Jeesal Cawston Park

Quality Report

Jeesal Cawston Park Hospital,
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Website: www.jeesal.org

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

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

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

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

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

Overall summary

We did not rate Jeesal Cawston Park because this was a focused inspection:

- Both lodges had blind spots where staff could not observe all areas. Staff mitigated risks to patients by updating patient risk assessments, carrying out one to one observations and escorting patients at all times. Managers reviewed these risks during monthly multidisciplinary meetings.
- A pharmacist attended the lodges once a week to carry out medication audits, staff kept patient consent to treatment with patient medical records and created an individual patient passport detailing both physical and mental health care needs.
- Staff knew how to report incidents, there was a clear system in place which alerted managers straight away to any incidents. Managers shared incident outcomes and lessons learnt in team meetings.

Summary of findings

- Staff developed easy read care plans and paperwork for patients. Staff involved patients with decisions and input in their care plan. There was a range of activities and treatments available for patients.
- Multidisciplinary meetings took place every four weeks. These meetings were attended by doctors, psychology staff, nursing staff, patients and family members.
- We observed staff interacting with patients in a positive respectful manner. We saw staff offering practical support to ensure individual patient needs were met. Staff knew each patient's preferences and needs.
- Managers invited family members to patient review meetings and collected feedback from patients and families about the care and treatment provided.

However:

- One staff member carrying out one to one observations reported that they were not confident in carrying these out. They reported that the hospital was not following their own policy.
- Care and treatment records did not include detailed descriptions of how staff were helping patients to address individual skills on a daily basis. For example, one patient had a goal of building relationships, but the actions required to do this were not specific.
- One member of staff could not find care plans on the provider's electronic records.
- Staff did not record all outcomes and the length of each episode of patient's individual section 17 leave, clearly on patient records.

Summary of findings

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Jeesal Cawston Park Hospital.

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

Summary of this inspection

Background to Jeesal Cawston Park

We carried out this inspection using the unannounced focused inspection framework. We inspected this location in response to concerns identified by a member of the public to the Care Quality Commission. This inspection focused on three domains, safe, effective and caring.

Jeesal Cawston Park provides assessment and treatment for people who have learning disability and mental illness. There was a registered manager and a controlled drugs accountable officer in place.

The hospital provides assessment and treatment for 54 people who are living with a learning disability and mental health needs, some of whom may be detained under the Mental Health Act 1983.

We inspected both Yew and Manor Lodges as part of our unannounced focused inspection. Both lodges offered three separate living quarters for either male or female patients. At the time of inspection, there were five patients receiving care and treatment. Four were detained under the Mental Health Act 1983 and the other person was subject to Deprivation of Liberty Safeguards.

The hospital was last inspected by the Care Quality Commission on 22 – 23 September 2015. The provider was rated as good for each of the domains at that time.

Our inspection team

Team leader: Lynda Day

The team that inspected the service consisted of one inspection manager, two inspectors and a CQC national professional advisor with experience in learning disabilities.

Why we carried out this inspection

We carried out a focused inspection on both Yew Lodge and Manor Lodge in response to concerns identified by a member of the public to the Care Quality Commission.

The inspection focussed on three of the domains, safe, effective and caring.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

During the inspection visit, the inspection team:

- visited both lodges, looked at the quality of the ward environment and observed how staff were caring for patients;
- met with three patients who were using the service;
- interviewed managers or acting managers for each of the lodges;
- spoke with 13 other staff members; including doctors, nurses, activity leads, assistant psychologist and health care support worker;

Summary of this inspection

- reviewed in detail six care and treatment records of patients:
- carried out a specific check of the medication management on both lodges; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients we spoke with said they liked staff. Patients said they got to see their family, had a nice flat and could go out with staff support.

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?

We did not rate this focussed inspection. We found that:

- Staff identified ligature points on the lodges and mitigated these through the environmental risk management plans. Staff accompanied patients who were identified as at risk, at all times.
- The lodge environments were clean.
- Staff carried a personal alarm or radio for safety. These radios were checked daily to ensure they are in good working order.
- Patients had regular activities and escorted leave.
- Each patient was receiving long-term individualised enhanced levels of nursing care on the lodges. This was a bespoke service set up to meet the individual needs of patients. At least one member of staff was allocated to each patient.
- We reviewed five patient records and found staff had completed and updated detailed risk assessments. Each patient risk assessment was scored, and reviewed at the monthly multidisciplinary team meetings.
- Observations policies were in date and in place. Records showed where managers had reviewed observation levels.
- No patients had been administered an intramuscular rapid tranquilisation medication on these wards over the last six months. The provider's tranquilisation policy was updated during June 2016 and included guidance from the Royal Collage of Psychiatry.
- A pharmacist attended the lodges once a week to carry out audits and ensured that the relevant guidelines were being followed in managing medicines.
- Staff knew what to record as an incident; we saw detailed records of various incidents relating to medications, treatment, and safety and paperwork issues. Managers reviewed these daily.
- Senior managers discussed incidents and lessons learnt at team meetings. We saw notes from multi-disciplinary meetings involving psychology, doctors and senior staff as how to manage and prevent further incidents.

However:

- One staff member carrying out one to one observations reported that they were not confident in carrying these out. They reported that the hospital was not following their own policy.

Summary of this inspection

- One member of staff told us that it could take some time for help to arrive, as the radio system did not always get an immediate response.

Are services effective?

We did not rate this focussed inspection. We found that:

- Patient records showed a comprehensive assessment of risk took place soon after admission.
- Staff had completed regular physical examinations for each patient. Staff had developed a system which helped patients to report how they were feeling and communicate to staff if they felt unwell.
- Staff followed National Institute for Health and Care Excellence guidance when prescribing medications. We saw the hospital used a 'hospital passport' for each patient's medical record. This ensured staff had quick up to date information regarding patients physical health needs alongside medications.
- Records showed staff kept detailed accounts of patients nutrition and hydration needs. Staff worked with a dietician to assess any individual patient dietary needs.
- The provider supported care staff to complete the national care certificate. Managers said that this training was role specific.
- Multidisciplinary meetings took place every four weeks. These meetings were attended by doctors, psychology staff, nursing staff, patients and family members.
- The hospital's Mental Health Act administrator was available to offer staff support. We saw a guide for staff when checking detention paperwork.
- We reviewed six medication records and saw staff kept a copy of consent to treatment with each patient medication charts.
- Staff read patients their rights under the Mental Health Act routinely. We saw easy read information that staff worked through with patients to promote their understanding.
- Staff encouraged patients to make their own decisions as much as possible. Staff reported that they had received training which helped them understand how to promote patient best interest decisions.

However:

- Care and treatment records did not include detailed descriptions of how staff were helping patients to address individual skills on a daily basis. For example, one patient had a goal of building relationships, but the actions required to do this were not specific.

Summary of this inspection

- Staff did not record all outcomes and the length of each episode of patient's individual section 17 leave, clearly on all records.
- One member of staff could not find care plans on the provider's electronic records.

Are services caring?

We did not rate this focussed inspection. We found that:

- We observed staff interacting with patients in a positive respectful manner. We saw staff offering practical support to ensure individual patient's needs were met. Staff knew each patient's preferences and needs.
- Staff actively encouraged patients to participate in their care plans and treatment. We saw where staff had used pictures and easy read documentation to help patients choose goals and activities.
- The hospital had invited family members to attend patient review meetings. We saw meeting minutes where family members had shared thoughts on ongoing treatment plans.
- Patients could give staff feedback at all times and during the weekly multidisciplinary team meeting.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- At the last inspection seventy six per cent of staff had completed training in the Mental Health Act. Figures for this inspection showed forty three per cent of staff had up to date training. However, we saw further training was booked for January 2017.
- The hospital's Mental Health Act administrator was available to offer staff support. We saw a guide for staff when checking detention paperwork.
- Staff did not record all outcomes of each episode of patient's individual section 17 leave. Staff did not record the length of each episode of patient's section 17 leave clearly on records.
- We saw staff kept detailed up to date risk assessments which included risk and contingency measures for staff to follow when patients are on leave.
- Staff spoken with had a good understanding of the Mental Health Act code of practice and principles.
- We reviewed six medication records and saw staff kept a copy of consent to treatment with each patient's medication charts.
- Staff read patients their rights under the Mental Health Act routinely. We saw easy read information that staff worked through with patients to promote their understanding.
- The Mental Health act administrator carried out audits of MHA papers to ensure paperwork was completed correctly and was legal.
- The hospital had access to one Independent Mental Health Advocate, who would support patients where required.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

- Ninety eight percent of staff had completed training in the Mental Capacity Act.
- There were no Deprivation of Liberty and safeguards applications in the last six months for the lodges. One patient was subject to DoLS.
- Staff we spoke with understood the principles of the Act.
- Staff assessed and recorded patients' capacity to consent. However, one set of paperwork was missing an updated patient signature.
- Staff encouraged patients to make their own decisions as much as possible. Staff said they had training which helped them understand how to include patient best interest decisions.
- Staff knew they could get advice from the Mental Health Act administrator regarding any Mental Capacity Act or Deprivation of Liberty and Safeguards issues.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- Both lodges had blind spots where staff could not observe all areas. Staff managed safety risks by one to one observations. There were CCTV cameras in the patients' main living areas. Staff updated individual risk assessments
- Staff had identified ligature points and mitigated these through the environmental risk management plans. Staff accompanied patients who were identified as at risk, at all times.
- The lodges complied with the Department of Health's guidelines on eliminating mixed sex accommodation. All bedrooms had ensuite facilities.
- The hospital did not have a clinic room or a seclusion room on either lodge.
- While there was a clinical waste bin on Yew lodge, Manor lodge did not have one.
- The environment was clean and adequately maintained with clean furnishings.
- Staff carried out infection control audits every three months. External infection control nurses completed a full yearly full audit. Staff had access to hand sanitiser, we saw infection control and hand washing posters up on both lodges.
- Staff carried a personal alarm or radio for safety. These radios were checked daily to ensure they were in good working order.
- One member of staff told us that it could take some time for help to arrive, as the radio system did not always get an immediate response.

Safe staffing

- On the day of inspection there was one qualified nurse working between these two lodges and six support nursing staff. This was the set level of staffing requirements.
- We found the number of staff matched the staffing rota.
- Managers would use bank or agency nursing and support staff across the hospital to meet the required number of staff per shift.
- Managers established staffing numbers and grade requirements using an electronic system developed by the provider.
- We saw staff engaging with patients on the lodges. Each patient was on one to one observations. Staff said they had enough time to spend with patients.
- One staff member carrying out one to one observations reported that they were not confident in carrying these out. They reported that the hospital was not following their own policy. However, observation rotas showed staff had breaks planned in after every 2 hour observation.
- Staff supported patients' to attend regular activities and receive escorted leave. We saw one patient had not been out of the ward for two and a half weeks, this was due to the hospital bus being broken and the alternative transport was being adapted. Staff were aware this patient had complex needs and continued to carry out activities on a one to one basis during the times this patient was unsettled and unable to go out. Activities included, cycle rides, puzzles, one to one psychology sessions and games.
- Staff were aware of who to contact when needing medical advice. A doctor could attend the ward quickly in case of emergency and staff would call 999 where necessary
- Managers keep electronic records of all staff training. New staff had a 13-day training programme which included mandatory training. Records showed sixteen percent of staff had three day training in First Aid. All other training records were over 75%.

Assessing and managing risk to patients and staff

- Patient records showed a comprehensive assessment of risk took place soon after admission. Staff updated risk assessments regularly.
- Each patient was receiving long-term individualised enhanced levels of nursing care on the lodges. This was a bespoke service set up to meet the individual needs of

patients. One patient had most of their contact with staff and visitors through an opening in a locked door. This patient was unable to mix with other patients. This was based upon an individualised risk assessment and agreed with commissioners.

- Treatment records were reviewed, these demonstrated that safeguards were in place, and met the requirements as detailed in the code of practice, with regards to long term segregation.
- Care and treatment records for each patient were reviewed. These showed that staff had completed and updated detailed risk assessments. These were reviewed at the monthly multidisciplinary team meetings. This allowed clinical staff to measure outcomes based on the risk assessments. Records showed where managers had reviewed individual observation levels for patients, based on measured outcomes of behavioural change.
- Staff used distraction techniques and talked calmly to patients to help manage behaviours. Staff we spoke with understood which techniques usually worked with individual patients. Staff said that restraint was always a last resort. We looked at three patient restraint records and found that staff had recorded restraint holds when necessary. Records showed one patient had been restrained to prevent self-harming, and one patient was restrained when they were angry after a visit. There were no records of prone restraint in the last six months.
- Staff received mandatory training in positive behaviour support planning, managing violence and aggression and de-escalation.
- No patients had been administered intramuscular rapid tranquilisation medication on these wards over the last six months. The provider's tranquilisation policy was updated during June 2016 and included guidance for the Royal Collage of Psychiatry.
- Ninety three per cent of staff had completed safeguarding training. Staff knew what should be reported under the safeguarding procedures. We saw records where staff had dealt with a potential safeguarding issue.
- A pharmacist attended the lodges once a week to carry out audits and ensure national Institute for Health and Care Excellence guidelines were being followed in managing medicines. Medicines were secured appropriately. Staff checked room and fridge temperatures to ensure medicines were kept as per manufacturing guidelines. There was no controlled drugs cupboards on the lodges, there were no patients on controlled drugs.

Track record on safety

- The provider had systems in place for the reporting and investigation of incidents. Action plans were in place following incidents.

Reporting incidents and learning from when things go wrong

- Staff knew what to record as an incident; we saw detailed records of various incidents relating to medications, treatment, and safety and paperwork issues. Managers reviewed these daily.
- Staff received feedback from managers about any incidents across the hospital within team meetings. Debriefs following serious incidents were available for staff and patients.
- Senior managers discussed incidents and lessons learnt at team meetings. We saw managers had received input from psychology, doctors and senior staff as how to manage and prevent incidents.

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

Assessment of needs and planning of care

- Staff had completed regular physical healthcare examinations for each patient. Staff had developed a system which helped patients to report how they were feeling and communicate to staff if they felt unwell.
- The hospital used an electronic record system for patient care records. We saw patient care plans were up to date. Senior managers were training staff on developing more detailed positive behaviour support plans. However, two staff reported that they did not always get time to look at the electronic records, some staff could not easily locate key information in those records, which meant they might not have up to date treatment intervention information.

Best practice in treatment and care

Wards for people with learning disabilities or autism

- Staff followed national institute for health and care excellence guidance when prescribing medications. We saw the hospital used a 'hospital passport' for each patient's medical record. This ensured staff had quick, up to date information regarding patients physical health needs alongside medications. Staff could pass this over to emergency services if needed.
- Care and treatment records did not include detailed descriptions of how staff were helping patients to address individual skills on a daily basis. For example, one patient had a goal of building relationships, but the actions required to do this were not specific.
- Patients had access to a variety of treatment and assessments from psychologists. occupational therapists, activity co-ordinators, therapists, doctors and nurses. The hospital was recruiting one speech and language therapist.
- A local GP visited the site every Friday; staff said it was easy to book an appointment by fax and the GP would come at any other time if needed. Staff logged all GP appointments in patient records. Records seen showed that patients had regular physical healthcare checks.
- Records showed staff kept detailed accounts of patients nutrition and hydration needs. Staff worked with a dietician to develop any individual patient dietary needs.
- The provider used health of the nation rating scales for people with learning disabilities to measure patient outcomes. We reviewed multidisciplinary team meeting minutes where patient goals were reviewed and used to measure progress.
- Managers completed several clinical audits, such as incident records, patient treatment engagement and file checks.

Skilled staff to deliver care

- The hospital employed a full range of staff to provide care and treatment to patients. These consisted of doctors, nurses, psychologists, mental health nurses, social workers, therapists and activity coordinators.
- The provider regally checked staff competence to carry out their job. We saw managers had logged training and development opportunities for staff.
- The provider supports staff to complete the National Care Certificate. Managers said training was role specific. One new member of staff said they had completed some training on fire safety, complaints, the Mental Health Act, advocacy, job roles and food hygiene.
- Staff were given supervision every two weeks when on probation and monthly thereafter. Staff said they could discuss patient cases, development and appraisals in supervisions. One member of staff said managers had changed the supervision structure, so they did not get a chance to discuss their own issues.
- We saw managers had raised issues with poor staff performance in team meetings, such as arriving late for shifts. Managers said this would then be dealt with as part of individual supervisions.

Multi-disciplinary and inter-agency team work

- Multidisciplinary meetings took place every four weeks. These meetings were attended by doctors, psychology staff, nursing staff, patients and family members.
- Managers held a handover at the start of every shift. Managers shared any update and changes to patients care plans.

Adherence to the MHA and the MHA Code of Practice

- The hospitals Mental Health Act administrator was available to offer staff support. We saw a guide for staff when checking detention paperwork.
- Staff did not record all outcomes of each episode of patient's individual section 17 leave. Staff did not record the length of each episode of patient's section 17 leave clearly on individual records.
- We saw staff kept detailed up to date risk assessments which included risk and contingency measures for staff to follow when patients are on leave.
- At the last inspection seventy six percent of staff had completed training in the Mental Health Act. Figures for this inspection showed forty three per cent of staff had up to date training. However we saw further staff training had been booked in January 2017.
- Staff had a good understanding of the Mental Health Act code of practice and principles.
- We reviewed six medication records and saw staff kept a copy of consent to treatment with each patient medication charts.
- Staff read patients their rights under the Mental Health Act, routinely. We saw easy read information that staff worked through with patients to promote understanding.
- The Mental Health act administrator carried out audits of MHA papers to ensure paperwork is completed correctly and is legal.

Wards for people with learning disabilities or autism

- The hospital had access to one Independent Mental Health Advocate, who would support patients where required.

Good practice in applying the MCA

- Ninety eight percent of staff had completed training in the Mental Capacity Act.
- There were no Deprivation of Liberty and safeguards applications in the last six months for the lodges. However, one patient was waiting for a previous DoLS application to be confirmed. Managers had been in contact with the local authority to move the application forward.
- Staff we spoke with understood the principles of the Mental Capacity Act 2005.
- Staff assessed and recorded patients' capacity to consent. However, one set of paperwork was missing an updated patient signature.
- We reviewed each medication record and saw staff kept a copy of consent to treatment with each patient's medication charts.
- Staff encouraged patients to make their own decisions as much as possible.
- Staff knew they could get advice from the Mental Health Act administrator regarding any Mental Capacity Act or Deprivation of Liberty and Safeguards issues.

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- We observed staff interacting with patients in a positive respectful manner. We saw staff offering practical support to ensure individual patient's needs were met. Staff knew each patient's preferences and needs.
- Patients we spoke with said they liked staff. Patients said they get to see their family, have a nice flat and can go out.

The involvement of people in the care they receive

- Staff actively encouraged patients to participate in their care plans and treatment. We saw where staff had pictures and easy read documentation to help patients choose goals and activities. Patients were supported to attend meetings with staff and family members.
- Patients had access to independent advocacy.
- The hospital invited family members to attend patient review meetings. We saw meeting minutes where family members had shared thoughts on ongoing treatment plans.
- The hospital completed a patient survey, where patients gave feedback on their treatment.
- Patients could give feedback to staff, management and doctors; we saw minutes from one meeting where a patient had said they wanted bigger portions of food.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure care and treatment records contain detailed descriptions of how service users' or patients' identified treatment needs are met.

Action the provider SHOULD take to improve

- The provider should ensure that staff carrying out one to one observations do so under the provider's policy.
- The provider should ensure staff record all outcomes and length of each episode of patient's individual section 17 leave, clearly on records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person-centred care. • Care and treatment records did not include detailed descriptions of how staff were helping patients to address individual skills on a daily basis. For example, one patient had a goal of building relationships, but the actions required to do this were not specific. Regulation 9 (3) b