Cedar House

Quality Report

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Date of inspection visit: 10 January 2018 and 30 January 2018 - 1 February 2018
Date of publication: 08/05/2018

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

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

Overall summary

We rated Cedar House as requires improvement because:

- Staff followed poor infection control practice on Tonbridge ward. The ward was dirty and a patient had heavily soiled and dirty bed linen. We had concerns that staff and the senior management team had not picked up on the cleanliness issues on Tonbridge ward, particularly the dirty bathrooms and kitchen. In addition a patient had been expected to sleep in heavily soiled and unpleasant smelling bed linen. However, the provider rectified these concerns during our inspection.
- Fixtures and fittings were not maintained to a satisfactory standard on all wards.
- Not all paperwork associated with the use of seclusion was completed. In the Care Quality Commission review of seclusion in December 2017, two patients commented negatively about their experience of seclusion, however when we returned in January 2018 changes had been made to their care plans regarding seclusion.
- 30% of the patients we spoke with made negative comments about the staff on the wards, for example that they did not care about them and that they did not have the time to spend quality time with them.
- We found that staff accompanying patients to hospital did not take written information about patients' physical health history to give to receiving healthcare professionals. The service relied on staff to verbally handover the patients' history which could potentially lead to errors.

However:

- Staff assessed patients' needs and delivered care in line with the patients' individual care plans. All patients received a physical health assessment. We carried out an unannounced visit to Cedar House on 10 January 2018 to look specifically at how the service monitored patients' physical health. We reviewed six patients' care records for the previous four weeks and found that, in the majority of cases, staff were responding to patients' physical health needs appropriately. Care plans were personalised, holistic and recovery focused. Patients' we spoke with told us that they were involved in the care planning process. Comprehensive risk assessments were in place for all patients on admission. All patients, where they had wanted to, and had consented to, had been involved in the risk assessment process.
- We spoke with 28 patients, individually and in a focus group. We also received 15 comment cards from patients. The majority of patients we either spoke with or received comment cards from, 70%, made positive comments about their experience of care in Cedar House. Patients told us they got the help they needed to assist them with their recovery.
- An excellent range of activities and groups were available to patients on all of the wards, facilitated by the activity co-ordinators, occupational therapy and ward staff. Patients had access to the education and therapy unit which was part of the recovery college, on site at Cedar House. The recovery college offered an extensive range of courses and groups.
- The physical and procedural security at Cedar House was provided to a consistently good standard. Staff applied operational policies and procedures effectively which ensured the safety of patients, visitors and staff. Overall safe staffing levels were maintained. Cedar House staff had a 93% completion rate for mandatory training.
- The provider's vision, values and strategies for the service were evident and on display in all of the wards. Staff on the wards understood the vision and direction of the organisation. Staff we spoke with were able to discuss the philosophy of the hospital confidently.
- All of the wards had access to governance systems which enabled them to monitor and manage the ward effectively and provide information to senior staff in the organisation and in a timely manner.

Summary of findings

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Services we looked at

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, treatment and rehabilitation services in a low secure environment. It has six wards and capacity for 40 patients. The hospital offers secure inpatient services for people with a learning disability or autism, who have offending or challenging behaviour and complex mental health needs.

- Folkestone ward provides a service for 14 male patients. Six of these patients have bedrooms in a separate part of the ward called the enhanced low secure ward. This area of the ward offers a service to patients who have particularly challenging behaviour and has higher staffing levels.
- Maidstone ward provides a service for eight female patients.
- Tonbridge ward provides a service to eight male patients.
- Poplar ward is a locked rehabilitation ward for five male patients. This ward is outside the secure perimeter fence.
- Rochester ward has three male patients as well as a single annex for one male patient.
- Ashford ward has one male patient.

We inspected the services provided at Cedar House seven times between June 2011 and October 2015. At the time of the last inspection, Cedar House was rated as good overall with a rating of good for our safe, effective, responsive and well led key questions and outstanding for caring.

We reviewed the wards at Cedar House between October 2015 and this inspection eight times through our Mental Health Act monitoring visits.

A registered manager and accountable officer were in post at Cedar House.

Our inspection team

The team that inspected the service included two Care Quality Commission inspectors, one Care Quality Commission Mental Health Act reviewer, one Care Quality Commission pharmacist, two nurses, one occupational therapist, all specialist advisors and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

Summary of this inspection

- Visited all six of the wards, looked at the quality of the ward environment and saw how staff cared for patients
- spoke with 28 patients individually and 10 patients also attended a focus group
- spoke with all the charge nurses for each ward and their managers
- spoke with 65 staff members, including doctors, nurses, support workers, activity workers, education staff, gym staff, occupational therapists and their assistants, psychologists and their assistants, student nurses, a pharmacist and social workers.
- visited all six wards at 06.00 to talk with eight night staff
- received feedback from four relatives
- received 15 comment cards from patients
- spoke with four external health and social care professionals, including two advocates
- spoke with two commissioners for the service
- interviewed the senior management team, including the hospital director
- held focus groups for patients, consultant psychiatrists, psychologists, occupational therapists, educational staff and other therapists and support services staff
- attended and observed 10 multidisciplinary clinical meetings
- attended and observed four patient meetings and therapy groups
- looked at 30 treatment and care records of patients, including 14 medicine records
- carried out a detailed check of the application of the Mental Health Act on Tonbridge, Rochester and Ashford wards.
- looked at six staff supervision records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received mixed feedback from patients. We spoke with 28 patients, ran a focus group and we received 15 comment cards from patients. The majority of patients, 70%, made positive comments about their experience of care in Cedar House. Patients told us that they found staff were caring, kind, professional and supportive towards them. Virtually all of the patients we spoke with felt actively involved in looking at choices for and making decisions about their care and treatment. Patients said staff treated them respectfully and that real improvements had been made to the quality of the food provided. Patients knew how to complain and all said they had been provided with this information. However 30% of patients said that, at times, staff did not care about their welfare and were too busy to spend quality time with patients.

Some patients with limited verbal communication were unable to tell us their experiences at the time of our inspection. We therefore used different methods, including observation, to help us understand their experiences. We observed positive and kind interactions between patients and staff. With one exception, carers told us staff were respectful, recognising the need for and importance of good communication.

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?

Requires improvement

We rated safe as requires improvement because:

- Staff followed poor infection control practice on Tonbridge ward. The ward was dirty and a patient had heavily soiled and dirty bed linen. The provider shared our concerns and rectified this concern during our inspection.
- During the Care Quality Commission review of seclusion in December 2017, not all paperwork associated with the use of seclusion was completed. Two patients commented negatively about their experience of seclusion, however on this inspection changes had been made to the patients' care plans regarding seclusion.
- Fixtures and fittings were not maintained to a satisfactory standard on all wards.

However:

- The physical and procedural security at Cedar House was provided to a consistently good standard. Staff applied operational policies and procedures effectively which ensured the safety of patients, visitors and staff.
- Overall safe staffing levels were maintained. Cedar House staff had a 93% completion rate for mandatory training
- Comprehensive risk assessments were in place for all patients on admission. All patients, where they had wanted to, and had consented to, had been involved in the risk assessment process.
- All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had.
- Staff knew how to recognise and report incidents on the provider's electronic based recording system.

Are services effective?

Good

We rated effective as good because:

- Staff assessed patients' needs and delivered care in line with the patients' individual care plans. All patients received a physical health assessment. Care plans were personalised, holistic and recovery focused. Patients' we spoke with told us that they were involved in the care planning process. We carried out an unannounced visit to Cedar House on 10 January 2018 to look specifically at how the service monitored patients'

Summary of this inspection

physical health. We reviewed six patients' care records for the previous four weeks and found that, in the majority of cases, staff were responding to patients' physical health needs appropriately.
- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE guidance in the delivery of the therapeutic programme that included nationally recognised treatments for patients.
- Staff participated in a wide range of clinical audit to monitor the effectiveness of the services provided. Action plans were developed to address any areas identified for improvement.
- All staff participated, at least weekly, in reflective practice sessions to also evaluate the effectiveness of their interventions. Senior clinicians provided patient specific training for staff where the clinical team assessed the treatment plan needed additional support and guidance.
- Staff received appropriate training, supervision and professional development. Over 93% of staff had updated mandatory training refresher courses recorded.

However:

- We found that staff accompanying patients to hospital did not take written information about patients' physical health history to give to receiving healthcare professionals. The service relied on staff to verbally handover the patients' history which could potentially lead to errors.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- 30% of patients we spoke with said staff did not always have their welfare as a priority and that staff were too busy to spend quality time with them.
- Tonbridge ward was dirty, the bathrooms were particularly dirty and a patient had heavily soiled bed linen.

However:

- We spoke with 28 patients, individually and in a focus group and we received 15 comment cards from patients. The majority of patients we either spoke with or received comment cards from, 70%, made positive comments about their experience of care in Cedar House.
- Patients told us they got the help they needed to assist them with their recovery.

Summary of this inspection

- Some patients told us they had been treated with respect and dignity and staff were polite, friendly and willing to help.
- All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. This information was very detailed and was summarised in the patients' individual support guides.
- We saw evidence of patient involvement in the care records we looked at, particularly captured in the individual support guidelines and care plan folders. This approach was person centred, individualised and recovery orientated. We also saw that all patients reviewed their care plan once every two weeks with the multi-disciplinary care team and in regular meetings with a member of the ward nursing team.
- Patients spoke positively about volunteering and work experience opportunities at Cedar House. They said this also enabled them to influence service development and give feedback on ideas for improvement.
- We observed kind and respectful interactions between staff and patients who had limited verbal communication.

Are services responsive?

Good

We rated responsive as **good** because:

- The provider had financed and supported a number of developments which patients commented on positively.
- The majority of patients made positive comments about the food provided.
- An excellent range of activities and groups were available to patients on all of the wards, facilitated by the activity co-ordinators, occupational therapy and ward staff. Patients had access to the education and therapy unit which was part of the recovery college, on site at Cedar House. The recovery college offered an extensive range of courses and groups.
- Patients and their relatives we spoke with all knew how to make a complaint should they wish to do so. In the patient survey 100% of respondents said they knew how to raise a complaint or pay a compliment.

Are services well-led?

Good

We rated well-led as good because:

- The provider's vision, values and strategies for the service were evident and on display in all of the wards. Staff on the wards understood the vision and direction of the organisation. Staff we spoke with were able to discuss the philosophy of the hospital confidently.

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- All of the wards had access to governance systems which enabled them to monitor and manage the ward effectively and provide information to senior staff in the organisation and in a timely manner.
- The senior clinical and management team met every morning to look at all areas of risk management. All incidents in the preceding day and night were looked at and lead investigators assigned.
- There was evidence of leadership at a ward level. The ward charge nurses were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support.
- Staff told us they felt able to report incidents, raise concerns and make suggestions for service improvements. Most staff were confident they would be listened to by their line managers.

However:

- The senior management team had not picked up the cleanliness issues on Tonbridge ward.
- Some staff said the charge nurses were not spending sufficient time on the wards.

Detailed findings from this inspection

Mental Health Act responsibilities

- All staff had received training on the Mental Health Act as part of their induction training.
- The provider made sure that all staff complied with the Mental Health Act requirements. Staff checked Mental Health Act paperwork regularly. Detention papers were available for review and were in good order throughout. The Approved Mental Health Professional reports were available in the files scrutinised.
- Evidence that rights had been explained to patients as required by section 132 of the Mental Health Act was found in all files. Staff explained patients' rights to them at appropriate times and made a note of anyone refusing the discussion. For those patients who would not regain capacity the responsible clinician completed an annual statement confirming rights had been explained to the nearest relative.
- The system for recording patient leave was thorough. Staff told us that a leave of absence procedure was in place on the ward, with patients being assessed prior to leave and their attire noted. Copies of Section 17 leave forms were kept in the patient individual folders.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had undertaken Mental Capacity Act (MCA) training. There was a MCA policy in place and staff told us about the principles of the Act and how they applied to their patients.
- Where appropriate patients had a mental capacity assessment relating to care and treatment. We also saw this reflected in care plans and additional assessments for specific interventions such as medical procedures and personal care delivery.
- Documentation was available around best interest decisions in patients' notes and staff told us confidently what this meant. Three out of four families told us they had been involved in discussions.
- The integrated governance meeting and the Mental Health Act administrator monitored adherence to the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- The physical and procedural security at Cedar House was provided to a consistently good standard. Staff applied operational policies and procedures effectively which ensured the safety of patients, visitors and staff.
- There was a single main entrance to enter and exit the hospital site with a double airlock operated by a central control room. An airlock is an additional locked room to pass through before gaining access to or exit from the hospital. This strengthens security in and out of the hospital. Cedar House had a dedicated control room team who co-ordinated the entry and exit of all staff, patients and visitors. The entrance environment for patients, visitors and staff was welcoming, with comfortable furniture, lockers for storing personal belongings, cold water to drink, bathroom facilities and a variety of relevant leaflets and information. The control room staff showed a high degree of professionalism and the area operated efficiently.
- With the exception of the locked rehabilitation ward, Poplar, all areas of the hospital were within the secure perimeter fence. This enabled safe and secure access for patients and staff around the whole site. Poplar ward was in a self- contained building, next to the control room and in close proximity to the rest of the hospital.
- The wards presented some challenges for clear observation of the patients and staff managed this through individually risk assessed observation levels. A staff member was available at all times in the communal lounge areas.
- Over 79% of staff had received training on managing ligature risks and staff knew where the high-risk ligature anchor points and ligatures were and how these risks were mitigated and managed. Staff had carried out ligature risk assessments using the provider's ligature audit tool at least once each year, last reviewed in April 2017. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounges and dining rooms and ensured they regularly monitored these areas. Ligature cutters were easily accessible in the wards' nursing offices. Any new risks that staff identified were reported through the provider's incident reporting system and were escalated onto the service line risk register. Staff reduced risk by individually assessing patients and increasing their levels of staff observation if required. The hospital was undergoing an improvement schedule to up-grade the anti-ligature specification of each ward and patients' bedrooms and bathrooms. At the time of our inspection, Folkestone ward was more advanced in having ligature free fixtures and fittings. Maidstone ward had also been identified for the higher anti-ligature specification and these works were due to commence imminently. Additional up-grade work across the hospital was planned for 2018.

Requires improvement

Wards for people with learning disabilities or autism

- The wards were gender specific and complied fully with national guidance on mixed sex accommodation.
- Accessible resuscitation equipment and emergency medicines were available on all wards in the clinic rooms or nursing offices. Staff checked emergency equipment regularly to ensure it was in working order. We found one box of syringes which was out of use by date by 10 months on Tonbridge ward.
- Cedar House had one seclusion suite on Folkestone ward, which was located on the main communal corridor. The suite had recently been refurbished and included easy to clean acrylic wall covers. The seclusion suite was clean, private, had a large reception or de-escalation area and the seclusion room was larger than the recommended size. There were good sight lines for observation throughout the suite. There were staff present throughout a period of seclusion and the staff were able to see and hear the patient at all times via a two way intercom system. The seclusion room had natural light, air conditioning, toilet and shower facilities and digital lighting. There was no clock available for patients and we were told it had been removed for new batteries to be put in. The seclusion suite had a dedicated staff office which had clear lines of site into all areas of the suite and this office was only used when the seclusion room was in use. However, patients requiring seclusion from any other wards would need to be transferred from their ward to the Folkestone seclusion room. The hospital manager told us that the female ward had an exclusion criteria for admissions that may require seclusion and that male patients, who required seclusion on other wards, would have individualised crisis response plan to manage the risk of transferring them to seclusion.
- Staff followed poor infection control practice on Tonbridge ward. There were several examples of this. Two bathrooms were dirty with excrement on the toilets and floors. Equipment such as mops and buckets should have been colour coded to indicate which floor the mop and bucket should be used in. For example, green for use in kitchen areas, red for use in toilets and bathrooms, blue for general low risk areas such as corridors and yellow for infection outbreaks. On Tonbridge ward, in the laundry room the mops heads, of various colours, were lying on the floor in a pile and were dirty. We witnessed staff using the green kitchen mop to clear excrement from a bathroom floor. We immediately raised our concerns to managers as this scenario presented a high risk of poor infection control. The kitchen used by staff and patients to prepare all meals was very untidy and was not clean. The oven and hob had been broken for some considerable time. A small temporary oven had been made available which was too small for the catering requirements on the ward. This issue had been reported and a new oven was being ordered. Both the broken cooker and hob and the temporary cooker and hob had food and dirt ingrained throughout both. The broken oven had old food and dirt all over it, as did the kitchen floor and worktops. The two fridges and the freezer in this kitchen were extremely dirty. Much of the food was not labelled correctly to indicate what the food was and when it expired. None of the food was stored correctly in sealed containers. Some food in the fridge had a past use by date. This put both staff and patients at a high risk of becoming unwell due to poor storage and consumption of food with expired use by dates. In addition, this ward operated a self-catering model for all meal provisions. The cupboards in the kitchen were dirty, cluttered and untidy throughout. One kitchen cupboard under the sink, which staff said should be kept locked, was open with four bottles of cleaning liquid/ chemicals in it. A cupboard in Tonbridge ward which was labelled, 'activities' was full of broken furniture and not activity resources. One patient's bed linen was extremely dirty, heavily stained and smelt very unpleasant. We immediately escalated our concerns about this with hospital managers. On Poplar ward two of the patients' toilets were heavily stained indicating they had not been thoroughly cleaned for a considerable period of time. Two patients on Tonbridge ward said they were unhappy about sharing a washing machine which had been regularly used to wash soiled linen. It was unclear whether the patients had expressed these concerns to staff as the provider informed us the washing machines were commercial machines capable of safely dealing with soiled laundry without the risk of cross contamination. They assured us they would explain this to patients during the next community meeting. However on the other wards, cleaning schedules were available in every area to indicate to staff which areas needed cleaning on each ward. One domestic cleaner

was available to clean on the wards, except Poplar and Tonbridge wards. Staff and patients were responsible for cleaning on these wards. Staff told us the night staff were expected to thoroughly clean the wards overnight.

- In response to our concerns about the poor cleanliness and infection control management on Tonbridge ward the hospital director took immediate action and put a plan in place to mitigate and reduce risks identified by our inspection team. Actions included a thorough clean of the ward, all mop heads were replaced and correctly stored, colour codes for mop heads and buckets were put in every bathroom and toilet and half hourly checks with staff sign sheets were put in place for every bathroom and toilet. In addition the main hospital kitchen, under the supervision of the catering manager, was to take over all meal preparation and provision of food until a review of cooking arrangements could be completed. All food was disposed of and the kitchen fridges and cupboards cleaned thoroughly. Staff were due to undertake refresher infection control training and the charge nurse was allocated to work with night staff to re-instigate a robust cleaning system on the ward together with environmental audits to ensure adherence to reviewed set standards. Any soiled bed linen, quilts or pillows were disposed of and replaced with new and clean linen.
- The provider had carried out quarterly environmental and health and safety audits and included, fire safety checks and drills, hazardous waste management, site maintenance and safely managing contractors on site.
- Fixtures and fittings were not always maintained to a satisfactory standard on all wards, for example, the televisions on Tonbridge and Maidstone wards were both broken and had not been replaced, however we were told by the hospital director that new ones had been ordered.
- All staff were issued with an alarm and radio when entering the hospital. Staff and patients told us that alarms were responded to quickly. We had raised concerns at our previous inspection in 2015 that the alarms sounded on every ward across the hospital and that all available staff attended the ward which sounded the alarm. Staff and patients had told us that this was quite disruptive as the alarm could not be deactivated in any other ward and could be sounding for several minutes at a time. On this inspection the alarm volume and pitch had been reduced so it was less obtrusive although it did still sound on every ward.

Safe staffing

- There were 25 whole time equivalent (WTE) qualified nurses and 123 WTE support workers working at Cedar House across the six wards. There were three vacancies for qualified nurses across the hospital and 19 vacancies for support workers at the time of our inspection.
- The service calculated staffing numbers by allocating a core 0.5 member of staff for every patient on day shifts and 0.375 staff for every patient on night shifts. Staff were then added to support any patients who were on increased levels of observation. The service employed a rota manager who completed staff rotas two months in advance. They had access to a bank of flexible staff and had a clear system to record their availability. They also had access to agency staff if required.
- Over a four week period from 1 January 2018 to 28 January 2018, out of 2016 shifts, 167 shifts (8%) were filled by staff from the flexible bank and 76 shifts (4%) were filled by agency staff. 42 shifts (2%) were not covered. The service used agency staff when required and this was predominantly on night shifts and at the weekend. We carried out a night visit during our inspection and spoke with agency staff, who showed they were familiar with patients and the environment.
- The service was understaffed by four staff across the site on two occasions in this four week period. We looked at handover sheets for these days and saw that staff worked cohesively to ensure the patients and they were safe. The hospital's senior charge nurse told us that systems were in place to cover staff shortages, such as charge nurses and educational staff prioritising supporting the wards.
- The sickness rate for the wards was 6.7% at September 2017, with the highest sickness rates on Ashford and Poplar wards and the lowest on Folkestone and Tonbridge wards. Senior managers had introduced a new initiative to interview all staff on return from sick leave and for staff not to work additional shifts following a period of sick leave. Staff told us they were confident that senior management arranged adequate staffing for the service. However, they acknowledged that

colleagues phoning in sick just before a shift or not turning up at all was an ongoing issue. In response to this issue, the hospital manager had introduced performance management for staff who regularly went sick for non-work related reasons. They were monitored for six months and if their attendance did not improve they were issued written warnings. Staff told us senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.

- We found the provision of qualified nurses across the hospital did not always allow one nurse to be based on each ward. Due to the location of the six wards inside the secure fence nurses could easily move between wards to attend to nursing duties such as administration of medication. However, Poplar ward was outside the secure fence and required staff to go through the secure control centre to access it. We found nine out of 28 day shifts and 24 out of 28 night shifts did not have a nurse allocated. Due to Poplar supporting patients who were stable, constant nursing support was not deemed necessary. However, during our inspection one patient was on one to one observations as there were no low secure beds available. There was a clear clinical rationale for this arrangement which was appropriate. The senior charge nurse informed us that during the day the charge nurses, who were based in the administration block directly opposite, offered nursing support to Poplar ward. At night the service had a protocol to allow staff to move through the control centre quickly to attend Poplar ward in emergency situations.
- We saw examples during our visit of extra staffing being made available. For example, to provide enhanced levels of observation of patients. However, this could mean taking staff from other wards, which presented those wards with additional pressure. Overall safe staffing levels were maintained.
- Staff said there was not always sufficient staff to deliver Section 17 leave. However we saw data that showed, between 1 August 2017 and 31 January 2018, Section 17 leave was cancelled 26 times out of 2117 (1%). These figures appeared to be reasonable and not adversely affecting patient experience and access to leave.
- Arrangements were in place to provide effective support which enabled clinical staff to spend their time in direct contact with patients, for example the service had employed two clinical administrators. This meant staff had time released to be able to prioritise the care and treatment of their patients.
- The service had a comprehensive and thorough workforce plan. The plan described the way safe staffing levels ensured the successful delivery of services in an effective way whilst maintaining safe standards of care. For example, nurse recruitment and retention continued to be a key issue across the organisation and there had been a number of identified actions to retain staff for longer including the secondment of support workers to complete their nurse training through the Open University, a review of nurse pay band structure and the introduction of nurse forums.
- Staff told us that they could always access a doctor if required. Doctors were flexible and responsive to requests to attend the wards when required. This included in an emergency. Medical staff told us that there were adequate doctors available over a 24 hour period, seven days a week, who were available to respond quickly to the wards in an emergency.
- Patients told us they were offered and received a one-to-one contact with a member of staff most days.
- Cedar House staff had a 93% completion rate for mandatory training which included 28 courses and included training on the Mental Health Act, the Mental Capacity Act, health and safety, personal security and safety, risk management, conflict resolution and physical intervention, delivering direct care and support, safeguarding, equality and diversity, emergency first aid and learning disabilities. The provider had sent staff individual letters asking them to complete mandatory training by December 2017. Staff were further incentivised to complete their training by being entered into a monthly prize draw for staff who had 100% compliance. Those not completing their training were subject to performance management.

Assessing and managing risk to patients and staff

- In the preceding six months to our inspection, there were 584 incidents of restraint with 28 patients and 11 of these restraints were carried out, initially, in the prone position. Prone restraint is a face towards the floor position which should be avoided as it can compress a person's ribs and limits an individual's ability to expand

their chest and breathe. Additionally, a person who is agitated and struggling needs extra oxygen and they are unlikely to get sufficient oxygen in the prone position. The highest number of restraints were carried out on the enhanced care area of Folkestone ward with 401 restraints. Staff carried out appropriate physical healthcare checks following restraint and rapid tranquilisation. Where there were any episodes of prone restraint recorded within the service, a physical intervention trainer was allocated to follow up with the staff involved, to understand why prone restraint was used. The physical intervention trainers offered advice, additional training and coaching to the staff involved to ensure lessons were learnt and the likelihood of reoccurrence was reduced. The taught approach was that prone restrain should not be used and that if prone restraint was used, for example for the administration of medication, then the patient should be turned to a supine or other safer position as soon as possible.

- Restrictive practices including physical intervention were monitored through the provider's electronic incident reporting system. The incidents were analysed monthly and trends monitored at corporate, hospital, ward and patient levels. Clinical improvement group meetings were held monthly in each ward where physical interventions were reviewed and clinical improvements, which should reduce such practices, were implemented. The model used across the hospital was positive behavioural support and all staff had received training. A four-stage restraint model was taught, which promoted standing and seated restraint over floor based restraint. The training included positive behaviour support training and comprehensive conflict resolution skills that focussed on de-escalation to minimise the use of physical intervention. All staff received training which included the management of actual and potential aggression. Staff practiced relational security and promoted de-escalation techniques to avoid restraints and seclusion where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict.
- In the preceding six months to our inspection, there were two episodes of long-term segregation (LTS). We looked at these instances in detail. All had a clear rationale for the commencement of LTS, with evidence that it was necessary as a 'last resort' of managing disturbed behaviour. Detailed care plans were in place and focussed on what needed to be achieved to end LTS, by patients and by staff. Considerations had been made on how to nurse the patients in the least restrictive manner possible in the circumstances, including access to fresh air, occupational therapy input, activities and opportunities for human contact. In addition, both patients received four hourly nursing reviews, an approved clinician review every 24 hours and a weekly review by the multidisciplinary team. Records were available which evidenced that this was happening.
- There were 160 incidents of seclusion in the six months prior to our inspection, 158 were on the enhanced care area on Folkestone ward. The care Quality Commission carried out an unannounced thematic review focusing on the use of seclusion, restraint and rapid tranquilisation in December 2017. The review was prompted by an incident involving a patient who required emergency hospital treatment following a period of seclusion. During our review two patients told us they felt that an explanation for the reasons for seclusion was not always provided, however we reviewed their care plans and found they had been involved in the reasons why seclusion was necessary. These patients also felt that staff were aware that patients self-harmed whilst in seclusion, their own wishes about medication whilst in seclusion were not respected and they felt staff did not listen to their needs whilst in seclusion. Staff told us they felt seclusion was used for prolonged periods at times and staff felt traumatised and distressed following recent incidents on the ward. However, they had access to the daily charge nurse clinic and reflective practice to debrief on these incidents. Not all seclusion documentation had been fully completed including, checklists, signatures, post seclusion de-brief, names of staff attending the de-brief, review of paperwork, first hour of seclusion date and signature and details of other strategies used prior to seclusion being implemented. We raised these concerns with the provider immediately following the review. We were awaiting a provider action statement following a thematic seclusion review carried out in December 2017 in response to these issues.
- We looked at 30 electronic care records across all of the wards. Comprehensive risk assessments were in place for all patients on admission. All patients, where they had wanted to, and had consented to, had been involved in the risk assessment process.

Requires improvement

Wards for people with learning disabilities or autism

- The overarching risk documentation and assessment method used at Cedar House was called the 'clinical assessment of risk and management' tool. Risk formulations and plans were consistently well planned, of a good standard and used structured professional judgement (SPJ) risk assessment schemes which staff had been trained to use. This included the sexual violence risk-20 assessment. A structured decision support guide, called HCR-20, was used to assess risk factors for violent behaviour. An assessment of protective factors was used to help reduce the risk of any future violent behaviour as well as offering guidance for treatment and risk management plans. Cedar House usedthe health of the nation outcome scales (HoNOS) for people with learning disabilities and the HoNOS-Secure, both of which are relevant to a learning disability population. The provider used the ARMIDILO-S, a recently developed sexual offending risk assessment tool, specifically for people with intellectual disability and the Northgate fire-setting risk assessment tool. All of this information was reviewed regularly and documented in the individual support guidelines for each patient. Reviews of risk were part of the multidisciplinary care review process. SPJ assessment schemes are recommended good practice by the Department of Health for implementation in forensic and secure settings.
- Reduction in the use of restrictive practices for each patient at Cedar House was achieved through the use of positive behaviour support (PBS) / Individual support guidelines (ISG) plans for every patient. These plans were developed in conjunction with the patient where possible. Psychology staff were fully trained and all staff had received in house training. The PBS/ ISG approach was taught during the provider's induction courses, including individual teaching of the individual PBS plans for each patient on the staff member's allocated ward. PBS /ISG training was linked to the annual physical intervention refresher courses, and regular refresher days for individual PBS/ISG training were provided for all wards.
- Patients were encouraged to discuss risk and these discussions took place in the 'my aims and goals' meetings, ward community meetings and care programme approach meetings.
- Any restrictions on the wards had been thought through with staff and patients before implementation or had a clear rationale. For example, patients admitted to the wards underwent searches to ensure no contraband was brought onto the ward. This was to ensure a safe environment for patients and staff and this had been put in place following incidents of contraband being brought onto the wards. Contraband is an item, which is banned from the ward such as weapons, drugs or alcohol. There was a list displayed showing these banned items. Staff told us that patient searches were completed in a supportive and dignified way, ensuring it was conducted in a private area of the ward. Staff were trained to carry out searches. Staff told us blanket restrictions were under ongoing review and staff proactively attempted to keep blanket restrictions to a minimum. For example, patients were able to purchase technological and electronic equipment as they wished, such as MP3 players, TVs and game consoles.
- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. A total of 89.7% of staff had received training in safeguarding adults at risk and were aware of the provider's safeguarding policy. From December 2016, for a period of 12 months 66 safeguarding concerns were raised and discussed with to the local authority safeguarding team. Of these 29 progressed to investigation. There was regular contact on a bi-monthly basis with a named local authority safeguarding lead. This individual supported the service and offered consultations around safeguarding incidents. This often resulted in the incident being managed informally and not requiring escalation to a safeguarding referral. They also delivered safeguarding information specific to the hospital as part of staff induction. The service also had an allocated police liaison officer who could intervene and talk to patients following incidents of assault. Safeguarding incidents, in particular patient on patient assault, continued to be an issue and we saw that the service and the local authority safeguarding team were working cohesively to address this issue.
- Medicines were managed safely. Medicines were stored securely and at the correct temperature, including medicines which required refrigeration. Appropriate arrangements were in place for ordering and storing medicines. People had medicines available when they needed them, including those prescribed on a 'when

required' basis. Controlled drugs (medicines requiring extra monitoring and security due to potential for misuse) were managed appropriately. Alerts for faulty medicines and devices were actioned in a timely manner.

- We reviewed prescription charts for 14 patients. These were signed and dated by the prescriber. One chart did not document the person's allergies. There were a small number of missed doses of medicines on a few patients' prescription charts. Where patients had refused medicines, the reasons were recorded on the chart. Consultants reviewed patients' medicines regularly. A pharmacist clinically screened patients' prescription charts on a weekly basis. This helped to ensure patients were receiving the most clinically appropriate treatment, which also aligned with any Mental Health Act requirements. The pharmacist and consultants regularly communicated with each other, and any actions required were followed up. The pharmacist also undertook monthly audits on medicines. Results were sent to all clinical staff to action, and incorporated into governance meetings to help drive quality improvement. Staff knew how to report medicines errors.
- Staff used behavioural support techniques to avoid the use of sedating medicines. Patients at the service had medicines information in either easy read, pictorial format, or both. Where appropriate, patients were also supported to administer their medicines themselves.
- For any patients wanting to see children from their family, processes and protocols had been put in place to accommodate this. Each request was risk assessed thoroughly by the social work team, to ensure a visit was in the child's best interest. Separate and secure family rooms were available away from the ward areas in the control room area.

Track record on safety

- The provider reported eight serious incidents requiring investigation in the 12 months prior to October 2017. These involved three incidents of patients swallowing batteries, two incidents of aggression, two incidents of self- harm and one allegation of sexual assault. The provider had carried investigations to establish the root cause of the incidents.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the provider's electronic based recording system. All incidents were reviewed by the multidisciplinary teams on each ward, at least weekly. Incidents were also discussed at the senior management team meeting which took place daily. Lessons learnt from incidents were both patient specific which led to changes to a patient's individual care and treatment plan and systemic or environmental. Patient specific issues were communicated via care plans, individual support guidelines and the 'my aims and goals' meetings. Senior clinicians provided patient specific training for staff where the clinical team assessed the treatment plan needed additional support and guidance. Where systemic or environmental issues were identified as contributing factors these were discussed through the ward based 'clinical improvement groups' and through the hospital wide clinical governance process. A clinical governance newsletter summarised key issues discussed and any lessons learnt to prevent reoccurrence and was sent to all staff. In addition, regular ward based reflective practice sessions were held where key themes and issues were discussed. As well as learning lessons these sessions ensured staff felt adequately supported. The provider's quality team also produced a regular briefing with lessons learnt more widely across the organisation and this was also shared with the staff. Managers investigated all incidents to try to establish the root cause. After all incidents, staff and patients had been offered a de-brief session to immediately address any lessons to be learnt. Psychology staff prepared an individualised spreadsheet which listed any incidents for every patient on all wards. This was presented at every patient's clinical meeting as well as quarterly at the local integrated governance meeting.
- During meetings we attended managers discussed safety issues which was in keeping with an open and transparent culture and their duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We looked at the policy called, 'being open' which explained the

process by which the required standards would be met to ensure quality and consistency of communication following incidents which give rise to significant harm and how the organisation will meet its duty of candour obligations. The provider had ensured prompts had been put into the electronic incident reporting system which ensured that duty of candour was considered. In 2017 all staff undertook mandatory training on duty of candour.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We carried out an unannounced visit to Cedar House on 10 January 2018 to look specifically at how the service monitored patients' physical health. We reviewed six patients' care records for the previous four weeks and found that, in the majority of cases, staff were responding to patients' physical health needs appropriately. The handover sheets showed that when a physical health issue had been raised with ward staff, actions were taken in response to this. Handover sheets contained actions for staff in relation to patients who had complained of a physical health problem. We cross referenced the actions specified on the handover sheet against the care notes for each patient and found that the actions were documented correctly and had taken place, for example taking physical observations or making a referral to a speech and language. We saw that patients were referred and supported to attend the GP clinic and an example of the GP attending a best interest meeting for a patient with chronic obstructive pulmonary disease who wanted to restart smoking after a period of cessation. However, we identified one instance where a patient, who ultimately required admission to a general hospital, was not seen by an appropriate trained member of staff in a timely manner causing a delay of two days.
- The service kept records of when patients attended healthcare appointments away from the hospital site. The accompanying staff member completed a health appointment feedback form which summarised the outcome of the appointment. These forms were then scanned onto patients care records. We saw examples of these and found they were completed with appropriate detail. However, we found that accompanying staff did not take written information about patients' physical health history to give to receiving healthcare professionals. The service relied on staff to verbally handover the patients' history which could potentially lead to errors.
- The service had recently employed a health promotion nurse on a full-time basis. They were trained in general nursing and took a lead in monitoring patients' physical health needs. We saw examples of them carrying out intervention such as full chest examinations. Their role was also to provide training to staff and identify areas of improvement. They had arranged workshops for staff in how to use the malnutrition universal screening tool, which identifies adults, who are malnourished, at risk of malnutrition (undernutrition), or obese and the Waterlow assessment that assesses the risk of patients developing pressure ulcers. The service had also introduced a quarterly physical health improvement group that was attended by psychiatrists, GP and the health promotion nurse. We looked at minutes from this meeting and saw the team were looking at introducing smoking cessation, cervical screening and initiatives to address obesity.
- Staff assessed patients' needs and delivered care in line with the patients' individual care plans. All patients received a physical health assessment, called the 'Cardiff enhanced service for the care of adults with learning disabilities'. Staff identified and managed risks to physical health. In addition to psychiatrists working as part of the multidisciplinary teams, a general practitioner (GP) visited the unit regularly every week. We spoke with the visiting GP who ran a weekly clinic at the hospital for patients who were not able to attend the GP surgery. They saw on average seven patients a week at the hospital clinic and three patients at the surgery. The GP worked closely with the health promotion nurse and staff to improve the information contained in referrals. They felt that communication with the consultant psychiatrists was good and they attended a bi-monthly meeting where they gave feedback on patients seen in clinic. They completed annual health checks for all patients and produced physical health

action plans that were included in patient's six monthly progress and planning reviews. The GP felt that the clinic room they used was appropriately resourced and the service responded promptly to requests for additional equipment, such as screens to maintain patient's privacy and dignity.

- All patients were registered with a local dental surgery which provided a dentist with specialised training in providing care to people with learning disabilities and autism. All patients who had been within the service for over 12 months had the opportunity to see the dentist. Patients were offered regular reviews for their vision and audiology appointments. A regular review of communication needs, particularly how the patient might communicate pain or distress, was undertaken. This included providing support to the patient to enable and empower them to manage their own health and make decisions about their own healthcare. This included providing information in a format that patients could understand. All staff we spoke to were very confident in their ability to assess physical health care needs and provide robust care and treatment plans. The health promotion nurse told us that all patients received a complete physical health check every year and we saw evidence of this in the patients' care records. All patients had a health action plan which detailed their health needs, the professionals who support those needs and a log of various physical health appointments which included, for example dentistry, eye care, speech therapy and physiotherapy.
- Care plans were personalised, holistic and recovery focused. All wards used the care programme approach as the overarching method for planning and evaluating care and treatment. Wards used nationally recognised good practice recovery tools called the 'Life star, my shared pathway, this is me and health action plans'. All of these processes focussed on patients' strengths and goals. Staff had fully implemented these approaches. This enabled a consistent approach during assessment, implementation and evaluation of patient's care and treatment.
- Patients' told us that they received a copy of their care plans, which they kept in a folder called, 'my care plans' or the, 'blue floppy folder'. The care plans were individually worded and where appropriate made use of pictures and symbols which patients told us they understood. Patients we spoke with told us that they were involved in the care planning process and that the plans were recovery focused. There were many examples of staff applying this individualised approach to patients. The clinical meetings we attended discussed patients as individuals with unique needs.
- All patients had an individual support guide which detailed their unique behaviours and listed things which may upset them such as feeling ignored or being told what to do. The guide went on to describe positive strategies which had been taught to patients. These positive support plans included learning ways of coping with being upset. Examples included engaging in activities, not getting bored, participating in psychological therapies, using coping strategies and talking to staff to gain support. All of the guides were written in accessible language, easy read formats, with the use of pictures and symbols so that patients could understand them easily. All staff told us they had received training in positive behavioural support in order to consistently and proactively implement this approach, training records showed that this was the case.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE guidance in the delivery of the therapeutic programme that included nationally recognised treatments for patients such as psychology.
- Patients had access to a variety of psychological therapies either on a one to one basis or in a group setting. Psychologists, occupational therapists and activity therapists were part of the multidisciplinary teams and were actively involved. Patients had access to a range of psychological and occupational therapies such as cognitive behavioural therapy, drama and movement therapy, music therapy, art therapy and dialectical behavioural therapy and these were delivered via one to one sessions and in groups. There was evidence of detailed psychological assessments and assessments of neuropsychological functioning. Specific psychological therapy work was available for a variety of offending behaviour. Patients told us therapies had helped to decrease their anxiety and had equipped

them to address their issues and journey to recovery. The medical director and hospital director received NICE guidance updates and all relevant changes were highlighted in the hospital clinical governance meetings.

- All patients were assessed using the 'health of the nation outcome scales' (HoNOS) for secure services and learning disabilities. These covered twelve health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- Every patient had an individualised occupational therapy treatment plan which was based on the model of human occupation re-motivation process. MOHO is the acronym for the Model of Human Occupation, which is a therapeutic model that occupational therapists use to case formulate patients abilities and future care needs. The MOHOST is a screening tool that highlights deficits that require further assessment, in addition to acting as an outcome measures.
- The provider used technology to support patients effectively. For example, staff had been trained to use the, 'brain in hand' app on touch devices. The apps had been personalised to offer 10 patients assistance, prompts and education in managing their anxiety and any deterioration in mood. Staff and patients gave us examples of positive changes, such as strengthened coping strategies, staff learning how to help patients' best, improved communication and learning dialectical behavioural therapy skills.
- The provider had sourced training for staff in providing a model of well-being which included, positive emotions, engagement, relationships, meaning and achievement.
- Staff participated in wide range of clinical audit to monitor the effectiveness of the services provided. Areas covered included, capacity to consent, physical healthcare, care programme approach, nursing cares plans, episodes of restraint, seclusion, self-harm behaviour and developing easy read formats for patient feedback. Action plans were developed to address any areas identified for improvement.
- All staff participated, at least weekly, in reflective practice sessions to also evaluate the effectiveness of their interventions.
- A local integrated governance meeting was held monthly and incorporated feedback and discussion which included, care and effectiveness, risk management, patient safety and patient and carer experience. All wards were represented. Areas of best practice discussed at the governance meeting included person centred care planning, assessing and managing positive risk taking, accessible and easy read documentation and engaging family and friends. All of these areas had associated audits which identified areas of best practice and other areas to work on to further improve the quality of service provision.

Skilled staff to deliver care

- The staff on all of the wards came from a variety of professional backgrounds, including medical, nursing, psychology, occupational therapy, social work, activity and sports staff, teaching staff and pharmacy and were all fully integrated into the service. All staff were trained in learning disabilities and autism.
- Staff received appropriate training, supervision and professional development. Over 93% of staff had updated mandatory training refresher courses recorded. All new staff attended a comprehensive and thorough three week induction programme followed by a 12 week mentorship period. The induction programme for all new employees included teaching on autism and communication, intellectual disability and patient specific positive behaviour support training. In addition it was mandatory for all support staff to achieve the Pearson Edexcel Level 2 Diploma in Health and Social Care for England which included a unit on, 'Understanding the context of supporting individuals with learning disabilities'.
- The provider supported a nurse leadership programme in collaboration with the Royal College of Nursing and was run every year for 24 nurses across the wider organisation. As part of the course the nurses learn leadership skills and have an opportunity to co-consult with their colleagues on issues in their practice. They are also asked to undertake a project to address an area of practice improvement and implement this within their service using the leadership skills obtained. Previous projects have included the use of post incident debrief for patients and staff, improving the effectiveness of multidisciplinary working to improve patient outcomes, increasing staff morale and changes to staff employment benefits.

Requires improvement

Wards for people with learning disabilities or autism

- In collaboration with Greenwich University the role out of the nurse associate apprenticeships was ready to start in spring 2018. This offered a clear career development opportunity for support workers. The service was currently allowing their senior nurses to rotationally cover a charge nurse who was on maternity leave. This allowed them to do this role for three months each and contributed to their professional development.
- All aspects of clinical training took into account the needs of the patient population, for example safeguarding adults at risk and updates on the Mental Capacity Act and the Code of Practice for the Mental Health Act.
- Staff were also encouraged to attend longer internal and external training courses. A number of staff members, for example, had attended training on dialectical behaviour therapy. Further individual patient specific training was delivered on an as required basis as well as teaching on broader topics including the SPELL (structure**,** positive (approaches and expectations), empathy**,** low arousal**,** links.) framework, developed by the National Autistic Society and TEACCH (Treatment and education of Autistic and related communication-handicapped children) which is a service, training, and research program for individuals of all ages and skill levels with autism spectrum disorders.
- All staff we spoke to said they received individual and group supervision on a regular basis, at least every six weeks, as well as an annual appraisal. A senior support worker started at 5am to enable night staff to receive supervision. We looked at staff records which showed that this was the case. The charge nurses had recently started having supervision from an external psychologist to look at ways to better support their support workers. They told us they were considering introducing an initiative which required staff to rotate round each ward. They had listened to feedback from staff who felt they had been identified as 'a weak link' when asked to move from the more challenging wards. They hoped this initiative would support staff and also help them learn new skills such as escorting patients on leave and using de-escalation skills. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the ward.
- All wards had a regular team meeting and all staff we spoke with described morale as mixed but in the main good. Staff said their team managers were approachable and supportive. Topics recently covered included managing and learning from incidents, care planning, the 'brain in hand' initiative and setting managing self- harm behaviour.

Multi-disciplinary and inter-agency team work

- The service had fully integrated and adequately staffed multidisciplinary teams throughout Cedar House. We observed care reviews and clinical hand over meetings on most wards and found these to be effective and involved the whole multidisciplinary team. All members of the team were given space and time to feedback and add to discussions in meetings. We observed the handover on Folkestone ward and found that patients' presentation over the last 24 hours was clearly described to staff.
- We observed inter-agency working taking place, with primary care as a particularly positive example. Patients had access to all secondary care provision. The health promotion nurse carried out long-term condition management, for example for patients with diabetes or cardiac problems. Staff worked closely with the local acute hospital and, in addition had visiting dieticians, podiatrists, physiotherapists, speech and language therapists and specialist tissue viability nurses. Staff maintained strong links with community based treatment teams such as dentists and opticians and encouraged patients to access these in line with the social inclusion programmes. We observed patient review meetings that were attended by their allocated community nurses from their home area.

Adherence to the MHA and the MHA Code of Practice

- All staff had received training on the Mental Health Act as part of their induction training.
- We carried out a Mental Health Act review on Tonbridge ward, Rochester ward and Ashford ward, which included examining all Mental Health Act documentation for patients on the wards.
- We were awaiting a provider action statement following a thematic seclusion review carried out in December 2017.

Requires improvement

Wards for people with learning disabilities or autism

- Outstanding actions from the previous Mental Health Act monitoring reviews on the three wards visited during the course of this inspection were as follows. Rochester ward did not have any patient information displayed in a format that they may understand, such as pictures and easy read leaflets or art work in secure notice boards, this was still the case during this inspection. There were no de-escalation rooms available on Rochester or Tonbridge wards. Patients would need to be taken to the seclusion room on Folkestone enhanced low secure ward to access seclusion which may impact on their dignity and respect. This was still the case for the patients.
- The provider made sure that all staff complied with the Mental Health Act requirements. Staff checked Mental Health Act paperwork regularly. Detention papers were available for review and were in good order throughout. The Approved Mental Health Professional reports were available in the files scrutinised.
- Evidence that rights had been explained to patients as required by section 132 of the Mental Health Act was found in all files. Staff explained patients' rights to them at appropriate times and made a note of anyone refusing the discussion. For those patients who would not regain capacity the responsible clinician completed an annual statement confirming rights had been explained to the nearest relative.
- The system for recording patient leave was thorough. Staff told us that a leave of absence procedure was in place on the ward, with patients being assessed prior to leave and their attire noted. Copies of Section 17 leave forms were kept in the patient individual folders.
- In 11 out of 13 files reviewed there was evidence that consideration of capacity to consent to treatment was present.

Good practice in applying the MCA

- All staff had undertaken Mental Capacity Act (MCA) training. There was a MCA policy in place and staff told us about the principles of the Act and how they applied to their patients.
- There were no Deprivation of Liberty Safeguard (DoLS) applications in the previous six months to January 2018. Where appropriate patients had a mental capacity assessment relating to care and treatment. We also saw this reflected in care plans and additional assessments for specific interventions such as medical procedures and personal care delivery.
- Documentation was available around best interest decisions in patients' notes and staff told us confidently what this meant. Three out of four families told us they had been involved in discussions.
- The integrated governance meeting and the Mental Health Act administrator monitored adherence to the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, dignity, respect and support

- We spoke with 28 patients, individually and in a focus group and we received 15 comment cards from patients. The majority of patients we either spoke with or received comment cards from, 70%, made positive comments about their experience of care in Cedar House. However, 30% of patients we spoke with said staff did not have their welfare as a priority. The two patients we spoke with as part of the Care Quality Commission seclusion review in December 2017 spoke negatively about their experiences. During this inspection the care plans relating to the use of seclusion for these patients had changed. Some patients told us that staff, were too busy to spend quality time with patients; others said staff were available for them most of the time. During our inspection, we saw positive interactions between staff and patients who had limited verbal communication . Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. Staff showed patience and gave encouragement when supporting patients.
- We had concerns that staff had not picked up on the cleanliness issues on Tonbridge ward, particularly the dirty bathrooms and kitchen. In addition a patient had been expected to sleep in heavily soiled and unpleasant smelling bed linen. A number of patients said some of the furniture on Tonbridge and Maidstone wards was stained and soiled and they were unhappy about having to use it. However, we were provided with evidence that furniture was deep cleaned when it became soiled.

Requires improvement

Wards for people with learning disabilities or autism

- The staff from the wards received 17 compliments in the previous year.
- All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. This information was very detailed and was summarised in the patients' individual support guides.
- Despite the complex, and, at times challenging needs of the patients using the service, the atmosphere on all of the wards was calm and relaxed. We saw a number of swift interactions where staff saw that patients were becoming agitated, distressed or overly stimulated, particularly with visitors on the wards. Staff immediately attended to their patients in a kind and gentle manner.
- We spoke to staff who were able to confidently discuss their approach to patients and the model of care practiced across all of the wards. They spoke about enabling patients to take responsibility for their care pathways.

The involvement of people in the care they receive

- Where patients had a planned admission to the wards they had already received information about Cedar House before admission. The information booklets welcomed patients and gave detailed information about health needs, the multidisciplinary team providing care, treatment options, medicine and physical health needs, treatment options, daily life on the ward, recreation and leisure needs .The booklet orientated patients well to the service and patients we spoke to about the booklet had received a copy and commented on it positively.
- We saw evidence of patient involvement in the care records we looked at, particularly captured in the individual support guidelines and care plan folders. This approach was person centred, individualised and recovery orientated. We also saw that all patients reviewed their care plan once every two weeks with the multi-disciplinary care team and in regular meetings with a member of the ward nursing team.
- During our inspection, we joined a number of multidisciplinary care review meetings on a number of the wards where the views and wishes of the patients were discussed with them. Options for treatment and therapy were given to the patients to consider at all of the meetings.
- Information was advertised on all of the wards about local advocacy services available. An advocate was available for four days a week.
- The provider had set up an initiative called, 'conversation into action' which involved staff and patients participating through workshops and forums to think about and give ideas as to how the quality of services could be improved. Ideas from these events were then implemented through action plans. Examples of changes made included patients participating in staff recruitment and the development of the peer trainer role.
- Regular feedback was sought by surveys such as the 'family and friends plus 5' test.
- The provider carried out a patient engagement survey in 2016. An action plan was developed to address any issues raised and was developed into an easy read format and discussed at each wards community meeting. Areas identified for improvement included, meeting with staff in the clinical team when a patient wanted to and having a wider choice of activities in the week, evenings and at weekends.
- Patients had a number of ways of being actively involved in giving feedback about the service and also getting involved in shaping services. For example, each ward ran a weekly community meeting at a regular fixed time which all staff linked to the ward and patients on the ward were encouraged to attend. Standing agenda items included health and safety and ideas for how the service could improve. Patients were supported to take the roles of chair, time keeper and 'praise note reader'. At every meeting patients and staff wrote each other compliments, called 'praise notes'. These were read out and on Maidstone and Folkestone ward placed on the 'praise tree' for everyone to see. An easy read record of the meeting was completed. The advocate attended all community meetings. Examples of patient ideas which were taken up included, the acquisition of a tepee tent for the patients on Folkestone ward to have an overnight camping experience, a request from patients on Maidstone ward to have their own fridge to store fresh, healthy food and snacks and patients wanted more contact with animal the introduction of a buddy system for new patients admitted to Cedar House and the provision of a 'welcome bag' for new patients which would include key items, for example a toothbrush and

toothpaste. Any issues or ideas raised at the ward community meetings were a standing agenda item for each ward's clinical improvement group and the hospital wide, monthly, clinical governance meetings. Each ward was also encouraged to have a patient representative in their clinical improvement group.

- Individual departments within the hospital also had systems in place to receive feedback from patients. For example, the catering department provided each ward with daily menu feedback forms for the patients to access if they wish to comment on each day's menu and offer any suggestions for improvement. The catering team also held catering forums for patients led by the catering manager and head chef which included tasting sessions. The Royal College of Psychiatrists 360 appraisal system invited patient feedback.
- Patients spoke positively about volunteering and work experience opportunities at Cedar House. They said this also enabled them to influence service development and give feedback on ideas for improvement. For example, three patients were assisting with the extensive garden areas, one patient was working with the hospital maintenance team, another was enjoying making a birdhouse and one patient worked alongside the catering team.

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

(for example, to feedback?)

Good

Access and discharge

- At the time of our visit there were no vacant beds at Cedar House. Bed occupancy in the preceding six months to our inspection was 100%. Data from the Cedar House quality report identified three patients with delayed discharge. Two delays were due to an absence of appropriate placements and patients requiring bespoke services due to their level of complexity and one delay due to a guardianship referral being needed. Placements had been identified for two of the patients with planned discharge dates in the spring.
- The provider was part of the local 'Transforming Care Community Infrastructure group', where stakeholders supported by the local transforming care leads planned local social services for individuals who were currently in hospital and for whom no existing service for move on had been identified as appropriate.
- Key clinical and managerial staff attended a bed management and referrals meeting. This meeting oversaw the inpatient secure care pathway. The bed management meeting monitored all actual and potential inpatient delayed discharges.
- Patients were not moved between wards unless clinically indicated. Some patients were admitted away from their home areas due to the specialist services available at Cedar House. Plans were discussed and put into action to enable family and friends to travel to the hospital to see their relatives.
- We spoke with patients who had progressed through the secure care pathway. Some came from prison or medium secure services. A number of these patients had identified housing to move into in the community. On Poplar ward patients told us that they appreciated the opportunity to exercise much more independence and in preparation for their discharge from hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- All of the wards had a full range of rooms and equipment to support care and treatment delivery. However, the communal areas of the wards were rather bleak with bare walls and little availability of easy read information or art work to soften the appearance of the wards. The provider acknowledged this and outlined the difficulties in making the environment suitable for patients on the autistic spectrum. They also had ongoing challenges with patients removing items displayed on walls and had taken the decision to provide patients with the necessary easy read information through individual soft folders.
- Patient bedrooms could be personalised where requested and this was evident in some of the rooms we were invited to look at. All patients, if they could manage to, had a key to their bedroom and could gain access at any time. Patients were all able to store their possessions securely.

- Patients had access to telephones to make private calls on the wards.
- Each ward had access to large outside gardens, all within the perimeter fence. Poplar ward had access to its own large garden area. Patients told us on all of the wards that they enjoyed planting the ward gardens and maintaining them. The provider had financed and supported a number of developments which patients commented on positively. For example, the tent with electricity available for the patients to experience an overnight camping trip experience, an award for building a tree house, garden sheds and planting areas, the beauty and spa salon on Maidstone ward, the music summerhouse, guinea pigs available for the patients on Maidstone ward and the hospital cat.
- We had concerns at our previous inspection in 2015 about the quality of the food provided and at that time all of the patients we spoke with, who received catered food from the main kitchen, made some negative comments about the quality and variety of food served. On this inspection considerable improvements had been made and the majority of patients made positive comments about the food provided. The 'food tasting forum' continued to try to further improve the quality of food provided. Staff told us that patients had their own snack boxes to supplement their diets. All of the patients who self-catered spoke positively about the ability to do this and all wards with the exception of Folkestone ward had self-catering opportunities. Self-catering was stopped temporarily on Tonbridge ward whilst the kitchen was thoroughly cleaned and a risk assessment carried out to ensure good infection control practice was followed.
- There were facilities available on all of the wards for patients to make cold or hot drinks or to have snacks throughout the night and day
- Daily and weekly activities were advertised and available on and off all wards. An excellent range of activities and groups were available to patients on all of the wards, facilitated by the activity co-ordinators, occupational therapy and ward staff. Patients had access to the education and therapy unit which was part of the recovery college, on site at Cedar House. Staff showed us the sensory room in the unit which offered a variety of electronic, individual and interactive activities available to patients. The recovery college offered an extensive range of courses and groups. The activities were varied, recovery focused and aimed to motivate patients. Patients were actively encouraged to make suggestions for activities they would like. Sessions were available on a wide variety of skills based learning and included educational courses, social skills training, fun activities and creative groups. The female patients on Maidstone ward had been approached by staff to look at their needs individually such as setting up female specific gym sessions. During our inspection we joined a number of these activities and found them inclusive, creative and enjoyable. Patients told us that staff were responsive to patient requests for activities. They told us, for example, about the dog walking sessions which staff set up in response to patient's requests. A number of the groups were co-produced and provided by, 'peer trainers', who were patients trained and supported to provide sessions for fellow patients and staff.
- Many educational opportunities were available for patients to access. There were a range of award scheme development and accreditation network (ASDAN) courses on offer. ASDAN is a practical way of learning using fun tasks to learn instead of more traditional teaching methods. The courses included music, art, science, history, sports, English, shopping, cooking and budgeting skills.
- Occupational therapy was available across all wards and a variety of therapy sessions were available on all wards. They operated a model that focused on a holistic, person-centred and recovery-based approach.
- A dedicated gym instructor provided group and individual activities. The gym was well-equipped and patients all received an induction and personalised plan. The instructor delivered a range of sports courses for patients. Patients' success was widely advertised and celebrated. Patients on Poplar ward were assisted to use gym facilities in the local community, in preparation for their discharge.

Meeting the needs of all people who use the service

- Rooms were available to meet the needs of patients with physical disabilities and activity areas were accessible.

Requires improvement

Wards for people with learning disabilities or autism

- Staff respected patients' diversity and human rights, and asked about people's cultural, language and religious needs at admission. Contact details for local faith representatives were available. A dedicated multi-faith area was available.
- Interpreters were available and used when required. Leaflets were available explaining patients' rights under the Mental Health Act.
- There was a paucity of information available on Tonbridge and Rochester wards. More information was available on Maidstone, Poplar, Folkestone and the enhanced low secure area on Folkestone ward. All wards had information on how to complain and advocacy available. There was little information presented in an easy read or pictorial format in communal areas. The 'Cedar Times' magazine updated patients and staff, for example on any planned charity events, helping to prepare for seasonal events and competitions to enter.
- A choice of meals was available which enabled patients with particular dietary needs connected to their religion or culture, and others with particular individual needs or preferences, to eat appropriate meals.

Listening to and learning from concerns and complaints

- From October 2016 for a 12 month period there were 107 formal complaints in the 12 months preceding the inspection, seven were still being investigated. Overall the provider upheld 24 of these and partially upheld a further 30 complaints, which showed us that the provider was fair and transparent when dealing with complaints.
- Copies of the complaints process were on display in all of the wards and in the ward information handbooks. Patients and their relatives we spoke with all knew how to make a complaint should they wish to do so. In the patient survey 100% of respondents said they knew how to raise a complaint or pay a compliment. An Independent advocate attended the hospital every week and supported patients to raise concerns or complaints as required.
- Staff confidently described the complaints process and how they would handle any complaints. Staff told us that they try to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. All staff were trained in their induction programme on the hospital complaints, concerns and compliments policy and easy read posters were displayed on the wards and at the control centre to inform patients and visitors of the procedure. Information was also included in the patient information book and the relative and carer book. The provider carried out audits of the formal complaints and the complaints data to ensure the policy and procedures were being followed.

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

Good

Vision and values

- The provider's vision, values and strategies for the service were evident and on display in all of the wards. Staff on the wards understood the vision and direction of the organisation. Staff we spoke with were able to discuss the philosophy of the hospital confidently. The provider had worked to embed it's aspiration of 'nurturing the world one person at a time' across our organisation. Staff told us they aim to provide a high quality, safe and secure environment which encourages the development of skills and competencies in adults with learning disabilities through a person centred approach.
- The ward charge nurses had regular contact with the hospital director and senior medical staff. The senior management and clinical team were visible on the wards and staff said that they visited the wards regularly. We heard mixed feedback from staff about the senior clinical team and the director responsible for Cedar House. Some staff said that they often felt disconnected with the senior management team. Other staff were confident the response from the senior management team would be proactive and responsive.

Good governance

- All of the wards had access to governance systems which enabled them to monitor and manage the ward effectively and provide information to senior staff in the organisation and in a timely manner. One example of this was the quality scorecards which were published

monthly and covered the quality of data provided, incident analysis and trends, mandatory training compliance, staff sickness rates and complaints data for each ward.

- We looked at the performance management framework and saw that data was collected regularly. This was presented in the monthly integrated governance meeting, across the hospital and in ward meetings. Where performance did not meet the expected standard action plans were put in place. Managers could compare their performance with that of other wards through the scorecards and this provided a further incentive for improvement. All wards were meeting their key performance indicators and that the information provided was accessible and well-advertised.
- The senior clinical and management team met every morning to look at all areas of risk management. All incidents in the preceding day and night were looked at and lead investigators assigned. The team ran through a brief update on every patient and looked in more detail at the care plans for those patients on enhanced levels of observation and any patients in long term segregation. Safer staffing was considered as well as any pressures on the staffing rota or any key events planned for that day. Additional discussion took place about any Care Quality Commission notifications required, any acute hospital admissions or deterioration of physical health, any complaints made, any patient referrals or discharges planned, any visitors planned for the day, any clinical governance issues and any outstanding actions from the previous day's meeting. The senior clinical and management team had an updated and detailed view of all key issues facing the hospital, every day. We were however disappointed that the senior team had not picked up the cleanliness issues on Tonbridge ward.
- All ward charge nurses told us that they were encouraged by their managers to operate autonomously in managing their wards and received good support from the hospital director and senior clinical staff.
- All ward charge nurses we spoke to were familiar with and actively participated in the formulation of the Cedar House risk register, which we viewed. Managers were able to articulate how the hospital risk register contributed to the Huntercombe Group's overarching risk register.
- The provider had developed a board assurance and escalation framework. Cedar House had a local clinical governance meeting which fed back into a divisional governance meeting which in turn fed into the organisation wide quality and assurance group. This group received contributions from the nurse's forum, safeguarding forum, patient safety forum, health and safety committee and the service user engagement forum. Information was gathered and a standardised audit programme developed and carried out by peer reviewers from other hospital sites managed by the provider. The early warning escalation scorecard was developed to further support corporate oversight across the organisation units and provided monthly feedback to very senior managers on the performance of the hospital on health and safety, quality and patient experience.

Leadership, morale and staff engagement

- There was evidence of leadership at a ward level. The ward charge nurses were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. However some staff told us the charge nurses were not always present on the wards every day. The culture on the wards was open and encouraged staff to bring forward ideas for improving care.
- Charge nurses ran daily clinics where staff could come along and discuss any work or personal issues they had. Charge nurses could raise any staff issues, such as sickness management reviews or flexible working requests. Challenging clinical and patient issues could also be raised and discussed.
- Staff told us they felt able to report incidents, raise concerns and make suggestions for service improvements. Most staff were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to ward practice. In the most recent staff survey, general themes related to staff expressing that they did not always feel adequately supported within their roles and that they

did not feel they had enough recognition for the work they did. Staff also commented on experiencing high levels of aggression within the work place. Following on from this feedback the senior management team set up a number of initiatives to improve communication and ensure that staff felt valued and supported in their roles. For example, the 'conversation in action' forums and the 'you said and we did' initiative. Examples of changes made in response to feedback included, staff had complained about high staff vacancies and managers responded by successfully recruiting more staff and reviewing staffing levels at the weekend. Staff said that they did not always feel appreciated so managers set up two staff award schemes where patients voted for a staff member of the month who had, 'gone above and beyond' their role or who was a 'happy' staff member. Feel good Fridays was introduced to provide activities for staff such as, yoga, relaxation, origami, treatment therapies, mindful colouring and Zen stone designs workshop. A Happy birthday poster was prepared each month with staff names on it and birthday cards sent to staff on their birthday. A 'shout out' compliment board was developed which encouraged staff to complement one another. Staff we spoke with spoke positively about these initiatives.

- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- The Cedar House hospital was an accredited member of the Royal College of Psychiatrists quality network for low secure mental health services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure all ward areas maintain appropriate levels of cleanliness and staff use cleaning equipment correctly to avoid risk of cross infection.
- Ensure that all patients have access to clean bed linen to maintain their dignity and systems are in place to ensure soiled linen is detected and changed in a timely manner.

Action the provider SHOULD take to improve

- Ensure fixtures and fittings are maintained to a satisfactory standard (broken televisions).
- Ensure all paperwork associated with the use of seclusion is completed.
- Ensure when staff accompany patients to hospital they take written information about patients' physical health history to give to receiving healthcare professionals. The service relied on staff to verbally handover the patients' history which could potentially lead to errors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Areas of Tonbridge ward (kitchen, laundry room, two bathrooms, bedrooms and toilets) were visibly dirty. On Tonbridge ward the incorrect colour mop heads were used for cleaning a bathroom area. This is a breach of Regulation 12(2)(h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect One patient had dirty and heavily soiled bed linen which compromised their dignity. This is a breach of Regulation 10(1)