Jeesal Cawston Park

Quality Report

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

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.

Overall summary

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

The Care Quality Commission is currently undertaking enforcement action at Jeesal Cawston Park to cancel the provider's registration and prevent the provider from operating the service. This is subject to ongoing review. The service was rated as inadequate and put into special measures following an inspection in June and July 2019. The service was re-inspected in November 2019 and February 2020, however insufficient improvements were made, and the hospital remained in special measures and a Notice of Decision was issued for closure subject to legal process.

This inspection was an unannounced, focused inspection in response to the provider notifying us of two incidents relating to patient safety. We looked at specific key lines of enquiry during this inspection relating to patient safety and the provider's governance systems. It was not the purpose of the inspection to review the special measures status, which remains in place.

Summary of findings

We found evidence to substantiate our concerns regarding patient safety as enhanced patient observations were not completed in line with the provider's observation policy. Although we found managers had taken action to address these concerns, further improvements were required to prevent incidents from continuing to occur.

We did not re-rate this service at this inspection. The rating of inadequate from the inspection in February 2020 remains unchanged.

We found the following areas required improvement:

- Enhanced patient observations were still not completed in line with the provider's observation policy, despite the provider implementing strategies to address this concern. We saw evidence from a recent incident in which a staff member had fallen asleep whilst completing patient observations. Evidence also suggested that patients who should have been cared for on one to one observations were cared for on intermittent observations, which was not based on the patients risk level or behaviour. One to one observations are designed to support patients who are deemed as a higher risk of harm to themselves or others.
- We were not assured that all serious incidents were investigated, reviewed and that lessons learned were shared with staff. The provider did not have an established forum to discuss serious incidents and the Registered Manager and Head of Communications and Quality were unable to tell us who had oversight of the quality of patient care. We were informed that the Head of Communications and Quality focused on Communications. Reviewing and learning from incidents was also a concern at our previous two inspections in February 2020 and November 2019.
- The governance systems in place were not sufficiently embedded to provide adequate oversight and monitoring of the quality and safety of the service. The provider had worked to make improvements to the process of audits however many scheduled audits were not completed. Governance and audit processes were highlighted as areas of concern with our last three inspections of the service in June and July 2019, November 2019 and February 2020.
- Staff did not always manage risk to patients and themselves well as patient risk assessments and treatment and support plans were not always reviewed following incidents or within appropriate timescales. Therefore, we were not always assured that staff were aware of risks for individual patients.
- Staff did not notify CQC of all reportable safeguarding incidents in a timely manner. We highlighted this to managers at the time of our inspection who informed us they would correct their CQC reporting process.
- The provider could not provide assurance that they could deploy enough registered nurses and support staff with the right skills and competence to meet the needs of the people using the service and to manage patient risks. We were not assured that staffing rotas were accurate, and we saw evidence of staff shortages in incident logs and when speaking with carers. Staff shortages were a concern at our previous inspection in February 2020.

However:

- Staff completed comprehensive initial risk assessments for patients in which they identified triggers and strategies to support patients. Initial treatment and support plans also highlighted patient risks.
- The overall number of reported incidents at the hospital had decreased, which managers believed was due to an increase in patient activities and not just because of a reduced number of patients at the service.
- Staff we spoke with felt that the Registered Manager had an open and transparent leadership style and had improved communication within the service. As a result, staff felt more involved and comfortable to raise concerns.

Summary of findings

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Wards for people with learning disabilities or autism

Summary of this inspection

Background to Jeesal Cawston Park

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

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

There are 57 registered beds.

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

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

• The Manor – a 16 bedded ward which accepts both male and female patients (at the time of this inspection, the Manor was closed for refurbishment)

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

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

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

There were 23 patients in the hospital at the time of inspection. Following enforcement action taken in November 2019, a Notice of Decision remained in place which prevented the hospital from admitting any patients to any ward without prior written agreement from the Care Quality Commission.

The Care Quality Commission has inspected Jeesal Cawston Park Hospital on six occasions within the last 18 months. Following the inspection in June and July 2019, we issued the hospital with a warning notice for a breach of regulation 17 of the Health and Social Care Act (2008) and placed it into special measures. We told the provider they must make improvements to the leadership and governance processes to keep patients safe. We carried out a further inspection in November 2019 to assess whether the provider had made the required improvements. However, we found further concerns that required urgent action. We took further enforcement action in November 2019 which prevented the hospital from admitting any patients to any ward at the hospital without prior written agreement of the Care Quality Commission. During our inspection in February 2020, we found further concerns relating to managing patient risks and governance systems. Following this, we began further enforcement proceedings to cancel the hospital's registration as a provider in respect of the regulated activities:

a) Treatment of disease, disorder and injury; and

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

Whilst the enforcement process is ongoing, we are maintaining enhanced engagement with the provider and monitoring of the service. Various other stakeholders are also monitoring the provider such as Clinical Commissioning Groups, local safeguarding authorities and NHS E.

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

Our inspection team

The team that inspected the service comprised of one CQC inspection manager and one CQC inspector.

Summary of this inspection

Why we carried out this inspection

This inspection was an unannounced, focussed inspection in response to concerns received by CQC prior to this inspection. We carried out this inspection to look at incidents relating to patient care and safety. We looked at what action the service was taking to avoid incidents from occurring again. We looked at specific key lines of enquiry during this inspection relating to patient safety and service governance systems.

How we carried out this inspection

We have reported in the following domains:

- Safe
- Well led

This was a focused inspection to explore concerns relating to patient safety and to look at the governance systems in place to monitor, review and improve the quality of the service. Therefore, our report does not include all the domains and headings usually found in a comprehensive report. Furthermore, in response to the COVID-19 pandemic, the inspection team only accessed office areas on site to limit direct contact with patients and did not visit wards and other patient areas. Due to active cases of the virus on site, communication with patients was via telephone only.

The inspection was undertaken during the COVID-19 pandemic and consideration of the difficulties has been reflected in any judgements. However, although this is considered, we are required to ensure patients receive safe care and treatment therefore where information received by the inspection team suggests there may be a risk to patients, we have highlighted this within the report.

Before the inspection visit, we reviewed information that we held about the service and recent incidents that we had been notified of. We asked the local safeguarding authority for information on the service prior to this inspection.

During the inspection, the inspection team:

- spoke with one patient who was using the service
- spoke with six carers of patients who were using the service
- spoke with the Registered Manager and managers overseeing various elements of the service
- spoke with one social worker
- received information from the local safeguarding authority
- spoke with an independent advocate
- looked at six care and treatment records of patients
- reviewed incident logs and incident forms
- reviewed CCTV footage of incidents
- and looked at a range of policies, procedures, meeting minutes and other documents relating to the running of the service.

What people who use the service say

- We spoke to one patient who told us that on two separate occasions they had seen a staff member asleep during the night shift in a ward area.
- We spoke to six carers of patients, who had mixed views on the service. Two carers felt the service had involved them in their relative's care, however four carers were not happy with the level of involvement and communication they received from the service.

  One carer told us they did not have any introduction to the service, and they were not able to contact their relative for a substantial amount of time after they were admitted.
- Three carers told us that there was a lack of meaningful activities for patients, and staff were rarely visible.
- Four carers told us they were happy with the care that was given to their family members and staff were friendly, caring and approachable.

Summary of this inspection

- Two carers highlighted that responses to complaints were not satisfactory as responses were slow and they did not feel listened to.
- One carer told us that staff from the hospital had not been responsive to the physical health issues of their family member.
- We spoke to one independent advocate for patients at the hospital who highlighted concerns that the hospital did not report all safeguarding incidents and staff did not take responsibility for doing this. They were concerned that patient observations were not being completed safely as incidents were occurring whilst patients were on enhanced observations. They reported that staffing levels were low, and that staff were slow to respond to patients' needs.

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?

Ratings are not provided for this type of inspection.

We found the following areas for improvement:

- Staff did not complete patient observations safely and in line with the provider's observation policy. Prior to the inspection, managers from Jeesal Cawston Park informed us of a concerning incident in which staff had intermittently fallen asleep whilst completing 1:1 patient observations. We were also informed of other occurrences where staff had fallen asleep whilst completing observations however, we found no further CCTV evidence of such incidents.
- A carer told us that their relative was removed from 1:1 patient observations and placed on intermittent observations. We were concerned that this practice may have an impact on patient safety however the provider informed us in this case this was to prevent cross-contamination from COVID-19.
- We were not assured that all serious incidents were investigated, reviewed and that lessons learned were shared with staff. There was not an established forum to discuss serious incidents and managers were not able to tell us who had oversight of the quality of patient care.
- Staff did not always manage risk to patients and themselves well. Four out of five patient risk assessments and treatment and support plans that we looked at were either not reviewed following incidents or not reviewed within appropriate timescales.
- We were not assured that staffing rotas ensured there were adequate levels of registered nurses and support staff to meet the needs of the people using the service and to manage patient risks.
- Staff were not notifying CQC of all reportable safeguarding incidents in a timely manner. We highlighted this to managers at the time of our inspection who informed us they would correct their CQC reporting process.
- Safeguarding incidents, including actions required from the local safeguarding authority and lessons learned from safeguarding incidents, were not discussed within any set staff meeting. Therefore, we were not assured that staff and managers were aware of ongoing safeguarding enquiries or areas of concern that may need attention.

However:

Summary of this inspection

- Staff completed comprehensive initial risk assessments for patients in which they identified triggers and strategies to support patients, and initial treatment and support plans also highlighted patient risks.
- Staff completed environmental risk assessments for patients who had a history of using objects to harm themselves.
- Staff kept up to date with their safeguarding training. Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns.
- The number of reported overall incidents at the hospital had decreased which managers believed was due to an increase in patient activities and not just because of a reduced number of patients at the service.

Are services effective?

This is a focused inspection and we did not inspect this key question.

Are services caring?

This is a focused inspection and we did not inspect this key question.

Are services responsive?

This is a focused inspection and we did not inspect this key question.

Are services well-led?

Ratings are not provided for this type of inspection.

We found the following areas for improvement:

- The governance systems in place were not sufficiently embedded to provide adequate oversight and monitoring of the quality and safety of the service. Clinical governance meetings were not effective at improving quality and managers were unable to tell us who had oversight of quality improvement at the hospital.
- Managers did not have sufficient oversight of the management of serious incidents, including completing reviews of serious incidents and sharing learning with staff. The process of recording serious incidents was unclear.
- The provider had made some improvements to the process of audits however several scheduled audits had not been completed therefore we were not assured that audit processes were robust and embedded.

Summary of this inspection

- Further work was required by managers to ensure that staff were completing patient observations safely to ensure there were no further patient incidents resulting from staff not adhering to the supportive observation policy.
- Managers did not ensure the provider's corporate risk register was reflective of current risks. The risk register did not include concerns around patient safety, despite recent incidents.

However:

- Staff we spoke to felt that the Registered Manager had a transparent and open management style and had improved communication within the service. As a result, staff felt more involved and comfortable to raise concerns.
- Managers implemented COVID-19 meetings with staff to ensure key information was relayed during the pandemic and to make key ward decisions.
- Managers had acted to address the performance of staff such as those who did not complete patient observations safety. However, further work was required to eliminate avoidable incidents as evidenced in this report.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to determine an overall judgement about the Provider.

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

Mental Capacity Act and Deprivation of Liberty Safeguards

We do not give a rating for the providers compliance against the Mental Capacity Act or Deprivation of Liberty Safeguards. We use our findings to determine an overall judgement about the Provider.

We did not review the provider's adherence to the Mental Capacity Act or Deprivation of Liberty Safeguards during this inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	N/A	N/A	N/A	N/A	N/A	N/A

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe staffing

The provider did not have enough oversight of staffing rotas to ensure there were adequate levels of registered nurses and support staff to meet the needs of the people using the service and to manage patient risks.

Staffing rotas did not distinguish between registered nurses and support staff, therefore it was unclear if the provider had a suitable level of qualified staff on duty. After raising this concern with the provider and requesting further information, we were provided with one week's data of registered nursing numbers on duty. We were informed that this had to be extracted from the provider's rota management system separately. During this week, registered nurse levels met the provider's requirements for 37 out of 42 shifts. The provider informed us that registered nurses were not at their required service levels for all shifts because of the impact of COVID-19. However, previous inspection reports also noted concerns regarding appropriately skilled staffing on the wards.

We reviewed minutes of staff meetings which highlighted that managers had not factored staff absence into staff rotas. Therefore, managers could not be assured that the appropriate number of staff were present at each shift. It was not clear if this had been addressed within staff resource planning meetings. The provider informed us that on a day-to-day basis there is a Person in Charge to ensure appropriate staffing levels. The provider also operates a first and second on call system for issues that occur outside of working hours, such as staffing numbers.

During the inspection, we saw evidence that changes to patient observation levels were not always based on the patient's behaviour and risk. We saw evidence from meeting minutes that a patient was moved from 1:1 observations with staff to intermittent observations which the provider informed us was to prevent cross contamination of COVID-19 by reducing staff movement in the hospital. However, the use of patient observations should be based on patient risk and behaviour. We did not see evidence of this in the provider's decision to reduce the patient's observation levels. The provider's observation policy states that intermittent observations check the patient's wellbeing every 15-30 minutes and are used as a precaution, whereas constant 1:1 observations are to ensure intervention is immediately available for the patient and others' safety due to the increased risk. Furthermore, we spoke with a carer of one patient who told us that their relative had been taken off their 1:1 observations and placed on general observations, due to staff shortages. The carer told us scheduled trips out of the service, prior to the COVID-19 pandemic, were often cancelled due to staffing levels. Two other relatives and an independent advocate we spoke with told us they were concerned about staffing levels. The provider's incident log highlighted lower than anticipated staffing levels, however it was not clear that this directly impacted patient safety on the occasions in which this happened. The provider informed us that authorisation from the Responsible Clinician was required before patients' observations were amended however we are concerned that a reduction in a patient observation levels could have impacted upon patient safety. Concerns relating to staff shortages was highlighted during our last inspection of the service in February 2020 in which there was evidence that staff shortages were affecting the ability to carry out patient observations.

Managers informed us they held resource management meetings to manage staff absence, agency usage and review activities for patients alongside service resources.

There had been a gradual reduction in the use of agency staff between December 2019 and April 2020 from 31% to

25% for support workers and from 60% to 42% for qualified nurses. The provider informed us that agency usage had improved further in May 2020, which was 21% overall. There had also been a reduction in the number of patients at the service, potentially triggering this trend.

Managers continued to provide staff with additional training in supportive observations. All staff were required to complete a supportive observations workbook and read the provider's supportive observations policy. Managers told us that due to concerns that agency staff were not completing patient enhanced observations in line with the provider's policy, there was a requirement for agency staff to complete these tasks before starting at the hospital. At the time of this inspection, 73% of agency staff had completed the supportive observations workbook and 76% had read the provider's supportive observations policy. Despite this action, incidents relating to patient observations had still occurred.

Managers addressed poor performance of agency staff who were not adhering to the supportive observations policy therefore putting patient safety at risk. Managers took action to prevent agency staff from working at the service and highlighted their concerns to the agency.

Assessing and managing risk to patients and staff

Staff did not always manage risk to patients and themselves well. Staff completed comprehensive initial risk assessments for patients in which they identified triggers and strategies to support patients. Initial treatment and support plans also highlighted patient risks. However, risk assessments were not always reviewed following incidents or within appropriate timescales.

We reviewed five patient risk assessments. For four of the five patient risk assessments, it was not clear how these were reviewed and updated. One patient's risk assessment was not reviewed following an incident involving the patient swallowing an object, despite this already being a known risk for the patient. Following this incident, it was not clear how staff would be aware of the increased level of risk for this patient or how they may need to increase their support for the patient. Therefore, we were not assured that staff were always reviewing and updating patient risks following changes in patient behaviours, incidents or following a review of the care they received. There was no evidence that risk assessments were reviewed in multi-disciplinary patient meetings. A carer we spoke with told us that their relative had been put on a liquid only diet due to risk and that this was not routinely reviewed until they asked the provider to review it. However, upon reviewing the patient's multi-disciplinary review notes, it was clear the provider had been reviewing the patient's food intake in relation to risk.

Staff did not always review patients' treatment and support plans following a change in patient risk. We reviewed a patient incident report which stated that action had been taken to review the patient's care plan, however when we looked at the care plan, this action had not taken place. Out of the five treatment and support plans that we reviewed, four were not reviewed within the appropriate timescales. One review of a patient's treatment and support plan was two months overdue.

Staff completed environmental risk assessments for patients who had a history of using objects to harm themselves.

During staff handovers, we saw evidence that staff were identifying patient risks. For example, staff had signed a quality and safety checklist when starting their shift, in which they confirmed they were aware of a patient's risk factors such as self-harming behaviours.

Staff discussed changes in patient risk during ward morning meetings and how to minimise any impact to staff, however it was not clear how actions were monitored following these discussions.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. At the time of inspection, 98% of staff were up to date with safeguarding training.

Staff we spoke to 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.

The service employed two social workers whose role involved overseeing safeguarding referrals, completing safeguarding audits, liaising with the local authority and acting as a point of support for safeguarding advice for other staff in the service. We reviewed meeting minutes in

which staff were encouraged to ask for support with safeguarding referrals from the provider's social worker. We spoke to one social worker who felt supported in their role and knew who to contact for further support. We were told that external supervision was available for further support with patient concerns.

The service had an appropriate safeguarding policy in place which highlighted forms of abuse and how to report a safeguarding concern. Staff were also provided with information within patient safety bulletins on how to report a safeguarding concern and what happens with a safeguarding alert. The safeguarding policy distinguished between incidents in the service that required internal action only and incidents which required notification to the safeguarding authority. The policy stated that minor incidents which only occur on one occasion are for internal action only, however it was not clear how staff reviewed the number of incidents specific for each patient or their severity level.

We spoke with an independent advocate for patients at the service during the inspection. The advocate had not been at the hospital during the COVID-19 pandemic but raised concerns that prior to this, in late 2019 and early 2020, they were concerned that staff were not always completing safeguarding referrals appropriately. However, we sought feedback from the local safeguarding authority prior to the inspection, who told us that safeguarding referrals were usually submitted, although occasionally delayed, and there were seven open section 42 enquiries for the service. The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. The open section 42 enquiries for the service included concerns relating to observations on patients not being correctly completed, incidents of alleged abuse and concerns around patient risk. One of the social workers who we spoke with at the time of inspection, who oversaw safeguarding as part of their role, was aware of these enquiries and concerns. We were told that staff had been working to improve the relationship with the local safeguarding authority, which resulted in an improvement in discussion of patient incidents and identifying further actions the service should be taking to keep patients safe.

The service held a safeguarding tracker in which safeguarding incidents were recorded alongside actions that had been taken. It was evident from the service safeguarding tracker that despite initial safeguarding incidents being reported to the local authority, there were several safeguarding incidents for which an expected interim report had not been completed. Staff informed us they were working to complete these retrospectively.

Staff were not notifying CQC of all reportable safeguarding incidents in a timely manner. Staff informed us they would wait to report incidents to CQC, until the local safeguarding authority told them they were opening a section 42 enquiry. This meant that CQC was not receiving certain safeguarding notifications and that others were not reported in a timely manner. The provider's safeguarding policy did not include information on how, or when, to report incidents to CQC. We highlighted this to managers at the time of our inspection who informed us they would correct their CQC reporting process.

Staff completed safeguarding audits in which themes of incidents were reviewed and open section 42 referrals highlighted. Safeguarding was discussed within the provider's clinical governance meeting in which brief progress updates were provided, such as communication with the local safeguarding authority and problems with recording information on incident forms and the safeguarding tracker. However, these updates were identical across two sets of clinical governance meetings, suggesting that the problems with recording had not been addressed between the meetings.

Safeguarding incidents were often discussed in daily ward morning meetings. However, the service did not appear to discuss the contents of safeguarding audits, actions that required completion from section 42 enquiries or lessons learned from safeguarding incidents within any set staff meeting. Therefore, wider staff and managers at the service may not be aware of ongoing safeguarding enquiries or areas of concern that may need attention.

Track record on safety

Between February 2020 and May 2020, four serious incidents were recorded at the service. A serious incident is an incident that has resulted in serious physical or emotional injury or damage to property essential to the security and effective running of the hospital. Of the four incidents reported, two incidents related to patient

self-harm. At our last inspection in February 2020 we reported that 32 serious incidents had occurred over a 12-month period. This would suggest there had been a reduction in serious incidents at the service. Managers informed us that there had also been a reduction in all other incidents, including physical interventions. Patient numbers at the service had been decreasing since our last inspection, however the reduction in incidents still appeared to be a reduction over and above the impact of lower numbers of patients at the service. Managers explored this trend and advised us that fewer incidents were occurring due to an increase in patient activities and a focus on staff engaging with patients' activities.

The service previously reported incidents in which staff members were not completing patient observations correctly. During our last inspection in February 2020 we had considerable concerns that patient observations were not being completed as per the patient's support plan and that staff were inappropriately using tablet computers for personal internet usage rather than carrying out patient observations. Managers addressed the inappropriate use of tablet computers with staff by restricting internet access. One of the triggers for this inspection was in response to two patient incidents; one in which patient observations were not being completed safely, and a separate incident involving patient restraint. The latter is subject to ongoing investigation. We reviewed CCTV footage of the incidents, clinical notes and documentation relating to the incidents of concern. We also viewed a random selection of CCTV footage from recent incidents that the service had recorded on their incident log. The CCTV footage confirmed that staff had not completed patient observations safely as they had fallen asleep. We did not find further CCTV evidence of incidents in which patient observations were not completed correctly. However, one patient informed us that a staff member had recently fallen asleep on two occasions in patient areas during the night. We raised this with the provider who investigated the concern by reviewing CCTV footage, however the provider could not substantiate or provide assurance regarding the patient's claim.

Two carers who we spoke with during the inspection told us that they were concerned about their relative's safety in the service and that staff were not completing patient observations correctly. One of the carers informed us that a member of staff was asleep when they visited their relative.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report, however the provider was inconsistent at reviewing and learning from incidents.

All staff reported incidents electronically using a specified incident reporting form. Incidents were collated onto an incident register which included all minor, moderate and serious incidents. We reviewed three patient incidents to check if they were recorded appropriately. For all three incidents, we found staff recorded them via an electronic incident form, updated the patient's clinical records and recorded them on the provider's incident register. However, staff did not always update patient risk assessments following incidents.

Incidents that were subject to a Root Cause Analysis (RCA) were recorded on a separate database. An RCA is an investigation led by the provider following a serious incident and reported to the clinical commissioning group (CCG). When we requested a record of the provider's serious incidents, we were informed that these had been extracted separately from the provider's electronic recording system and it was unclear how the service distinguished serious incidents from all other incidents that occurred at the service. Incidents on the RCA database did not match the serious incidents information that we were provided with. The RCA database highlighted who was responsible for monitoring the investigation and listed actions and lessons learned from the incidents. The lessons learned from incidents were very brief and actions did not have timescales. It was not clear where the actions were reviewed to ensure they had been completed. Managers were not able to tell us who had overall responsibility for monitoring serious incidents.

The provider's Serious Incident and Never Events policy highlighted two forms of incident reviews; a Root Cause Analysis for serious incidents and a service level review for incidents that were not classed as a serious incident. The policy defined the criteria for a serious incident, however there was limited detail around what type of incident would warrant a service level review. We were aware of a current incident that was being investigated by HR relating to a patient restraint, however it was not clear which process this fell into and after speaking with staff, we were told an initial review of the incident had not taken place.

Wards for people with learning disabilities or autism

The provider had not ensured that all incidents were appropriately reviewed, or shared lessons learned for all relevant incidents with the wider service. During our inspection, we were provided with two service level reviews and two lessons learned bulletins from patient incidents. The two service level reviews were from 2019 and highlighted contributory factors towards the incident, root causes, lessons learned and recommendations. The two lessons learned bulletins highlighted relevant learning points for each incident, however the provider's action points were identical across the bulletins and stated 'for use by all units to discuss in handovers/ward meetings'. They did not identify who was responsible for implementing the learning points or when this should be completed by. During our previous February 2020 inspection, we found the same concern. Managers informed us that the service level reviews and lessons learned exercises were shared with the wider staff group, however it was not clear what other learning exercises had taken place or been shared with staff.

During the inspection we reviewed the provider's incident log and a random selection of CCTV footage of incidents. We did not identify any serious incidents that had taken place during the night, which had previously been a hotspot for incidents occurring. We noticed that a staff member had been wearing headphones on a night shift which managers addressed. We were informed by a patient that staff had fallen asleep at night however the provider investigated this and could not find evidence of this.

Upon reviewing a patient incident relating to self-harm by swallowing an object, we were not assured that a formal review, including immediate learning from the incident, had taken place. The provider was complying with the local safeguarding authority's review and actions from this incident. However, as this patient was on 1:1 observations, something which managers knew was an area of concern for the service, we would have expected to see a full review, initiated by the provider, into how this occurred and lessons to be learned.

Incidents were discussed in ward morning meetings, however immediate learning from incidents did not appear to be discussed. The service was not holding regular full staff meetings in which incident management was discussed. Following our inspection, managers informed us that they were changing the format of their morning meetings so that concerns from incidents could be escalated to management.

The provider's Post Incident Support policy referred to a framework of support and a 3-stage post-incident process whereby reviews occurred: immediately, in the days after the incident and within two weeks following the incident. The provider was not following the 3-stage post-incident process within their policy as reviews were inconsistent with no assigned individual to complete actions from the reviews. Managers informed us that due to the COVID-19 pandemic, incident forms were being signed off via the provider's electronic reporting system, however this process still did not include any immediate or longer-term learning exercises.

Since our last inspection in February 2020, the provider had sent regular 'patient safety bulletins' to staff which highlighted complaints, service updates, the number of serious incidents, arising patient safety issues, lessons to learn and a list of completed audits. The bulletins were effective in communicating brief key messages such as outstanding audits and key service or staff updates. However, certain information needed further detail to prove beneficial, such as lessons to learn, as these often included generic statements such as 'operate a no blame approach' or percentages of patients who knew they had a care plan. The lessons learned section of this bulletin did not relate to specific incidents and needed further work to be effective.

Managers acknowledged that incident management and lessons learned processes needed further embedding at the service. Managers informed us of their plans to begin holding a Patient Safety and Quality Review Committee in which reviews of incidents would be discussed and actions taken forward. Analysis of incidents and lessons to learn would then be circulated to staff. There were no meetings in which incidents were reviewed and shared at the time of inspection. For example, the clinical governance meeting did not review incident management. Therefore, the provider was limiting its ability to learn from incidents and prevent avoidable incidents from occurring again.

Managers told us that staff were offered de-brief sessions following incidents however these were not currently being recorded.

Wards for people with learning disabilities or autism

Managers had identified a trend of incidents related to staff not completing patient observations safely and that these incidents often occurred during the night. Managers had acted to address these concerns with the staff involved, including removing staff from the service and sending an impactful letter to all staff highlighting the importance of patient safety, specifically in relation to incidents that had occurred during the night. Managers had implemented actions to prevent this from happening again such as, completing night visits, increasing the visibility of management on units and offering staff additional support during the night. Despite the actions being taken to address these concerns, it was not clear where this issue was being formally reviewed and actions monitored, as following the incidents there was no evidence of a Root Cause Analysis or service level review, nor was this included on the provider's risk register.

The provider's psychology team completed a monthly analysis of incidents which reviewed the number of incidents over a 24-month period, where incidents were occurring, the severity of incidents and the number of times restraint was used. The figures confirmed a downward trend in incidents towards the end of 2019 and the beginning of 2020. Managers also completed an analysis of restraint and physical observations in May 2020 in which incident forms where restraint was used, and subsequent physical observations, were reviewed. The provider noted that an improvement had been seen in staff undertaking vital observations following patient restraint, from 88% to 100%. The figures were helpful to identify trends and improvements, however it was not clear how the service used this information to learn lessons from the data, implement actions to improve patient safety or share information with wider staff.

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

This is a focused inspection and we did not inspect this key question.

Are wards for people with learning disabilities or autism caring?

This is a focused inspection and we did not inspect this key question.

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

This is a focused inspection and we did not inspect this key question.

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

Leadership

During our last inspection in February 2020, we highlighted the change in roles of the leadership team and the appointment of the new Chief Operating Officer (COO), who subsequently took up the post of Registered Manager. Therefore, the Registered Manager had a large role in which the COO part of the role also consisted of working across the wider Jeesal Group and the Registered Manager part of their role consisted of working directly at the hospital. During this inspection, the Registered Manager continued to demonstrate a good understanding of the challenges faced by the service and had recently addressed his concerns with staff and taken further action against agency staff who were not complying with the provider's policies and procedures. Staff we spoke with felt that the Registered Manager had a transparent and open management style which had led them to feel more involved and comfortable to raise concerns.

The hospital had a Head of Communication and Quality; however, we were told by the person in that role and the Registered Manager that their key role was communication. We were unable to ascertain who was leading on the quality part of the role.

Governance

The governance systems in place were not sufficiently embedded to provide adequate oversight and monitoring of the quality and safety of the service.

Managers held monthly clinical governance meetings, however the meetings did not consistently review incidents, risk management, patient experience or the effectiveness of the hospital's systems and processes. Instead, the meetings often consisted of brief department updates and often focused on the provider's action plan relating to current CQC enforcement activity. Therefore, the meeting lost sight of its core purpose and objectives. Further work was required to ensure the meeting abided by an appropriate agenda. Actions from clinical governance meetings were assigned to individuals with dates for completion then reviewed and monitored on an electronic task system.

Managers did not have sufficient oversight of the management of serious incidents including completing reviews of serious incidents and sharing learning with the wider staff team. The process of recording serious incidents was unclear. Despite seeing a number of service level reviews and lessons learned exercises, we were not assured that these were taking place for all serious incidents. The provider's root cause analysis (RCA) database highlighted just one incident in 2020 that was subject to an RCA review despite the provider's serious incident register highlighting four serious incidents that occurred between February and March 2020. Managers would therefore not be able to identify why incidents might be occurring and unable to address concerns to improve patient safety.

Managers told us of plans to implement a Patient Safety and Quality Review Committee to improve patient safety, discuss root cause analysis, serious incidents and lessons learned from incidents. We were informed that actions from incident reviews would be created and reviewed at the meeting. At the time of our inspection these meetings had not taken place and it was not clear where these items were being discussed in detail at present. Further work was required to begin the meetings with appropriate oversight to ensure their effectiveness and the wider dissemination of outcomes to staff. During our last inspection in February 2020, we highlighted the provider's governance processes as a concern, and it was unclear what overall improvements to governance systems had been made since then. Further work to establish the Patient Safety and Quality Review Committee was required, in order to establish whether improvements were being made in this area.

Managers had not implemented regular full staff meetings to collectively share information and address any problems in the service. Nurses held ad-hoc meetings and the service held ward morning meetings which briefly addressed recent events that had occurred on that ward. There were no formal local ward team meetings in place to discuss ward-specific business or full staffing meetings. Following our inspection, managers informed us they were amending morning meetings to include the nurse in charge, streamline the agenda and ensure issues were escalated to senior managers.

The provider had made some improvements to the system of audits. The provider had an audit manager in post and an audit schedule and process in place. The clinical audit effectiveness committee met in February 2020 to discuss the providers annual audit plan. We were provided with evidence of a physical observations audit at the inspection and an audit of the 12-point discharges following the inspection therefore we did see some emerging audits. However, percentage figures of completed audits did not accurately reflect the number of completed audits therefore the provider's scheduled audits were not completed within their timescales. Key audits that related to areas of concern within the service had not been completed such as an audit of risk assessments and incident forms. We were told by the Deputy Hospital Director that a number of audits had not been completed as planned due to the impact of COVID-19. Although the provider was able to demonstrate some improvements in audit planning and scheduling, we are not yet assured that audit processes are robust and embedded. Managers acknowledged that audits were currently not being used to drive change at the hospital.

During our most recent three inspections of this service in 2019 and 2020, we highlighted concerns regarding audits and a disconnect between audit and governance processes. During our last inspection in February 2020, managers told us the hospital audit process was being reviewed to align with the priorities identified at governance meetings. Managers did not provide a

timescale for this review, however it did not appear any improvements had been made to align priorities identified from governance meetings. It was not evident what the provider's priorities from governance meetings were.

The service completed daily checklists which checked environmental risks and patient observations using a pre-set template. Managers completed weekly ward reviews and fortnightly quality and safety reviews which reviewed patient medication, seclusion, environment risks, safeguarding referrals, staffing and care records. The quality of the reviews varied. For example, sometimes staff would directly check that staff were completing patient observations correctly and whether staff knew the patient's risks, whereas some reviews were very brief such as stating 'night checks ongoing' or stating past actions that had been completed. In a previous inspection in June and July 2019, we reported that monthly reviews were absent of information to track the effectiveness of the patient's support plan and to track patient progress. The provider had highlighted this concern in their quality and safety reviews in which patient support plans were now reviewed and adjustments were highlighted. However, it was still not clear how the provider measured patient progress. It was also unclear how these reviews fed into the provider's overall governance or quality processes.

Managers implemented COVID-19 meetings with staff to ensure key information was relayed during the pandemic and to make key ward decisions. The provider also discussed COVID-19 matters within their Clinical Governance meetings in which numbers of positive cases were discussed alongside suspended activities due to the virus, adapting care plans for COVID-19 positive patients, PPE supplies and communications with stakeholders relating to COVID-19. The provider highlighted that special measures had been taken in response to COVID-19 and that the impact had affected their ability to improve the service at speed.

Management of risk, issues and performance

Since our last inspection in February 2020, the service had implemented a number of actions to manage performance and risk for the safety of patients. However, despite these actions, patient safety incidents were still occurring. Action managers had taken, following concerns that staff were not completing patient observations correctly during the night time, included preventing agency staff from working at the hospital and addressing their concerns directly with the agency involved. Managers also wrote a direct letter to all staff informing them of the seriousness of their concerns and the impact that this could have on both the safety of the patients and the future of staff employment. Furthermore, managers encouraged accountability from nurses by highlighting their responsibilities and encouraging them to lead as the Nurse in Charge whilst on shift. Managers conducted ward night checks, in addition to daytime quality checks, to check staff were completing observations correctly, were aware of patient risks and that these were discussed during staff handovers. Staff reported they found these visits useful in reiterating key messages. Staff continued to complete a patient observations workbook for agency staff of whom 73% had completed the workbook. Despite these actions to address concerns around patient observations, a recent incident had occurred prior to this inspection in which a staff member who was on 1:1 patient observations at night had fallen asleep, potentially impacting the safety of the patient. We were also told by a patient during our inspection that a staff member had fallen asleep on duty on two occasions. The provider investigated these incidents and were able to discount one allegation but were unable to identify the date of the second incident due to the lack of detail provided, so were unable to address the concern. In response to this, managers said they would increase their checks on staff, ensure management night checks were completed at various times and introduce a 'stay alert' programme for night staff in which exercises, stretches and wellbeing advice would be provided.

It was clear that managers had taken initial actions to address concerns around patient observations, however further work was still needed to continue with this progress in order to prevent similar incidents from continuing. For example, during one management night visit it was reported that a staff member on patient observations was not aware of the patient's risks, yet it was not clear what action was taken as a result of this. Additionally, a documented CCTV review of staff observations reviewed footage during the daytime rather than during the night which was the period of most concern. Managers needed to further embed these processes to prevent more incidents from occurring.

Managers did not have sufficient oversight of staffing levels and rotas. We were not assured that staffing rotas were reflective of correct staffing levels due to concerns raised in staff meetings. It was not clear how managers ensured the

appropriate number of qualified staff were on duty for each shift as rotas that we were provided with on inspection did not differentiate between registered nurses and support staff. We did not see evidence that managers were reviewing the staffing mix when scheduling staff rotas.

Managers did not ensure the provider's corporate risk register was reflective of current risks. The risk register held three risks which did not include concerns around patient safety, despite recent incidents. It was not clear who had oversight of the risk register or where this was reviewed.

The service kept a Business Continuity Plan detailing guidance for emergencies such as fires, serious assaults and IT outages. There was no guidance for large numbers of staff absence and the document was not updated during the COVID-19 pandemic. However, the provider had implemented COVID-19 ward meetings to make key ward decisions and take appropriate actions.

Engagement

Patients had opportunities to give feedback on the service by completing surveys about their experience and through 'Our Voice' meetings. However, it was not clear how feedback from the meetings was taken forward. For example, patients highlighted that off-site visits were cancelled at short notice and patients had requested more group activities. Managers informed us that off-site visits were impacted by COVID-19. Actions were created from 'Our Voice' meetings and assigned to individuals to take this forward however it was not clear where the actions were reviewed and if they were completed. Managers informed us that actions were monitored via an electronic system and via the senior patient advocate, however as we were not provided with evidence of this, we were not yet assured if actions from these meetings had been completed.

Managers held a staff meeting to discuss family involvement in January 2020 in which plans for family forums, carer event days and gaining feedback from family members were proposed.

We spoke with six carers of patients during the inspection and we received a mixed response regarding how involved they felt with the service and how happy they were with their relative's care. Three carers told us that involvement was poor and two carers specifically mentioned poor communication with doctors. One carer told us they did not have any introduction to the service, and they were not able to contact their relative for a substantial amount of time after they were admitted. However, as admissions to the service had stopped in November 2019 due to CQC enforcement activity, this issue would have occurred at least 6 months prior to this inspection. Two carers also highlighted that the provider's response to complaints was not satisfactory. However, the provider's complaints dashboard highlighted the majority of complaints had been responded to on time, with the exception of 2 agreed extensions. The focus of this inspection did not explore the providers complaints process in detail. Two out of the six carers that we spoke with felt they had been provided with good information and felt involved in their relative's treatment.

Senior leaders engaged with other stakeholders, including commissioners, through visits and telephone calls.

Staff had some opportunities to engage with senior leaders. Leaders had recently held an open staff forum in response to CQC enforcement action and senior leaders informed us that they were present at ward morning meetings. However, regular full staff meetings were not occurring at the time of inspection therefore it was not clear how key agenda items would be relayed to staff. The Head of Communications and Quality told us a key part of her role involved working to engage staff and receive their feedback. We were told this consisted of updating staff and acting as a bridge between the Registered Manager and the wider staff group. The Head of Communications and Quality also told us of increased engagement with staff due to the COVID-19 pandemic. A communication log was maintained detailing key emails sent to staff including updates from HR, updates on COVID-19, CQC enforcement action and general service updates.

Learning, continuous improvement and innovation

Managers had not provided a set time for staff to consider opportunities for improvement which led to change or innovation. Despite managers completing some quality checks within the service, it was not clear how other staff used quality improvement methods themselves.

The provider attended a meeting in February 2020 with the National Autistic Society (NAS) who reviewed progress with the service to identify criteria for autism accreditation. The NAS highlighted that further development was required in continued professional development for staff to help produce positive outcomes for autistic people. They

highlighted that staff at the service had a detailed insight into the person-centred and complex support needs of patients however further work was required to inform a good understanding of how each autistic person communicates and socially interacts.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

These are new actions noted during this inspection. Please note, although these 3 specific actions are new actions from this inspection, Regulation 9 and Regulation 12 had been breached upon previous inspections of this service in June/July 2019, November 2019 and February 2020.

- The provider must notify CQC of all incidents that affect the health, safety and welfare of people who use the service and do so within a timely manner. [Regulation 18: 18 Care Quality Commission (Registration) Regulations 2009: Notification of Other Incidents.]
- The provider must ensure all patient care plans are reviewed within appropriate timescales. [Regulation 9 (3) (b) HSCA (Regulated Activities) Regulations 2014: Person Centred Care.]
- The provider must ensure all patients' risk assessments are updated within appropriate time scales and following incidents. [Regulation 12(1) (2) (b) (d)(g)(i) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment].

The regulation breaches listed below had already been identified in previous inspections and were again noted at this inspection. These breaches form part of ongoing enforcement action.

- The provider must ensure they have oversight of staffing rotas to deploy enough staff with the appropriate qualifications, skills and experience to meet patients' care and treatment needs and ensure patient safety [Regulation 18 (1) (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing].
- The provider must ensure staff correctly carry out supportive observations correctly in accordance with the supportive observation policy and patient care plans [Regulation 12(1) (2) (b) (d)(g)(i) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment].
- The provider must ensure that all serious incidents are reviewed and lessons are learnt effectively across the hospital after incidents [Regulation 12(1) (2) (b) (d)(g)(i) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment].
- The provider must ensure that regular audits are completed and they are effective, comprehensive, robust, and contain the necessary detail to appropriately oversee the service to be able to make changes where required [Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance].
- The provider must ensure that robust governance systems and processes are sufficiently established and embedded to be identify, monitor and maintaining the quality and safety of care to patients and that improvements are made in a timely manner [Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance].

Action the provider SHOULD take to improve

- The provider should ensure their corporate risk register is reflective of current risks such as patient safety.
- The provider should ensure that relevant staff are able to review the number of safeguarding incidents and their severity for each patient, to ensure action taken either internally or as a referral to the safeguarding team, is completed in line with their safeguarding policy.
- The provider should ensure their Serious Incident and Events policy clarifies incidents that would warrant a Service Level Review.
- The provider should review their staff meeting structures to ensure staff and ward teams have a forum to discuss concerns and share information.
- The provider should ensure accountability of a set individual for the oversight of quality improvement at the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The above regulation had not been identified previously in past inspections. Reference to other regulations as listed within the Areas for Improvement section of this report, had been breached over previous inspections of this service in July/July 2019, November 2019 and February 2020. Jeesal Cawston Park is in special measures and all enforcement actions following the previous inspections in 2019 and 2020 remain in place. We did not look at all concerns at this focused inspection but those we did had not been fully addressed. The provider is subject to a Notice of Decision to close the service and is currently going through the legal process. Therefore, we are unable to add further detail whilst the legal process is ongoing.