Cedar House

Quality Report

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Date of inspection visit: 21, 23, 24, 27 July 2020
Date of publication: 11/09/2020

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

Ratings

Overall rating for this location

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

Overall summary

Following this inspection, the Care Quality Commission issued a warning notice due to immediate concerns about the safety of patients using the service. We required the provider to make significant improvements to the safety of the service by 7 September 2020. The provider decided to suspend any new admissions at this time while they address concerns raised.

This inspection was a focused inspection; we did not provide a rating. The purpose of the inspection was to follow up on concerns that were found at the last inspection in February 2020 where the hospital was rated inadequate and placed in special measures. At the last inspection we found that the hospital was not always able to meet the complex needs of some of the patients. There was high use of restraint on patients and for long periods of time. Some patients had been in long term segregation for longer than was necessary. The environment was unclean and damaged in places. Ligature risk assessments were carried out but did not clearly state mitigation to reduce the risks. There was a lack of presence of senior and multi-disciplinary team members on the wards, and some staff did not always know patients well and what their needs were. We also had concerns raised about patients' safety due to the high number of incidents at the hospital.

On 21 July 2020 we undertook an unannounced focussed inspection at Cedar House, the inspection continued remotely on 23, 24 and 27 July 2020. During the inspections we found:

Summary of findings

- Staff and patients told us there were not enough staff to meet the needs of the patients and that they did not always feel safe. The staffing attendance register confirmed there were not always enough staff on duty. One ward often had only one member of staff to support five patients on night shifts. Staff were often deployed to other wards to help out due to lack of staffing, this then left their ward and patients who required a certain level of staffing short. This meant there was an increased risk of harm to patients and staff.
- There was a high number of incidents of aggression resulting in harm from patients to other patients or patients to staff. Subsequently, there were a high number of incidents of restraint used on patients. Staff were regularly off sick due to assaults on them which resulted in injury or stress. Following incidents there was a lack of learning or improvements made.
- There was only one emergency equipment bag for the entire hospital. In this bag there were some emergency medicines used should a patient go into respiratory distress which can be a side effect of taking benzodiazepine medicines. Not all staff were aware that these medicines were at the hospital and there was mixed knowledge of this within the management team also. This placed patients at risk should they need this emergency medicine.
- We reviewed medicines records on Folkstone and Folkstone enhanced low secure (ELS) wards. We found there was high use of PRN (as required) medicines used to manage patients' behaviour and some staff told us this was used before other de-escalation techniques were used.
- Care plans and positive behaviour plans used by staff providing day to day care for patients were conflicting and did not give clear direction of how staff should meet patients' needs. These care plans were not person centred or written appropriately for patients with a learning disability.
- There was no section at the front of the long files which gave brief summaries of patients' needs and risks. This meant that should staff need to check information on a patient quickly, this was not easy to find.
- Staff told us that ward managers, senior management and the clinical team did not spend much time on the wards. This meant that staff and patients did not get the support and input from other members of the team consistently.
- We carried out observations and found that although staff managed patients' behaviours well, there were little other interactions between staff and patients.
- Patients physical health needs were not always monitored effectively or as regularly as required.
- During our inspection we were given conflicting information from staff and the management team with regards to patients' needs, staffing levels required and what emergency equipment was available.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively in identifying improvements needed, or where they did there was no clear plan that ensured these changes were made.
- Staff morale was low due to lack of safe staffing levels and the high number of incidents in the hospital.

However:

- The hospital was clean throughout.
- Some improvements had been made since our last inspection in February 2020. The provider had begun works to improve the environment of the hospital.

Summary of findings

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Services we looked a:
Wards for people with learning disabilities or autism

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 ward for male patients.
- Folkestone enhanced low secure (ELS) ward – six-bed ward for male patients. This area of the ward provided a service to patients who had particularly challenging behaviour.
- Maidstone ward – six-bed ward for female patients.
- Tonbridge ward – eight-bed ward for 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.

Cedar House is registered to provide the following regulated activities;

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- caring for people whose rights are restricted under the Mental Health Act
- diagnostic and screening procedures
- learning disabilities
- mental health conditions
- treatment of disease, disorder or injury

Our most recent comprehensive inspection of the hospital took place in February 2020. We rated the hospital as 'inadequate' overall and placed the hospital into special measures. We told the provider they must;

- ensure the wards are clean and well furnished
- ensure the environment is safe and mitigation of risks identified and actions taken to minimise potential risks
- ensure any restrictions are individually assessed and are following least restrictive practice
- ensure that ward staff feel appropriately supported by the senior management team and wider multidisciplinary teams
- ensure that governance processes identify and address areas for improvement in the service including ward cleanliness and environmental safety

Our inspection team

The team that inspected the service comprised of the head of hospital inspection for the region, 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

In February 2020 we carried out a comprehensive inspection of Cedar House due to concerns noted in the information we collect about the service and information passed to us from other sources. Concerns were related to the use of restraint, seclusion and segregation, as well as the service's culture and environment.

This inspection was a focused unannounced inspection to follow up on these concerns, plus further concerns raised with us over the high number of incidents occurring at Cedar House and the safety of patients and staff.

Summary of this inspection

How we carried out this inspection

As this was a focused inspection, we did not re-rate the service as we only looked at some of the key lines of enquiry across three domains; safe, effective and well led.

Prior to the inspection, we reviewed information that we held about the location. We also sought feedback from professionals.

During the inspection visit on 21 July 2020, the inspection team;

- visited four wards at the hospital, looked at the ward environment and observed how staff were caring for patients
- spoke with four patients
- spoke with the hospital director and the nursing care manager
- spoke with five other staff members; nurses, support workers and a trainee forensic psychologist
- looked at eight care and treatment records of patients and nine patients' medicines records
- reviewed staff induction and training.

We carried out further inspection activity remotely on 23, 24 and 27 July 2020, where we;

- spoke with nine patients and four relatives and carers
- spoke with eleven staff members; nurses, support workers and a rota coordinator
- looked at a range of documents relating to the running of the service, such as training records, staffing rotas, staff attendance registers, handover forms and policies

Following the inspection, we sought feedback from professionals, which included concerns about the safe care and treatment at the hospital and the high amount of incidents that occurred.

What people who use the service say

Patients told us there was not enough staff and they didn't feel safe due to high numbers of incidents and aggression from other patients. Some patients told us this had affected how much they could do with regards to activities and leave.

Patients also told us that staff were nice but not always easy to talk to. They told us that they had some nice experiences and activities at the hospital.

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?

Following this inspection, the Care Quality Commission issued a warning notice due to immediate concerns about the safety of patients using the service. We required the provider to make significant improvements to the safety of the service by 7 September 2020. The provider decided to suspend any new admissions at this time while they address concerns raised.

During our inspection we found:

- Staff and patients told us there were not enough staff to meet the needs of the patients and that they did not always feel safe. We reviewed the provider's rotas and staff attendance records, which showed that in a 23 day period in July there was 54% of shifts where there were not the numbers of staff the provider had identified as necessary.
- Staff told us that often they were asked to help out on another ward due to lack of staffing. Often this left a ward short of staff and patients short of their assessed staffing levels. For example, if a patient has been assessed as needing 3:1 staff for enhanced observations and this reduced to 2:1 because staff were needed elsewhere. We observed patients not having the assessed levels of staff. When staff moved wards it meant, the staff did not always know patients' needs well or what de-escalation techniques worked for them should they become destressed. This could put staff and patients at risk of harm.
- Staff told us that there was frequently only one member of staff on nights on Poplar ward. This was supported by the records that we reviewed. This meant there may be a delay in summoning assistance in the event of an emergency and may put both staff and patients at risk.
- There was a high number of incidents of aggression resulting in harm from patients to other patients or patients to staff. Subsequently, there were a high number of incidents of restraint used on patients. Staff were regularly off sick due to assaults on them which resulted in injury or stress.
- Incidents were recorded and reported to the appropriate people, but we found there was a lack of learning and improvements made by the provider following incidents.
- There was only one emergency equipment bag for the entire hospital. In this bag there were some emergency medicines

Summary of this inspection

used should a patient go into respiratory distress which can be a side effect following taking benzodiazepine medicines. Not all staff were aware that these medicines were at the hospital and there were mixed knowledge of this within the management team also. This placed patients at risk should they need this emergency medicine.

- We reviewed medicines records on Folkstone and Folkstone enhanced low secure (ELS) wards. We found there was high use of PRN (as required) medicines used to manage patient's behaviour and some staff told us this was used before other de-escalation techniques were used.

However;

- The hospital was clean throughout.
- The provider had begun improvements to the environment to make it more pleasant and safe for patients.

Are services effective?

During our inspection visits we found:

- Care plans and positive behaviour plans used by staff providing day to day care for patients were conflicting and did not give clear direction of how staff should meet patients' needs. These care plans were not person centred and or written in a way which was appropriate for patients with a learning disability. Staff had not always read care plans when working with a patient. There was no section at the front of the long files which gave brief summaries of patients' needs and risks. This meant that should staff need to check information on a patient quickly, this was not easy to find.
- Staff told us that ward managers, senior management and the clinical team did not spend much time on the wards. This meant that staff and patients did not get the support and input from other members of the team consistently.
- Patients physical health needs were not always monitored effectively or as regularly as required.

However;

- The provider had improved their induction process for new staff, and this was more comprehensive.

Are services well-led?

During our inspection visits we found:

Summary of this inspection

- During our inspection we were given conflicting information from staff and the management team with regards to patient's needs, what staffing levels were required and what emergency equipment was available.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively in identifying improvements needed, or where they did there was no clear plan that ensured these changes were made.
- Staff morale was low due to lack of safe staffing levels and the high amount of incidents in the hospital.

However:

- There were some improvements following our last inspection with regards to the environment. The hospital director had an improvement plan to continue the improvements and monitor the cleanliness of the hospital.

Wards for people with learning disabilities or autism

Safe	
Effective	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

The hospital was in need of updating and repair. Some of these works had started and the hospital director had a plan in place to improve the environment. However, we noted there was a secure door that had been broken by a patient four days previously and was not due for repair for another week. This meant that staff needed to use another entrance that was not so secure, and staff needed to be extra vigilant with safety until this was fixed.

Ligature points for the purpose of strangulation were risk assessed. However, we noted risk assessments were generic across the wards and could be further improved with clearer mitigation of risks implemented. Not all staff knew where the risk assessments were to access them should they need to.

Staff had access to infection prevention and control policies, and regular team meetings kept staff informed on the COVID-19 pandemic. There were adequate supplies of personal protective equipment such as gloves and masks. We observed staff wearing face masks throughout the inspection.

All wards were clean. The provider had improved their cleaning schedules and had implemented quarterly deep cleans following this being raised as a concern at our last inspection.

Safe staffing

Staff and patients told us there were not enough staff to meet the needs of the patients and that they did not always feel safe. We reviewed the provider's rotas and staff attendance records, which showed that in a 23 day period in July there was 54% of shifts where there were not the numbers of staff the provider had identified as necessary.

Eleven out of 13 staff told us there were not enough staff on duty each shift. This meant that staff did not always get a break, patients did not always get the assessed number of staff observing and engaging with them, and incidents were not always managed appropriately using the least restrictive option. We observed two staff respond to a patient becoming distressed. Another patient was behind the staff and was provoking the distressed patient. Due to there not being enough staff this meant there were not enough staff to manage both patients. This could have led to incidents and an increased risk to patients and staff.

Patients and staff told us that, often, leave or meaningful activities were cancelled or delayed due to staff shortages. This meant that patients were being restricted.

During the inspection staff told us and we observed that patients on enhanced observations did not always get the assessed number of staff required to reduce risks to themselves and others. There were discrepancies about which patients were on different levels of observations from different staff, safeguarding referrals and patient records. We observed that two patients on Folkestone ward did not have the correct level of observations as documented in their care file from staff during the time we observed them. This meant that patients were at increased risk of coming to harm either from themselves or others.

There was frequently only one member of staff on nights on Poplar ward. Between the 01 July 2020 and 21 July 2020 there were 14 night shifts where there was only one member of staff on duty. This meant there may be a delay in summoning assistance in the event of an emergency and may put both staff and patients at risk.

Medicines management

We reviewed nine medicines records and found that there was a high amount of PRN (as and when required) medicines used to manage patients' behaviour, many of these were used at the highest dose guidance. Some staff told us that medicines were used before other de-escalation techniques were tried which meant staff were not choosing the least restrictive options. We noted that PRN protocols were not always detailed with when to administer medicines.

Wards for people with learning disabilities or autism

There was only one emergency equipment bag for the entire hospital. In this bag there were some emergency medicines including Flumazenil which is used should a patient go into respiratory distress following taking prescribed benzodiazepine medicines. Not all staff were aware that these medicines were at the hospital and there were mixed knowledge of this within the management team also. This placed patients at risk should they need this emergency medicine.

Reporting incidents and learning from when things go wrong

Staff told us there were a high number of assaults on staff from patients and a high number of patients assaulting each other, these often resulted in physical injuries such as bruises, cuts and swelling. Subsequently, there were a high number of incidents of restraint used on patients. In May 2020 there were 23 incidents of physical aggression towards staff, in June 2020 there were 25 incidents of physical aggression towards staff and in July 2020 there were 34 incidents of physical aggression towards staff. In May 2020 there were 11 incidents of patient on patient assaults, in June 2020 there were five incidents of patient on patient assaults and in July 2020 there were two incidents of patient on patient assaults. Staff were frequently injured by patients at work. On Folkestone ward in July 2020, 6 staff were off sick with work related injuries. We were not assured that the provider had assessed and mitigated the risks to patients and staff.

The provider had reported incidents to the relevant agencies when incidents occurred. However, we reviewed the providers incident reports and information we had received from them in relation to incidents. There was insufficient analysis of incidents to identify trends and to improve from learning.

The provider had reported incidents appropriately to the relevant agencies when incidents occurred.

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

Assessment of needs and planning of care

Staff did not always provide care and treatment based on national guidance and best practice. Care records we reviewed were inconsistent and not always appropriate to the patient. For example, there was a lack of easy read documents in patients care plans who had a learning disability. Positive behaviour plans were created but we did not see evidence that patients were involved in these. The positive behaviour plans were written by psychologists and used clinical wording that patients may find hard to understand.

Positive behaviour plans and care plans had conflicting information in them so staff did not always have up to date information on patients' needs. One patient who had a sensory impairment did not have a care plan regarding alternative ways of communicating to them. We were not assured that staff providing direct day to day care to patients were following these plans fully. Some staff we spoke with were unaware of some patients needs and care plans, or what strategies to use when providing care to the patients. Staff told us that when they were asked to work on an alternative ward, they did not always know patients' needs well.

Patients physical health needs were not always monitored effectively or regularly. One patient was on medicines for constipation; there was no detail in their care plan around this and there was no monitoring of bowel movements and no risk assessment.

Skilled staff to deliver care

The provider had updated their induction programme and staff told us this was comprehensive. Some staff did feedback that due to Covid-19 restrictions the induction was as good as it could be but was not as comprehensive as it should be. We noted there was quite a lot of new staff starting since Covid-19 restrictions started.

Multi-disciplinary and inter-agency team work

Staff fed back that there was a lack of multi-disciplinary team work. The management team, ward managers and psychologists were not often on the wards, staff felt there was a lack of support due to this. This was a concern raised at the last inspection in February 2020. The provider has told us that ward managers and psychologists will now be spending more time on the wards.

Wards for people with learning disabilities or autism

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

Culture

Staff told us morale was affected by the high number of incidents, the needs of some patients being too high for the hospital, the lack of staffing and staff that knew patients well. Staff told us how they had to go without breaks often and that they felt burnt out. We received mixed feedback with regards to how supported staff felt.

Staff had access to access extra supervision and counselling following incidents.

Staff told us that there was a lack of management and multidisciplinary team presence on the wards, and that this impacted on how supported they felt.

Governance

The leadership team disputed that there were not enough staff and considered that the high number of incidents was due to them being 'good reporters'. We were given conflicting information around rotas staffing models and patients' observation levels. We were not assured that the staffing arrangements on night shifts at Poplar ward were safe, with only one member of staff supporting five patients on a frequent basis. This meant that there was a lack of recognition, understanding and oversight from the leadership team of the seriousness of the concerns which we raised during and after the inspection. Following the serving of the warning notice, the leadership team have confirmed that there will always be two members of staff on Poplar ward at night.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider MUST review their staffing establishment needs to ensure there are enough suitable staff to meet patients' needs and observation levels required at all times.
- The provider MUST improve their governance processes to have greater oversight that enables them to recognise improvements needed, learn from incidents and reduce risks to patients and staff.
- The provider MUST ensure that there are no wards with staff lone working.
- The provider MUST ensure that all staff are knowledgeable of the patients they care for.
- The provider MUST ensure that ward managers and multi-disciplinary team members are present on the wards supporting front line staff.
- The provider MUST ensure there is adequate emergency equipment and medicines available and that staff know what and where they are.
- The provider MUST review patients when required medicines and write patient specific guidance to support staff administer these medicines appropriately and consistently.
- The provider MUST ensure that staff effectively monitor patients' physical health needs and that these are reviewed in a timely manner.

Action the provider SHOULD take to improve

- The provider should review patients' care plans and positive behavioural plans and write these in a way that patients understand and that are individual to them.
- The provider should review their care files and ensure that information is easy for staff to find, clear and that all documents relating to the patient are consistent and do not have conflicting information on them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014: Safe care and treatment The provider did not always carry out physical health checks regularly or appropriately. This was a breach of regulation 12(1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014: Safe care and treatment There were not always safe staffing levels. Patients on enhanced observations did not always get the prescribed number of staff to reduce risks to themselves and others. There were a high number of patient on patient, and patient on staff injuries from incidents of aggression. There was high reliance of restraint and PRN medicines used to manage patients' behaviours. There was only one emergency equipment bag across the whole site. In this bag were emergency medicines. Nurses were not aware of Flumazenil availability. There was regularly only one member of staff working on Poplar ward which is off the main secure site. This meant that staff member would have a delay in getting back up if needed and was not safe. There was not adequate oversight and monitoring from senior management to recognise risks to patients and staff to mitigate risks.

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 12(a)(b)