for their bedrooms and games room.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated safe as **inadequate** because:

- All wards we visited were furnished but looked tired and showed signs of damage that could present a safety risk for patients. Four of the six wards were visibly unclean.
- The ligature risk assessment did not identify individual control measures for some of the recorded risks. The ligature risk assessment did not identify new potential areas of risk resulting from changes being made to the environment.
- Whilst there were always enough staff on each shift, there was an increasing vacancy rate and increasing use of agency staff. Therefore, some regular staff members felt there were not enough staff who knew patients well enough to provide good quality care and meet patient needs at all times. Patients told us that staff were not always available to talk to or facilitate activities. The service had high levels of restraint. Some staff were concerned that unfamiliar and inexperienced staff would not always follow de-escalation techniques known to support the patient before restraint was used.
- We found blanket restrictions on all the secure wards. Button batteries were not allowed on the wards.
- The hospital was not always able to adequately meet the complex needs of some of the patients. These patients had behaviour that was very challenging for staff to manage. The measures in place to manage their needs and risks (such as long-term segregation and use of physical restraint) had impacted on their quality of life.

However:

- Clinic rooms were fully equipped, with accessible emergency drugs that staff checked regularly.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).
- The staff knew how to report incidents and had opportunities to learn from incidents.
- Staff received and were up to date with mandatory training.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Staff supported patients with their physical health and encouraged them to live healthier lives. The full-time health promotion nurse oversaw a clear physical health pathway throughout the hospital and referrals to other specialists could be made.
- Sensory profiles were created by the occupational therapy lead for all patients with a diagnosis of autism. The sensory profiles were comprehensive and holistic.
- Each patient had separate documentation to their nursing care plans, that were produced with and for the patients that enabled the patients to give a fuller picture of their wishes, likes and dislikes in an appropriate format for their individual needs and abilities.
- The service had purchased licenses for a technology aid to support patients. Patients had phone devices with the app and were offered personalised assistance to manage their anxiety.

However:

- Staff were supported with regular supervision and an appraisal.
- Support staff had limited understanding of section 17 leave (Mental Health Act) and why people could and could not go out on leave. Support workers had a limited understanding of the Mental Capacity Act.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and generally maintained their dignity. They supported patients to understand and manage their care, treatment or condition.
- In general patients told us that staff were kind and respectful of patients. They said that staff took the time to listen to them, even when short staffed. We spent time on all wards and observed many positive interactions between patients and staff. Staff showed patience and treated patients with respect. The staff we spoke with had a very good understanding of their patients and this was reflected in the interactions we observed. Staff were responsive when caring for patients.
- Families told us that staff were friendly and good at communicating. They felt the service was open and honest. They felt their loved ones were receiving good care and that staff had the patient's best interests at heart.

Summary of this inspection

- Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could feedback in weekly community meetings about a variety of topics such as staffing and improvements to the service activities.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- Some of the patients had been receiving care and treatment at the hospital for a very long time, between three and ten years. There were significant delays to discharge for a small number of patients although managers told us they had worked with commissioners to identify and support patients moving to alternative placements.
- All the wards at the service were bare and there was very little on the walls.
- However:
- Staff supported patients with advocacy and cultural and spiritual support.
- Staff supported patients with activities outside the service, such as work, education and family relationships. Patients enjoyed visiting a local stable and looked after a range of animals on the hospital site. Staff used a full range of rooms and equipment to support treatment and care. The service had an academy centre which had a range of activity rooms and a café.
- Each patient had a folder located in the staff office which contained personalised, holistic information about themselves.
- Information, where possible, was displayed in easy read and pictorial formats. The service produced a magazine that advertised events such as the hospital talent show and summer fete and this was available on the wards.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- Nursing staff we spoke with told us there was a divide between the ward staff, the multi-disciplinary team and the senior management team who were based in a building outside the secure perimeter. Some staff felt there was a lack of visible presence from the wider multidisciplinary team members and senior management team on the wards. Staff felt that concerns on the wards were overlooked by the senior management team and decisions were made without discussion with the ward staff or an appreciation of what was happening on the ward. The senior management team were not aware that the nursing staff felt there was a divide that needed to be addressed.

Summary of this inspection

- Nursing staff told us that whilst ward managers were largely supportive, they were located in offices away from the wards which meant they were not always available.
- Governance processes did not operate effectively and did not identify areas for improvement. For example, we did not see that the lack of cleanliness and environmental risks on some wards had been identified and addressed.

However:

- The service collected reliable information and analysed it to understand performance. The information systems were integrated and secure.
- The service supported staff to develop their professional qualifications. The provider developed their qualified staff by funding a nurse leadership programme run by the Royal College of Nursing. Support workers were supported to access nursing qualifications.
- The service had introduced some innovative projects. These included an app to support patients and the development of the family liaison nurse role.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff were up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. The provider's training data showed that 98.77% of relevant staff had completed their Mental Health Act level one and level two training. Also, 98.77% of the non-clinical workforce, such as domestic and kitchen staff had received training in Mental Health Act awareness. The provider stated that this training was mandatory for all staff and renewed every year.

The service had a designated Mental Health Act administrator who had extensive training and knowledge in the Act. Patients had easy access to information about independent mental health advocacy and patients who lacked capacity to self-refer were referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was authorised by the Responsible Clinician and the Ministry of Justice where relevant. Support staff had a limited understanding of why some patients could have section 17 leave and others couldn't.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

The Mental Health Act administrator completed quarterly audits. The provider's Mental Health Act legislation manager also conducted an annual full audit for assurance.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was included as mandatory training for all staff to complete. Staff were up to date with their training. However, they had a limited understanding of the five principles.

Ward managers had recently completed capacity assessment training. The service appropriately assumed patients had capacity. Staff told us that when they assessed patients as not having capacity, they made decisions in the best interests of patients and considered the patients' wishes, feelings, culture and history.

There was a clear policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Inadequate

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Inadequate

Safe and clean care environments

All wards we visited looked tired and showed signs of damage. Four of the six wards were visibly unclean.

Safety of the ward layout

Rochester, Tonbridge, Maidstone, Folkestone and Folkestone ELS wards were all within a secure perimeter fence. This allowed safe access around the site for patients and staff. Patients of Poplar ward were able to access the facilities on the secure site without escorts.

Staff could observe patients in all parts of the wards. Convex mirrors were in place to mitigate potential blind spots. Most of the dining areas were locked on the days of our inspection. Some patients had keys to the dining areas and kitchens of their wards following risk assessment by staff. CCTV covered the communal areas of the wards. Staff could access this after an incident had occurred.

There were potential ligature anchor points on all wards. A ligature anchor point is a fixed point from which patients can tie things to self-harm. All wards had a ligature risk assessment completed in the last 12 months. The ligature audit identified most potential ligature anchor points on the wards. It did not include the clocks and light switches that had been boxed in. The provider informed us that the boxing in had been added since the previous ligature audit had been carried out. Clocks on all wards were covered using a wooden frame and a plastic cover to prevent patients from removing the batteries. The frame then created a potential ligature risk. Some of the light switches on Folkestone ELS ward were covered using a wooden frame and a plastic cover to prevent damage. The frame created a potential ligature risk.

Some of the control measures identified in the ligature audit were not individual to the identified risks but were generic measures for each ward. For example, there were not actions identified to reduce or remove each individual risk. When the inspector spoke with the hospital's member of staff who was responsible for the ligature audit they were told that the provider's quality assurance team (the team that is external to the hospital) had given the same feedback to the hospital about the lack of identified individual control measures to reduce or remove some of the individual ligature risks. The wards carried out individual patient risk assessments as part of the referral criteria for patients being admitted to each ward.

Copies of the ligature risk assessments were on staff noticeboards. However, not all staff were aware of this as some staff members told us that they had not seen a copy of the ligature risk assessments. Ligature cutters were available to staff on all wards and this was identified on the ligature risk map. Ligature risk maps were observed in the nursing offices on the wards and provided a visual map of the high-risk areas of the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were issued with keys, personal safety alarms and radios at the control room to the secure site. All rooms on the wards had nursing call alarms. When we inspected, the nursing call system on Folkestone ward had a fault for the last two days, which meant that the alarm was set off without any trigger. This was on the maintenance log, awaiting repair. We had

concerns that this was not helpful in creating a therapeutic environment for patients. During our inspection responders from other wards repeatedly left their wards to respond to calls from Folkestone ward that were false alarms. Patients on Tonbridge ward spoke to us about the repeated alarms and the impact the noise had on them. Control room staff told us that they performed nightly checks on a random sample of the personal safety alarms. The provider had a policy in place to check the alarms and what to do if an alarm did not work. The policy included where to record the checks and faults with any security alarms. We did not see any evidence that records of the nightly checks of personal safety alarms were being kept and staff could not tell us where these were kept. However, since the inspection, the provider had investigated and provided evidence to demonstrate that checks are now taking place.

Maintenance, cleanliness and infection control

All wards we visited looked tired and showed signs of damage. Folkestone ELS ward had undergone maintenance in the past 12 months due to the damage caused by a single patient on the ward. However, repairs had not been finished. One bedroom was not in use at the time of the inspection as it needed the ceiling repaired. Plaster work was patched but not painted over. One bedroom on the ward had recently been re-boarded using reinforced materials to prevent further damage. However, screws used to cover the light switch were not tamper proof and posed a risk that patients would be able to access the screws and light switches by unscrewing them. The bathroom and shower room on Folkestone ELS ward had a significant amount of damage. The floor had been pulled up from the sides and posed a risk that it could be broken off and used as a weapon. Screws were protruding from the wall and were not tamper proof. This had not been recorded as an issue with maintenance. We made the provider aware of these risks and asked them to take immediate action. When we returned to the ward five days later, short-term repairs had been made. A long-term plan was in place to make the bathroom and shower room safe. Tonbridge ward was without a television in the patients' lounge but a new one had been ordered. Staff told us a patient had damaged the television. The hospital manager told us that a small number of patients had caused the damage to the wards, particularly Folkestone ELS ward.

The hospital was actively working to support patients to manage their behaviour. The environmental damage on Folkestone ELS ward had reduced as a result of the support plans in place.

Tonbridge ward had a smell of damp throughout due to a recent flood through the ceiling of a patient's bedroom. There was visible water damage on the ceiling of the lounge. There were visible damp stains on the ceilings of Folkstone ELS and Tonbridge wards.

All the wards were furnished. However, on Rochester ward one chair was ripped and the cushioning was exposed.

Four of the six wards were visibly unclean. The music room on Folkestone ward was dirty and the toilets were not clean. The shared bathroom and shower facilities on Folkestone ELS ward and Tonbridge ward looked visibly unclean. The patients told us that toilets could be dirty with faeces and get blocked in the night. The provider told us that one patient was regularly blocking the toilet at night which the provider was addressing. The service employed a health and safety lead who conducted a daily walk around to all wards. They prioritised concerns and escalated to maintenance. The hospital employed one cleaner for all six wards. The night nursing staff followed a cleaning schedule to maintain the cleanliness of the ward and recorded checks. The provider had an infection control policy in place and conducted monthly audits.

We looked at the current maintenance log books for all the wards. The checks were all up to date and where a problem was identified, these issues were recorded and triaged on a computer system for maintenance works. However, not all repairs had been completed until we asked the provider to complete them.

Seclusion room

The service had one seclusion suite on Folkestone ward. It had easy clean fixtures and provided privacy for patients in seclusion. Staff could observe all areas of the suite and were able to communicate with patients through a two-way intercom. The suite had a toilet and shower, appropriate lighting controls, air conditioning and a clock that could be seen easily. The seclusion room had its own garden.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible emergency drugs that staff checked regularly. Staff

checked, maintained, and kept the equipment visibly clean. The secure wards shared one resuscitation bag. This was based centrally and located in the multi-faith room. A resuscitation team was allocated daily to respond to emergencies. This was made up of a staff member trained in immediate life support, a senior nurse on site and two automated external defibrillator (AED) runners. The provider's training data showed that 91.04% of staff required to receive training in basic life support had completed it. All registered nursing staff had completed training in immediate life support. Defibrillation devices were located across the hospital and were easily accessible.

Safe staffing

Whilst there were always enough staff on each shift, there was an increasing vacancy rate and increasing use of agency staff. Therefore, some regular staff members felt there were not enough staff who knew patients well enough to provide good quality care and meet patients' needs at all times. The service had a nursing establishment of 28 registered nurses and 147 senior support workers and support workers across the six wards. The service reported a vacancy of ten registered nurses (36%) as of 21 January 2020. This was higher than reported at the last inspection (January 2019) of 6 qualified staff and 13 support worker vacancies. This service reported a vacancy of 19 support workers (13%). The vacancy rate for support workers was higher than reported at the last inspection. The service had a rolling recruitment programme in place and used many initiatives to recruit staff such as giving existing staff 'refer a friend' incentives and attending open days at universities.

Between 2 September 2019 and 24 November 2019, of the 6138 total working shifts available, 1267 (21%) were filled by bank and agency staff to cover sickness, absence or vacancy for registered nurses. Of these shifts, 180 (14%) of these were for a registered general nurse who was specifically engaged as part of an Exceptional Package of Care for a patient with respiratory failure. In the same period, 367 of available shifts were unable to be filled by either bank or agency nurses and support workers. Managers limited their use of bank and agency staff and requested staff known the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service calculated staffing numbers depending on patient numbers and increased levels of observation. The service employed a rota manager who completed staff rotas two months in advance. They had access to a bank of flexible staff and had a clear system to record their availability. Ward managers, with the attendance of a representative from each ward or shift leader had a morning meeting to discuss the staffing of each ward for the day. Ward managers, the senior nurse on site and shift leaders for each ward met each morning to identify challenges and risks and coordinate the running of the hospital. Measures were in place for when wards were short of staff. Staff members from other wards could be moved to the wards where the priority was higher. Suitably trained administration staff, activity and education staff and the senior management team could also be used to support wards and maintain the safety of the patients. The wards had a buddy system in place for ward managers. If a ward manager was absent, their buddy would support the ward. However, staff on Poplar ward felt that they were often left short staffed, as staff were often re-deployed from the ward to support other wards. Staff told us that registered nurses were sometimes asked to cover more than one ward whilst they were the only registered nurse on shift. The provider told us this was consistent with the operating model for the service.The wards were small and within a short distance from each other. Staff we spoke with raised concerns about staffing and the need to use staff who were unfamiliar with patient's and their needs. They explained that this may have an impact on the care they received. For example, two members of staff told us that staff did not always know the patients well due to movement of staff.

Staff told us that activities would be prioritised and if activities and leave could not be facilitated then they would be rearranged with the patient. During our inspection, we saw this was planned at the start of shifts to ensure all patients got opportunities to use their escorted leave. Patients also had access to many activities in the therapy area known as the Cedar Academy. We observed patients engaging with bingo, darts and breakfast club. The service employed educational staff and occupational therapists and these activities were rarely cancelled.

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

consultants who were available to wards. Staff felt they were easy to access routinely, and in emergencies. The service had on call arrangement to provide medical support for patients outside of normal working hours.

Mandatory training

Staff had completed and were up to date with all their mandatory training.

The service had a system in place to allow staff to complete training within their contractual hours. The service's human resources staff monitored training and sent reminders via email. This was included in the agenda for the clinical governance meeting.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident. The psychology team developed a care and risk management assessment for each patient. Nursing staff told us that they did not have much input into the risk assessments of patients but did feed into this. Observations and incidents were fed to the senior management and psychology teams to review and update risk assessments accordingly. The provider assured us that they had a multidisciplinary process for reviewing these risk assessments, which included nursing staff.

The service had adopted a positive behavioural support (PBS) approach throughout the hospital. This is a person-centred approach to people with a learning disability who may be at risk of displaying challenging behaviours and seeks to understand the reasons for their behaviour so that unmet needs can be met. At the time of the inspection, 87% of staff had been trained in PBS and new staff received training on induction. The senior management team felt this had been embedded within the culture of the hospital.

Management of patient risk

Staff told us that unfamiliar and inexperienced staff would not always follow de-escalation techniques known to support the patient before restraint was used. As well as occasions when de-escalation was not used, there were also incidents when it had been used to good effect. The service provided us with a copy of the induction, shadowing and mentoring programme for new staff. This service had 536 incidences of restraint between 30 May 2019 and 30 November 2019. The number of restraint incidences reported during this inspection was higher than the 269 reported at the time of the last inspection. However, 79% of the increase in restraints all related to one patient. Staff told us that when staff were required to work on other wards, they did not have time to read behavioural support plans.

There was one incidence of prone restraint from 30 May 2019 to 30 November 2019. Prone restraint is where the patient is restrained face towards the floor. This can limit an individual's ability to expand their chest and breathe. The patient was quickly turned onto their back and the incident was reviewed by the senior clinical team the next day.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff completed physical healthcare checks in line with national guidance following restraint. Physical intervention trainers were available to staff and offered advice, additional training and support to ensure restraints were necessary and safe.

One patient required regular prolonged episodes of restraint as they had been deemed too high risk to be placed in seclusion due to self-harm. The patient had 65 episodes of prolonged restraint in the period from 1 September 2019 to 22 February 2020. Due to the duration of the patient's restraints, between 2 and 19 staff members were involved in each episode, as staff would be replaced after a period of time. The longest time the patient was restrained was 480 minutes and the average length of time the patient was restrained in these 65 episodes was 110 minutes. The patient had damaged the ward environment and property. In the six months prior to our inspection there had been 29 staff injuries during the course of these incidents. The hospital introduced a soft mechanical restraint tool to make the restraints less stressful for the patient and staff. It was designed to help reduce injury to patients that display challenging behaviour. This had been discussed at length by the provider's senior managers. The mechanical restraint policy had been updated accordingly and the use of the safety pod had been care planned appropriately. Staff injuries had reduced since they had introduced the safety pod.

The hospital had referred the patient to a more secure environment. The patient had been assessed by five different medium secure units who had not accepted the referral because they assessed his risk levels were too high

for their services. The service was waiting for an assessment for a transfer to high security at the time of our inspection. The impact of this inappropriately placed patient was considerable for both the patient and the hospital. The staff who were regularly involved in restraining the patient were tired and concerned about the welfare and dignity of the patient. All staff we spoke with on the ward the patient was on were concerned they had to continue to try to manage the patient in a low secure environment. The hospital managers had spent considerable time escalating their concerns about the patient's continued stay at the hospital. The hospital was trying to do everything they could to facilitate a transfer to a more appropriate placement for the patient.

The service had 24 incidences of seclusion between 30 May 2019 and 30 November 2019. Of these, 16 (67%) were for patients on Folkestone ward. The service had exclusion criteria for admissions, on wards other than Folkestone ward, for patients that may required seclusion. A procedure was in place to manage the risk of transferring patients from their wards to seclusion. Patients who had previously used the seclusion room had care plans in place, to support their safe transfer to the room. The number of seclusion incidences reported during this inspection was lower than the 45 reported at the time of the last comprehensive inspection in January 2019.

Between 30 May 2019 and 30 November 2019, there were no incidents whereby patients required rapid tranquilisation, via injection against their will, to manage aggressive or challenging behaviour.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There had been three instances of long-term segregation over the six-month reporting period. Rochester ward had three single person wards for patients. The care of the patient was reviewed in line with their long-term segregation policy.

Blanket restrictions

The service had implemented a blanket restriction on button batteries across the hospital, as a result of an incident resulting in the death of a patient. This meant that watches with batteries were not allowed on the site. The hospital had ordered watches that did not need batteries for staff members to use. However, patients' access to their own watches (which had button batteries)had been removed without being individually risk-assessed. The provider told us that patients were able to use watches that did not contain batteries.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Staff were trained in safeguarding vulnerable adults and 90% of staff had completed this training. Staff were required to complete training in safeguarding children and 89% of staff had completed this at the time of inspection. Staff could give clear examples of how to protect patients from harassment and discrimination. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional. Social workers employed by the service took the lead on safeguarding and made referrals to the local safeguarding authority. The hospital had a good relationship with the local safeguarding team who held monthly safeguarding meetings with the provider.

The provider had a policy where children were not allowed on-site.

The provider made 15 safeguarding referrals between 30 February 2019 and 30 February 2020. The number of safeguarding referrals reported during this inspection was the same as the 15 reported at the last comprehensive inspection in January 2019.

A safeguarding meeting was held monthly and attended by NHS England, Police liaison officers, the local authority and key members the Cedar house team. This ensured that all key stakeholders were kept up to date with actions from incidents.

Inadequate

Forensic inpatient or secure wards

Staff access to essential information

Patient notes were comprehensive and all staff said they could access information easily that was saved on the electronic patient records system. Records were stored securely on a computer-based system. Staff had access to two printed files for each patient, for quick access to information. Agency staff who regularly worked at the hospital had access to the notes with temporary login details. Whilst ward staff had access to nursing care plans, not all staff understood how to access other clinical records such as positive behaviour support plans and sensory profiles. Each ward office had a poster which stated where documents were located but some staff members we spoke with told us they could not locate all clinical records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes when safely prescribing, administering and storing medicines. However, we found the administration of medicine was not signed for on three separate occasions for three patients on Folkestone ward between January and March 2020. Medicine fridges were fitted with electronic thermometers which alerted staff if the temperature was not within range. Alerts for faulty medicines and devices were actioned in a timely manner. All medical devices were regularly calibrated by the physical health nurse, to ensure they gave accurate readings. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

There was clear evidence of the decision-making processes in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

The service had two trainee nurse prescribers; the health promotion nurse and a ward manager.

Track record on safety

Between 30 January 2019 and 21 January 2020 there were six serious incidents reported by this service. Of the total number of incidents reported, the most common types of incident were apparent / actual / suspected self-inflicted harm meeting serious incident criteria and disruptive / aggressive / violent behaviour meeting serious incident criteria. Following our inspection in May 2019 we told the provider they should ensure that all notifiable incidents were reported fully and to relevant bodies in a timely way. On review of their incident records at this inspection, we saw that all notifiable incidents were reported to relevant bodies appropriately.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff had a good understanding of what incidents to report and reported them on an electronic system. Staff said they raised concerns and reported incidents and near misses in line with provider policy. Staff told us that managers debriefed and supported patients and staff after any serious incident. Reflective practice sessions were held every Friday for staff to attend. Managers investigated incidents thoroughly. Incidents were discussed as part of the senior managers meeting and were discussed weekly at the ward clinical improvement group.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient prior to and on admission.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The full-time health promotion nurse, who was trained in general nursing, oversaw a clear physical health pathway throughout the hospital. All patients had a

comprehensive physical health assessment on admission, that covered baseline observations, height, weight, nutrition, risk of pressure ulcers, electrocardiogram and feet and oral hygiene.

Staff developed a care plan for each patient. Staff regularly reviewed and updated care plans and positive behaviour support plans when patients' needs changed. Nursing care plans covered all the main areas of the nursing care provided. The nursing care plans were written for the nursing staff and were not written in the voice of the patients. There was separate documentation that was produced with and for the patients that enabled the patients to give a fuller picture of their wishes, likes and dislikes in an appropriate format for their individual needs and abilities. All patients had their care and recovery needs monitored by recognised tools such as the outcome star, individual health action plans, my shared pathway and this is me.

The psychology team developed thorough positive behaviour support plans for each patient. These were present and supported by a comprehensive assessment. There was evidence that elements of these plans fed into the nursing care plans. The service had a positive behaviour support lead who could support staff and who contributed to the development of positive behaviour support plans for each patient.

Sensory profiles were created by the occupational therapy lead for all patients with a diagnosis of autism. We viewed all 18 of the sensory profiles for patients at Cedar House. The sensory profiles were comprehensive and holistic.

Best practice in treatment and care

Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the hospital. The hospital had a contracted team of psychologists and assistant psychologists who offered a range of psychological interventions to patients. This was delivered in a separate building called the education and therapies building. The team offered individual and group therapy aimed to help patients manage high-risk behaviours such as violence, sexual offending, and fire-setting; to help patients with post-traumatic stress disorder; and to support patients' moral development.

The service employed a lead occupational therapist who was supported by two occupational therapists, an academy teacher and three educational staff who worked in the Cedar Academy (the education and activity suite). The service had three activity co-ordinators who could take up to six patients off site at any one time.

Staff delivered care in line with best practice and national guidance. We reviewed 13 prescription charts for patients within the service and found the service followed National Institute for Health and Care Excellence guidance when prescribing medicines. All patients, whose records we viewed, were prescribed medicine within ranges recommended by the British National Formulary. We saw that medicines with sedating properties were only used as a last resort. The service provided patients with easy read and pictorial information on medicines. The service had a policy around self-administration of medicine to support patients' independence in this area. A contracted pharmacist visited the service weekly and conducted comprehensive audits around medicine management. They also provided staff with three training sessions a year in areas such as rapid tranquilisation and updates to national guidance.

The hospital could demonstrate that it had improved the treatment and care provided to some patients who had transferred from other hospitals and who were appropriately placed in their care at Cedar House. One patient had transferred from another service 12 months prior to our inspection. This patient had been in seclusion or segregated from other patients for over three years in their previous hospital. The patient's behaviour had been very challenging for the staff at Cedar House to manage since their transfer. However, the patient had made significant progress at Cedar House. The patient was now nursed on a general ward with high observation levels. The patient had taken community leave and had been able to celebrate their birthday with family members which they had not been able to do for many years. The hospital was also able to provide better support for the patient's physical health needs and the patient had been able to receive dental care after many years without any. The

patient's family had sent many compliments to the hospital regarding the care and treatment the patient was receiving and how much better they seemed since transferring to Cedar House.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. The service effectively responded to patients' physical healthcare needs and used a recognised early warning score tool to quickly identify any changes in a patient's physical condition. The health promotion nurse responded to physical health issues and escalated them to the visiting GP or general hospital where appropriate. The service had a designated room with appropriate medical equipment that was appropriate for facilitating these appointments. The visiting GP completed an annual physical health check appropriate for adults with learning disabilities. Patients, where possible, attended the GP's local surgery in the community. One patient with complex behaviour needs, had been supported to attend the dentist for the first time after many years of neglect and was supported to arrange dental treatment.

Patients' dietary needs were met by staff who assessed those needing specialist care for nutrition and hydration. Patients could be referred to other physical health professionals if needed, such as dietitians and tissue viability nurses. A patient told us that they were under the care of a dietitian and had a care plan in place to manage their diet.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The physical health nurse was the smoking cessation lead and offered a variety of smoking cessation and reduction programmes suitable for the patient group. Patients had access to an onsite gym and outdoor space.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The service recorded and monitored patients' general well-being by using the health of the nation outcome scales for secure services and learning disabilities. This assessed 12 health and social domains and enabled the service to monitor patients' progress or deterioration and, subsequently, their responses to interventions.

Staff used technology to support patients. The service had purchased licenses for a technology aid to support patients. Patients had phone devices with the app and were offered personalised assistance to manage their anxiety. The app alerted allocated responders to support patients if they were distressed. All patients had a weekly session with a senior support worker to discuss and make changes to the settings on their app. Patients were able to use the device whilst in the community.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service followed the provider's quality assurance framework and audited clinical effectiveness and treatment practice in line with The National Institute for Health and Care Excellence guidelines. The service produced quarterly reports which monitored incidents, physical interventions and seclusion. Ward managers conducted care plan and observation audits, monthly.

Skilled staff to deliver care

The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Staff were supported with appraisals and supervision. Managers provided an induction programme for new staff.

The service employed, contracted or had service level agreements with, staff with professional backgrounds in medical, nursing, psychology, occupational therapy, social work and pharmacology to provide care and treatment to the patients. However, ward staff told us that the psychology team were rarely present on the ward. All patients were registered with a local GP and staff could refer patients for speech and language therapy and dietetic services if needed.

Managers gave each new member of staff a full induction to the service before they started work. New staff completed a comprehensive two to four-week induction programme. Following induction, staff completed a six-month probation period where they were mentored and expected to complete workbooks to evidence competency in their role. This was in line with the care certificate, which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Staff received training on learning disabilities during their induction. Ward managers and senior managers told us that ongoing training days were created specific to the

patient, rather than generic autism and learning disability training. Nursing staff told us that they did not receive enough training specific to the patient group and care was informed by knowledge of the patients.

Managers supported staff through regular appraisals of their work. Staff received supervision every six weeks and were appraised every year. All staff were up to date with their supervision and over 80% of staff had received an appraisal. We reviewed a range of supervision records. A broad range of topics and opportunities were listed but notes were brief and often only referred to reading the relevant policies.

The service offered career progression opportunities for support workers. They funded support workers to do their three-year nursing degree, leading to a qualification as a registered nurse, and two-year associate nurse practitioner training. They had also secured funds to upskill current registered nurses to mentor the trainees. Support workers were also able to progress to senior support workers and access extra training in areas such as positive behaviour support, physical interventions and conflict management. One qualified nurse had been supported to develop the role of family liaison nurse. Staff had access to the provider-wide nurse leadership training. This took place over six months and included a five-day residential with workshops, as well as supporting staff to conduct a project at their service. The physical health nurse had been supported to complete their master's degree in advanced clinical practice.

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

Managers recognised poor performance, could identify the reasons and put appropriate measures in place in response to these. Between 30 December 2018 and 30 November 2019, two members of staff had been suspended while full investigations had been conducted and managers took appropriate action in response.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Some nursing staff felt that the psychology team were rarely present on the wards.

Staff held regular multidisciplinary meetings with relevant professionals, to discuss patients and improve their care. Patients had individual ward rounds every month to discuss their aims and goals. Comprehensive reviews were held every six months where all disciplines produced reports to outline patients' progress.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The senior management team reviewed all patients in a daily morning meeting and delegated any immediate actions to ward staff.

We attended one handover meeting and found they effectively prepared staff to manage risks and provide care and treatment on their shift. These handovers were also used to plan patients' leave and activities during the shift.

The service had effective working relationships with external teams and organisations. They used the experience of the local authority safeguarding team and mental health police liaison officer to resolve patient related incidents. The service worked with agencies such as NHS England and facilitated their care and treatment reviews on the hospital site. These aimed to reduce lengthy stays in hospitals and reduce health inequalities for people with learning disabilities or autism.

Case managers from NHS England and care coordinators from patients' local community teams regularly attended meetings. Staff told us that contact from community teams varied. The service found it difficult for community teams to take responsibility for their patient, if they are out of area. This has led to some delayed discharges.

Nursing staff felt there was a lack of visible presence from the wider multidisciplinary team members and senior management team on the wards. Staff told us that the occupational therapy team would only support on Folkestone ELS ward when the patients were settled in presentation. Due to the nature of the ward, occupational therapy might only visit the ward once a week. Staff acknowledged that the occupational therapy team were a good resource but were not involved often enough.

Good practice in applying the Mental Health Act

Staff were mostly implementing the Mental Health Act well. However, some staff did not have a good understanding of section 17 leave.

Staff were up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. The provider's training data showed that 98.77% of relevant staff had

completed their Mental Health Act level one and level two training. Also, 98.77% of the non-clinical workforce, such as domestic and kitchen staff had received training in Mental Health Act awareness. The provider stated that this training was mandatory for all staff and renewed every year.

The service had a designated Mental Health Act administrator who had extensive training and knowledge in the Act. They worked on site and ensured that staff complied with requirements such as patient rights, tribunals, detention papers and detention renewals. The Mental Health Act administrator examined Mental Health Act paperwork on admission. All admissions were planned. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from the Mental Health Act administrator who had their own support from the provider's Mental Health Act legislation manager. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity to self-refer were referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time. We looked at six records and all patients consistently received information regarding their rights under the Mental Health Act. The provider's policy stated this should happen every three months or sooner if there was a trigger such as a tribunal or change to status or mental state. A recent Mental Health Act monitoring visit carried out by CQC in August 2019, noted that patients on Folkestone ELS ward had been assessed as not able to understand the right to challenge detention, so information was only given to them once annually. The service used easy read information to support patients' understanding.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was authorised by the Responsible Clinician and the Ministry of Justice where relevant. However, support staff had a limited understanding of why some patients could have section 17 leave and others could not.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator completed quarterly audits. The provider's Mental Health Act legislation manager also conducted an annual full audit for assurance.

Good practice in applying the Mental Capacity Act

Staff were up to date with their Mental Capacity Act training. Staff understood the provider's policy on the Mental Capacity Act 2005. However, support staff we spoke with had a limited understanding of the five principles.

Mental Capacity Act training was included as mandatory training for all staff to complete. Support workers had a limited understanding of the five principles. The provider's training data showed that 89.81% of the workforce in this service had received training in the Mental Capacity Act. The provider stated that this training was mandatory for all services for all staff and renewed every year.

At the time of the inspection, no patients were subject to the Deprivation of Liberty Safeguards.

Ward managers had recently completed capacity assessment training. On review of patient care records, there were some capacity assessments. The service appropriately assumed patients had capacity. Staff told us that when they assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Capacity assessments we viewed were limited in their detail. However, one patient had a very detailed finance capacity assessment in place, which used visual prompts to aid the patient.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are forensic inpatient or secure wards caring?

Inadequate

Forensic inpatient or secure wards

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness and respected patients' privacy. Staff supported patients to understand and manage their care, treatment or condition.

We spent time on all wards and observed many positive interactions between patients and staff. Staff showed patience and treated patients with respect. The staff we spoke with had a very good understanding of their patients and this was reflected in the interactions we observed. Staff were responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it.

Staff directed patients to other services and supported them to access those services if they needed help. A general advocate attended the service every week and helped run the patient forum.

Patients were generally positive about the staff delivery care at the service. Two patients told us that staff were kind and respectful of patients. They said that staff took the time to listen to them. However, one patient told us that they felt bullied by the way staff spoke to them.

Families told us that staff were friendly and good at communicating. They felt the service was open and honest. They felt their loved ones were receiving good care and that staff had the patient's best interests at heart.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff involved patients and gave them access to their care planning and risk assessments. Each patient had a folder located in the staff office which contained personalised information about themselves. One patient's care record folder had a personalised positive behaviour flow chart, that clearly demonstrated triggers and how to support the patient. Staff told us that some patients developed presentations to inform staff about their specific care needs. This included a history of the patient, who they are and how they like to be supported. Patients were actively encouraged to chair their own review meetings.

Staff made sure patients understood their care and treatment. Patients' received copies of their care plans that contained pictures and symbols to support understanding which patients told us they understood. Patients' views, wishes, likes and dislikes were recorded in the "This is me" documentation which patients completed with support from staff as needed. However, the patients' views were not always referred to in the nursing care plan documentation.

In the six patient records we looked at, there was evidence of discussions of discharge planning.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could feedback in weekly community meetings about a variety of topics such as staffing and improvements to the service activities. The agenda was produced in an easy read format with pictorial aids. We observed one community meeting on Maidstone ward, where patients discussed how they could improve the social club, create a sensory garden and how to improve the relaxation room. Patients across the hospital were invited to be peer workers. One patient we met was currently training other patients to be peer workers. We observed a variety of meeting minutes from across the wards, which showed detailed actions as a result of patient feedback and where the actions had been met by the staff or patient in follow up meetings.

Staff and patients nominated and selected at random an employee of the month. Each ward has a winner that received a prize.

The service organised a variety of activities throughout the year for patients and their families. This included a patient talent show and summer fete.

Inadequate

Forensic inpatient or secure wards

The service had patient representation for different areas across the hospital. These included security, health and safety, and clinical governance. Patients were actively encouraged to attend the weekly community improvement group.

The service carried out an annual patient survey and feedback was consistent with what patients told us.

Patients were given an easy read questionnaire to feedback their experiences of physical interventions. This helped ward managers to design a more patient-centred debrief after they had been restrained.

Staff supported patients to make advance decisions on their care. Care plans were written for advance decisions for restraint. This considered gender of staff and preferred methods of restraint. A patient on Maidstone ward had also been supported to write a will.

Involvement of families and carers

Staff informed and involved families and carers appropriately. A family liaison nurse role had been introduced into the service in October 2018 to improve communication between the service and carers. The level of communication varied between wards, from giving weekly updates, advocating for families in ward rounds to providing regular support to carers. The family liaison nurse had a consistent approach with each family/carer. This included a dedicated phone number and email address to be contacted on. Carers we spoke with said there had been a significant improvement in the communication from the service since this role had been introduced. Some carers felt that communication could improve further and reported that they did not always receive feedback from actions completed by the family liaison nurse.

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

Some patients had very long lengths of stay and discharge was delayed because an appropriate placement had not yet been found.

The hospital had no vacant beds at the time of the inspection. Between 30 May 2019 and 30 November 2019 bed occupancy was 97%. The average length of stay varied from ward to ward.

This service reported one readmission between January 2020 and February 2020. The patient had previously been discharged to an adult social care facility provided by the Huntercombe group. Readmissions were not usual for this service. Staff told us that, in order to protect the patient from harm, they re-admitted the patient as the responsible authority would not take responsibility for the patient.

When patients went on leave there was always a bed available when they returned. Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Patients had previously been moved from the enhanced low secure ward to Tonbridge ward and Folkestone ward when the patients' risk reduced.

Staff did not move or discharge patients at night or very early in the morning. Staff told us that discharges and admissions were planned for Tuesdays, Wednesdays and Thursdays during working hours.

Discharge and transfers of care

In the six patient records we looked at, there was evidence of discussions of discharge planning.

Between 30 May and 30 November 2019, the service had five patients whose discharge was delayed. The provider's reasons for these delays were: lack of appropriate community settings; disputes with community teams around aftercare responsibilities; funding constraints; lack of appropriate legal frameworks in the community to supervise risks; and insufficient forensic expertise in community teams. To tackle the national shortage of specialised community beds for patients with complex learning disabilities, the provider had recently converted local accommodation to support some of these patients.

There was a considerable impact on the hospital, staff and patients by the continued presence of the patients whose discharge was delayed. One of the patients had been waiting for over ten years for a specialist community placement to be provided. This patient always needed three-to-one staffing levels and the hospital assessed the situation as high risk because of the patient's level of

acuity. Another patient whose discharge was delayed always needed one-to-one staffing levels and the hospital assessed their situation as medium risk with the staff struggling to manage patient risk.

Managers regularly reviewed length of stay for patients and monitored the number of delayed discharges. The hospital manager sat on the local 'transforming care community infrastructure group', where delayed discharges, their reasons, and potential solutions were discussed with local transforming care leads. The service was working closely with NHSE and the NHSE co-ordinator attended regular patient reviews to facilitate their discharge. The hospital worked hard to liaise with potential providers to ensure that appropriate placements were found for patients after discharge.

Facilities that promote comfort, dignity and privacy

All the wards at the service were bare. There was some evidence to suggest that sensory profiles for those patients who had autism had informed the environment of the wards. Each patient had their own bedroom and there were quiet areas for privacy.

Each patient had their own bedroom. On Maidstone ward, Poplar ward and Tonbridge ward patients were able to personalise their rooms. Staff said that patients could put up posters if they wanted to. All patients on Poplar ward had keys to their own bedrooms. Patients on Tonbridge ward had keys to their own bedrooms if they had been risk assessed as safe to do so.

All the wards at the service were bare, with very little artwork on display. The quiet room on Tonbridge ward was painted bright green. The patients and ward staff told us that the patients had been involved in the choice of the paint colour. There was some evidence to suggest that sensory profiles for those patients who had autism had informed the environment of the wards.

Patients had a secure place to store personal possessions. Patients had lockable cabinets in their bedrooms to keep personal items safe. Patients told us that they felt their belongings were safe. However, one carer expressed concern over their relative wearing other patients' clothing and their relative's clothing going missing. They felt the hospital staff were not supporting their relative to maintain their possessions.

Staff used a full range of rooms and equipment to support treatment and care. The service had an academy centre which had a range of activity rooms and a café. Maidstone ward had a pamper room run by a beautician and hairstylist. Patients told us that they really enjoyed using the pamper room. The service had a permanent camping tent with electricity and a tree house with electricity. However, one staff member said the trampoline had been broken for six months and due to financial restraints had not been fixed.

The service had quiet areas on all wards. Patients could see visitors in private rooms in the control centre. The service provided patients with a ward phone and phone calls could be made in private. Patients on poplar ward had their own mobile phones. The provider informed us that some patients on other wards could have their own mobile phones following risk assessment.

The six wards within the secure perimeter fence had access to large outside gardens. Patients needed to ask staff to unlock the door to the garden to access it. Poplar ward had access to its own large garden area. Patients on Tonbridge ward, Maidstone ward and the ground floor single person annex on Rochester ward had access to their own dedicated secure garden areas to access fresh air during daylight hours. Patients on Maidstone ward were able to do gardening or keep pets. Patients on Folkestone ward, Folkestone ELS ward and Rochester ward had access to the hospital grounds.

The service offered a variety of food. Patients were given a choice of food each morning for lunch and dinner. Generally, patients thought the food was good. However, one patient told us that portion sizes were small. Each ward had the opportunity to visit the hospital canteen for their meal, once a week. The service provided food in line with individual patients' nutritional needs. Patients on Tonbridge ward had self-catering opportunities on a rotational basis. Each patient had the opportunity to cook for themselves plus one other.

All wards had access to facilities where patients could do their laundry independently or with support from staff.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Some

patients shadowed members of the maintenance and catering team to gain work experience. There was evidence that on-site jobs, such a litter picking, were suggested to patients. The service has a relationship with a local stables where patients were able to groom the horses and clean out the stables.

The service kept chickens and goats on the hospital site and patients were encouraged to look after them. The service had been granted funding for a treehouse, which was frequently used by patients.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Each patient was encouraged to visit their family at least once every three months. If the patient did not have a family or friend they wanted to visit, they could have an outing of their choice.

Patients on Poplar ward were encouraged to spend time in the local community in preparation for their discharge from hospital.

Meeting the needs of all people who use the service

The hospital met the communication needs of patients. Staff supported patients with advocacy and cultural and spiritual support.

The service could support and adjusted for physically disabled people or other specific needs. Information was available in easy read for those who needed it. Two patients on Poplar ward had their own communication passport, so that staff could support their understanding. The provider informed us that some patients on other wards had communication passports as well.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The wards displayed relevant information to support patients, and their carers, in ward areas and the main entrance. Information, where possible, was displayed in easy read and pictorial formats. The service produced a magazine that advertised events such as the hospital talent show and summer fete and this was available on the ward.

Patients had access to spiritual, religious and cultural support. The service had a multi-faith room and staff told us that when they had enough staff, they would support them to religious places of worship. A senior support worker employed by the service was also a pastor and conducted whole hospital services.

At our focused inspection in May 2019 we said the provider should ensure that staff use activity plans with patients to promote routine and structure whilst still promoting patient choice and preferences. We saw evidence in patients' personalised folders that activity timetables were in place.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers told us they knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We observed posters in the control room and on the wards telling patients how they could raise a concern or complaint. Patients told us that that they received feedback from complaints and felt confident staff would support them to make a complaint and make changes to their care as a result. Staff could confidently explain the policy on complaints and knew how to handle them. Staff protected patients who raised concerns or complaints from discrimination and harassment.

This service received 74 complaints between 30 December 2018 and 30 November 2019. Of these, nine complaints were upheld. Managers investigated complaints and identified themes. The main themes highlighted by the service were patient attitudes and behaviour, staff attitude, and staff shortage. Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. This service received 24 compliments during the last 12 months from 30 December 2018 to 30 November 2019.

Are forensic inpatient or secure wards well-led?

Inadequate

Forensic inpatient or secure wards

Inadequate

Leadership

Senior managers were not visible in the service and nursing staff felt they did not understand the daily challenges on the wards.

Nursing staff we spoke with told us that there was a divide between the wards and the senior management team who were based in a building outside the secure perimeter. Some of the staff felt there was a lack of visible presence from the wider multidisciplinary team members and senior management team on the wards. Staff felt that concerns on the wards were overlooked by the senior management team and decisions were made affecting the wards, that were not applicable to the current situation faced by staff and patients. The senior management team were not aware that nursing staff felt this way. However, nursing staff felt supported by their ward managers. Ward managers were located away from the wards in the education and therapies centre within the secure perimeter.

The ward managers spoke highly of the senior management team and felt supported by their direct line manager.

Staff told us that, due to the levels of staffing and levels of observation for patients, staff felt they were unable to take breaks, due to the impact this would have on their colleagues. Staff felt that staffing levels impacted on the care being given to patients. Nursing staff felt that the provider did not equip them with the training needed, to give good care to the patient group.

Charge nurses ran daily clinics where staff discussed work or personal issues and accessed support with performance or sickness. The hospital manager monitored regular episodes of sickness in a fair and supportive manner. The service provided a range of services for staff such as occupational health, funded physiotherapy and paid days leave to support staff resilience.

The service supported staff to develop their professional qualifications. The provider developed their registered staff by funding a nurse leadership programme run by the Royal College of Nursing. Staff had opportunities to share good practice with colleagues from other settings and undertake a project to bring back to their service. Support workers were supported to access nursing qualifications. The service was also looking to develop a preceptorship programme for support workers.

A ward manager had been supported to take a sabbatical for six months.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

The provider's vision was 'nurturing the world one person at a time' and their values were understanding, innovative, excellence and reliability. These were displayed around the service.

Staff were aware of the vision and values of the organisation. These were discussed during induction and during supervision and team meetings. New staff attended a regional corporate induction to help them feel engaged with the wider organisation.

The provider had developed an audit framework in line with the regulations it was inspected against and based on national guidance. The framework was overseen by the provider's quality and safety team who advised services on areas needing improvement.

The provider was committed to supporting the local health and social care plan. They had recently converted property at another local site into accommodation to move their current patients into more appropriate adult social care accommodation.

Culture

Staff did not always feel respected, supported and valued by the senior management team. However, staff had opportunities for career development and the service offered wellbeing activities to support staff. Staff felt they could raise concerns without fear.

All the nursing staff we spoke with told us they did not feel supported by the senior management team, especially on wards with higher levels of acuity.

The service considered the wellbeing of their staff. They had a 'feel good Friday' every three months where staff

could access massages from colleagues with appropriate training and other activities to promote relaxation. Many staff were able to work flexible hours to support their personal circumstances. The service recognised staff birthdays and had an initiative that encouraged staff to complement each other. Staff had access to physiotherapy, counselling, osteopathy and acupuncture. On Folkestone ELS ward staff could take "wellness days; paid days off to support staff wellbeing.

Staff we spoke with felt they could raise concerns with senior management without fear. All staff we spoke with knew the whistleblowing policy.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider had systems in place to monitor governance from individual wards up to the provider's wider governance level. The hospital had a clinical improvement group that reviewed quality scorecards which provided data on incident analysis and trends, supervision and mandatory training compliance, staff sickness rates and complaints. This information fed into the service's clinical governance meeting which fed into the divisional governance meeting which in turn fed into the provider's quality and assurance strategy. However, governance processes had not identified or addressed some areas for improvement such as the lack of cleanliness or the need to improve environmental safety on some of the wards.

Management of risk, issues and performance

The systems and processes in place did not ensure all environmental risks were identified and mitigated. Leaders managed performance using systems to identify, understand, monitor risk.

The wards monitored risks and physical interventions through their electronic incident reporting system. The senior management team reviewed these daily and themes were escalated to the wards' clinical improvement groups. Patients in long term segregation were reviewed by this team weekly.

The systems and processes in place did not ensure all environmental risks were identified and mitigated. The boxed-in clocks and light switches had not been identified as potential ligature anchor points. Although environmental risk assessments had been carried out by the health and safety lead, some of the identified potential ligature anchor points did not have individual control measures identified to reduce or remove them. Control room staff were not following the provider policy to record checks on the safety alarms and radios. The senior management team were not able to monitor these checks. We did not see evidence that the cleanliness of the ward had been escalated to senior management.

In May 2019, we told the provider they should continue to ensure that all notifiable incidents are reported fully and to relevant bodies in a timely way. On review of the incident reporting system we noted that notifications required by regulatory bodies were identified and allocated to appropriate staff to action.

The senior nurse on site monitored safe staffing levels on a shift to shift basis. They could move staff across wards to manage staff shortages or pressures. In addition to this, the service had introduced a morning meeting to assist with this process.

The hospital had an up to date risk register that reflected the risks known to the service. Ward managers felt they had opportunities to feedback items to add to the risk register.

Information Management

The service collected reliable information and analysed it to understand performance. The information systems were integrated and secure.

The wards had clinical improvement groups that reviewed quality scorecards which provided data on incident analysis and trends, supervision and mandatory training compliance, staff sickness rates and complaints. This information fed into the service's clinical governance meeting which fed into the divisional governance meeting which in turn fed into the provider's quality and assurance strategy.

Staff felt they had enough equipment to carry out their role successfully.

Engagement

Inadequate

Forensic inpatient or secure wards

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Patients were given a variety of opportunities to feedback about the service being provided. A patient survey was conducted each year. The service had patient representation for different areas across the hospital. These included security, health and safety, and clinical governance. Patients were actively encouraged to attend the weekly community meetings or monthly clinical improvement group.

Staff feedback was gathered through staff surveys each year. The most recent staff survey had shown an improvement in provider communication and helping staff to improve how they do their job. The results showed staff dissatisfaction in the following areas: pay, support from immediate line manager and ability to influence important decisions. Action plans were created from the results to enable staff to feel more engaged with the wider organisation. All new staff now attend a regional corporate induction, and the organisation held the first National Huntercombe Hero Awards.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and leaders encouraged innovation and participation in research.

The service had introduced some innovative projects. These included the 'brain in hand' app and the development of the family liaison nurse. The psychology team were in the process of designing a group programme to support patients with stalking behaviours, using quality improvement methodology. At the time of the inspection, this was in the testing phase.

The service participated in the peer review from the Quality Network for Mental Health Services. At the time of inspection, the hospital was participating in the 2019 NHS commissioning for quality and innovation (CQUIN) which was "healthy bodyweight in adult secure mental health".

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

- The provider must ensure that the wards are clean and well furnished. (Regulation 12(2)(d)).
- The provider must make sure that the environment is safe and that mitigation for risks is identified and actions taken to ensure the safe care and treatment and health and safety of patients. The provider must ensure that all potential ligature risks are identified and staff know where ligature risks are on the wards and how to mitigate them. (Regulation 12 (2)(b)(d))
- The provider must ensure that restrictions are appropriate to the risk on the wards, are in response to individually assessed risks of patients, and that staff are following least restrictive practice. (Regulation 12(2)(a)).
- The provider must ensure that ward staff feel appropriately supported by the senior management team and wider multidisciplinary teams such as occupational therapy and psychology. (Regulation 18(2)(a))
- The provider must ensure that governance processes identify and address areas for improvement in the service including ward cleanliness and environmental safety. (Regulation 17(1)(2))

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

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 18 HSCA (RA) Regulations 2014 Staffing