

St Andrew's Healthcare Adolescents service

Quality Report


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

Ratings

Overall rating for this location

Inadequate 

Are services safe?

Inadequate 

Are services effective?

Good 

Are services caring?

Inadequate 

Are services responsive?

Good 

Are services well-led?

Inadequate 

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

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

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

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

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

Professor Ted Baker Chief Inspector of Hospitals

Chief Inspector of Hospitals

Overall summary

We rated St Andrew's Healthcare Adolescents service as **inadequate** because:

- Staff did not always treat patients with kindness, dignity compassion and respect. Eleven of the 15 seclusion rooms did not include furnishings such as a bed, pillow, mattress or blanket. We reviewed 13 episodes of seclusion where staff had not provided the patient with a mattress or chair. Observation records for nine episodes of seclusion detailed 28 entries describing the patient sitting or lying on the floor. Staff, on one occasion, did not respect a patient's privacy and dignity when changing the patient's clothing and did not ensure that female staff assisted with this for female patients. It was the inspection team's view that this practice was uncaring, undignified and disrespectful.
- Managers had not ensured that they consistently identified or addressed safety concerns quickly enough. There were sharp edges on door frames in seclusion rooms and extra care suites, blind spots in seclusion rooms and pieces of exposed sharp metal in extra care suites. Staff did not always follow safety procedures in relation to cutlery checks and food hygiene. Staff did not always check emergency equipment and medicines. Staff did not always record, accurately, the events that took place during incidents. There was discrepancies between incident reports, staff recollection and the images captured on CCTV.
- Staff did not follow best practice when using seclusion and long term segregation. We have raised this issue with the provider on 12 separate occasions following previous inspections of their locations. Medical, nursing and multidisciplinary reviews had not taken place as required by the Mental Health Act Code of Practice. Staff had not always completed seclusion care plans for patients, had not involved advocacy, or informed the local authority when required. Staff secluded three patients for longer than necessary.
- Staff applied blanket restrictions without justification. All wards had imposed set snack times for patients. Other restrictions included access to drinks and takeaways, patients not allowed to wear shoes on Meadow. Staff on Willow ward locked the patient's en suite rooms which meant patients had to request staff to unlock them for access. and staff locking en suites on Willow. Managers told us that patients themselves had requested set snack times and to not have shoes on wards. Staff provided minutes of community meetings, however only records for two wards indicated patient agreement.
- Managers had not always ensured that there were the required numbers of staff on all shifts. Managers had not filled 13% of shifts between 1 and 31 March 2019. Managers had used bank and agency staff to cover 47% of shifts. Staff shortages sometimes resulted in staff cancelling escorted leave, appointments or ward activities. Staff on Fern, Maple and Willow wards told us that the high use of bank and agency staff impacted on patient care as risk events increased due to inconsistencies in patient care.

Summary of findings

- The leadership, governance and culture did not always support the delivery of high quality, person-centred care in relation to the comfort of patients in seclusion and the application of blanket restrictions. The arrangements for governance did not always operate effectively. Governance arrangements had not always identified that staff practices were sometimes in breach of the Mental Health Act Code of Practice. The provider had not addressed issues with restrictive practices and the environment previously raised by the CQC. Provider audits had failed to address the issues with restrictive practices. Managers did not always deal with risk issues appropriately or in a timely way. Although the provider had carried out work to rectify hazards, it was incomplete. The provider did not have a system to check that the maintenance team had completed required works satisfactorily.

However:

- Managers had completed up to date ligature audits and risk assessments identifying all potential ligature points. Managers had displayed ligature 'heat maps' in each ward office highlighting high risk areas on the wards. Ligature cutters were located throughout the ward areas in secure boxes.
- Staff had completed a risk assessment for each patient, which they updated regularly and after any incident. Staff identified and responded to changing risks to, or posed by, patients. Staff had completed comprehensive mental health assessments and developed care plans to meet identified needs.
- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National

Institute of Health and Care Excellence. Interventions included a full therapy programme and the use of recognised rating scales to assess and record severity and outcomes. The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Staff had the experience, qualifications and the right skills and knowledge to meet the needs of the patient group. Teams held regular and effective multidisciplinary meetings. Managers ensured that staff received the necessary specialist training for their roles.

- Staff and patients had access to an extensive range of rooms and equipment to support treatment and care. All patients and carers spoken with reported that the environment and facilities were very good. Patients had access to the provider's college for educational activities. Each patient had an individualised timetable to meet their needs. There was a specially designed classroom for patients with autistic spectrum disorders. Patients had opportunities for work experience and access to the provider's on-site light industry workshop. Staff ensured that patients had access to appropriate spiritual support. The service had a multi-faith area and access to support for different religions.
- Leaders were visible in the service and approachable for patients and staff. Staff spoken with told us that the chief executive officer and operational and clinical leads for the service were visible on the wards. Staff told us that they felt respected, supported and valued. Staff said the management culture had changed for the better. A trauma nurse and occupational health service supported staff's physical and emotional health needs. The provider had invested in a programme of support to promote staff well-being.

Summary of findings

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Inadequate 

St Andrew's Healthcare Adolescents Service

Services we looked at

Child and adolescent mental health wards; Wards for people with learning disabilities or autism;

Summary of this inspection

Background to St Andrew's Healthcare Adolescents service

St Andrew's Healthcare Adolescents service registered with the CQC on 11 April 2011. The service has a registered manager and a controlled drug accountable officer. The Adolescents service is based in Fitzroy House, a purpose-built hospital, opened in January 2017 and situated on St Andrew's Healthcare Northampton site. The building offers sensory rooms, music and arts rooms, a sports hall, gardening areas and outside space (courtyards). The service offers education opportunities through St Andrew's college, which is Ofsted registered and rated as outstanding. The other registered locations at Northampton are men's services, women's services and acquired brain injury (neuropsychiatry) services.

St Andrew's Healthcare also have services in Birmingham, Nottinghamshire and Essex.

St Andrew's Healthcare Adolescents service has 11 wards and is registered to accommodate 99 patients. There were 77 patients at the service during our inspection.

St Andrew's Healthcare Adolescents service has been inspected ten times.

St Andrew's Healthcare Adolescents is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act

The service has a nominated individual and a registered manager.

This service was last inspected between October 2018 and January 2019. This was a focused inspection carried out in response to concerns raised about the service. We did not rate the service at this inspection. We found the following breaches of regulation 17, Good governance:

- The provider had not facilitated independent reviews of patient's in long term segregation in line with the Mental Health Act Code of Practice which states that 'where long-term segregation continues for three months or longer, regular three-monthly reviews of the patient's circumstances and care should be undertaken by an external hospital'. Staff employed by St Andrews had carried out the 'independent reviews'

of patients in long-term segregation on these wards. Although these staff members worked in a different St Andrew's hospital, or were from a different service on the same site, in CQC's view this is not consistent with the intention of the Mental Health Act Code of Practice.

A comprehensive inspection was carried out in May 2017. The service was rated as requires improvement overall. Safe was not rated, effective and well led were rated as requires improvement and caring and responsive were rated as good. We found the following breaches:

- Regulation 11, Need for consent; staff did not have a good working knowledge of the Mental Capacity Act; Gillick competence and Fraser guidelines.
- Regulation 14, Meeting nutritional needs; patients did not have free access to drinks, and had to request these from staff.
- Regulation 18, Staffing; wards only had one qualified staff member throughout the night on each ward, and so it was difficult for staff to take breaks; wards worked under establishment numbers as not all shifts could be covered by bank and agency staff. This impacted upon patient care; there was not robust supervision plans in place. Management supervision was undertaken through the annual appraisal process. No records were kept of clinical supervision. There could not be assurance that staff were monitored and supported appropriately.

At this inspection we found the provider had addressed some, but not all of the issues from the last inspections. The issues that remain are identified later in this report.

We visited the following services during this inspection:

Child and adolescent mental health wards

Wards for people with learning disabilities or autism

The adolescents service provides accommodation for male and female patients under the age of 18 years. We inspected the following wards:

- Maple ward a ten bed low secure service for girls under 18 years, who have complex mental health and rehabilitation needs.

Summary of this inspection

- Meadow ward a ten bed low secure service for girls under 18 years who have complex mental health needs.
- Willow ward a ten bed low secure service for girls under 18 years who have complex mental health needs.
- Sycamore ward a ten bed low secure service for boys under 18 years who have complex mental health needs.
- Marsh ward a ten bed low secure service for boys under 18 years, who have complex mental health needs.
- Brook ward a ten bed low secure service for boys under 18 years, who have learning disability and / or neurodevelopmental disability, who present with autism and / or mental health difficulties and / or challenging behaviours.
- Fern ward a ten bed low secure service for girls under 18 years with learning disability and / or autistic spectrum disorder and challenging behaviours.
- Bracken ward a ten bed medium secure service for boys under 18 years who have learning disabilities and / or autistic spectrum conditions.
- Acorn ward a ten bed medium secure service for boys under 18 years who have developmental disability and / or autism.
- Berry ward is currently closed. This is a female ward that can accommodate up to eight children and adolescents who have acute mental health needs.
- Oak ward is currently closed, however we found there were two patients 'sleeping over' from Acorn ward during the inspection.

This inspection was a comprehensive inspection and unannounced. The inspection took place over three days.

Our inspection team

Team leader: Victoria Green

The team that inspected the service comprised of one inspection manager, three CQC inspectors, two Mental Health Act reviewers, two specialist advisors with experience of working with children, young people and forensic services and an expert by experience.

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 the location.

During the inspection visit, the inspection team:

- visited nine wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with 27 patients who were using the service;
- spoke with twelve carers of patients using the service;
- spoke with the registered manager and managers or acting managers for nine of the wards;
- spoke with 63 other staff members; including doctors, nurses, student nurses, healthcare assistants, occupational therapists, psychologists and social workers;

Summary of this inspection

- attended and observed one multidisciplinary meeting, one bed management meeting, one patient community meeting and observed two episodes of care;
- collected feedback from two patients using comment cards;
- looked at 14 care and treatment records of patients, 58 positive behavioural support plans of patients, 25 sets of detention papers, 21 seclusion records of patients and four long term segregation records of patients;
- carried out a specific check of the medication management on nine wards including a check of 61 prescription charts; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 27 patients. Patients told us they felt safe on the wards and that permanent staff were friendly, supportive, kind and respectful. Some patients told us that agency staff were not always as nice as permanent staff. Five patients told us there were not always enough staff and this impacted on them getting leave and attending activities.

The majority (25) of patients told us they liked the food. Patients said the environment and facilities were good. Patients told us that the therapies and activities provided were good. Patients knew how to complain and were confident to do so. Most (26) patients told us that they received regular visits from their families.

We spoke with 12 carers. Six carers had children on Maple ward. Five of these carers told us communication from

nursing staff on the ward was poor. Some of the carers advised that their children had been on other wards within the service previously and staff communication had been very good on those wards.

Three carers told us that staff shortages impacted on their child getting leave and attending activities. Two carers told us that staff were inconsistent. One carer told us that staff had not followed her child's care plan which had resulted in her child experiencing distress and punching a wall. This resulted in injury to her child's hand requiring hospital attention.

All carers told us that the environment and facilities were very good. Other carers reported positive experiences with the service, telling us that staff were kind, brilliant, amazing, and the hospital was the best their child had been in.

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 rated safe as **inadequate** because:

- Managers had not ensured that they consistently identified or addressed safety concerns quickly enough. We found sharp door frames in nine seclusion rooms and five extra care suites. A Mental Health Act reviewer had raised this issue with the provider on seven separate occasions. We found blind spots in ten seclusion rooms and an exposed piece of sharp metal in two extra care suites. There was damage to the paint work in five seclusion rooms. Staff did not always record, accurately, the events that took place during incidents. There were discrepancies between incident reports, staff recollection and the images captured on CCTV.
- Staff did not follow best practice when using seclusion. We reviewed 21 episodes of seclusion. Medical reviews had not taken place within the first hour of seclusion in six episodes. Nursing reviews had not been carried out by two nurses in all instances. Continuing medical reviews had not always taken place every four hours. Multidisciplinary team reviews had not taken place for three episodes. Records were incomplete in 11 episodes of seclusion. Staff had not developed care plans for the patient's episode of seclusion in nine records and seclusion care plans were incomplete in a further six records. Staff had nursed a patient in conditions of seclusion, intermittently, for five days and had not implemented seclusion processes. Staff secluded three patients for longer than necessary.
- Staff did not follow best practice when using long-term segregation. We reviewed four episodes of long-term segregation. An approved clinician (who may or not be a doctor) had not formally reviewed the patient's situation at least once in any 24-hour period. Multidisciplinary team reviews had not always taken place as required. We could find no evidence of the multidisciplinary reviews including involvement of an independent mental health advocate. We were unable to establish, from the care records, whether staff had made the local safeguarding team aware of any patient in long-term segregation.
- Staff applied blanket restrictions without justification. All wards had imposed set snack times for patients. Other restrictions included access to drinks and takeaways. Meadow and Willow ward had restricted patients from wearing their shoes on the ward. On Willow ward staff kept patients' en suites locked and

Inadequate



Summary of this inspection

only opened on request. Staff did not record the reason for applying blanket restrictions in risk assessments. Managers told us that patients requested set snack times and to not have shoes on certain wards and that staff recorded this in community meeting minutes. Staff provided minutes of community meetings, however only records for Meadow and Bracken wards indicated patient agreement.

- Staff did not always complete safety checks appropriately. Four wards did not follow the cutlery checking process. Staff had not completed cutlery checking in/out forms correctly, therefore it was unclear how many items of cutlery there should be, and if any items were missing. There were unlabelled food items in fridges on Willow and Brook wards. Staff did not check emergency and medical equipment on Marsh and Acorn wards, as required by the providers policy which states staff are to carry out checks weekly. Since December, staff on Marsh ward had only carried out two checks. On Acorn ward, staff had only completed eight checks over the 14 weeks prior to the inspection. On Marsh ward we found five out of date drug testing kits and on Acorn ward staff had not tested the fridge temperature on five days in February and March 2019. Staff had stored aftershave in the medicines cupboard on Acorn.
- Managers had not always ensured established staffing levels on all shifts. Managers had not filled 13% of shifts between 1 and 31 March 2019. Managers had used bank and agency staff to cover 47% of shifts, although some bank shifts were additional hours by permanent staff. Staff shortages sometimes resulted in staff cancelling escorted leave, appointments or ward activities. We reviewed the record of a patient on Fern ward, who had a medical appointment cancelled as there were no regular staff to provide support. We reviewed the records for one patient on Maple ward whose planned leave was cancelled on nine occasions between 9 January 2019 and 17 March 2019 due to staff shortages. Staff on Fern, Maple, Acorn and Brook wards told us that staff shortages impacted on patients accessing escorted leave and activities. Staff on Fern, Maple and Willow wards told us that the high use of bank and agency staff impacted on patient care as risk events increased due to inconsistencies in patient care.
- The provider had not fitted or supplied call alarms in patient bedrooms. Staff had not completed risk assessments detailing how patients would summon help.

However:

Summary of this inspection

- Managers had completed up to date ligature audits and risk assessments identifying all potential ligature points. Managers had displayed ligature 'heat maps' in each ward office highlighting high risk areas on the wards. Ligature cutters were located throughout the ward areas in secure boxes.
- Staff had completed a risk assessment for each patient and updated them regularly and after any incident. Staff identified and responded to changing risks to, or posed by, patients. We observed staff responding quickly and effectively to a patient presenting with risk behaviours during our visit.

Are services effective?

We rated effective as **good** because:

- Staff had completed comprehensive mental health assessments for patients and developed care plans to meet the identified needs. These included 'Positive Behaviour Support' plans for the majority of the patients of the wards. We reviewed 58 'Positive Behaviour Support' plans, all were holistic, personalised and recovery orientated. Staff had updated care plans when necessary.
- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence. Interventions included a full therapy programme and the use of recognised rating scales to assess and record severity and outcomes.
- The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, teams included or could access occupational therapists, technical instructors, physiotherapists, clinical psychologists, social workers, pharmacists, speech and language therapists and dieticians. Staff had the right experience, qualifications, skills and knowledge to meet the needs of the patient group. Teams held regular and effective multidisciplinary meetings as evidenced in the ward round meeting we observed.
- Managers ensured that staff received the necessary specialist training for their roles. Staff told us that they had accessed courses in personality disorders, RAID (reinforce appropriate, implode disruptive) approach, dialectical behavioural therapy, autism and sensory integration and coaching.
- We reviewed 25 sets of Mental Health Act detention papers. These related to the patients' current period of detention

Good



Summary of this inspection

including, where applicable, section 19 (authority for transfer from one hospital to another under different managers) and section 20 (renewal of authority for detention). The detention papers were complete and appeared to be in order.

- Staff we spoke with demonstrated knowledge of the Mental Capacity Act, Gillick competency and Fraser guidelines. The Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe. Staff explained that once a patient was 16, the Mental Capacity Act would apply and they were required to gain patient's consent to share information with parents.

However:

- Staff did not always explain to patients their rights under the Mental Health Act. We reviewed the care records of 25 patients detained under the Mental Health Act. In seven records it was not evident that staff had provided patients with information about their rights at the point of the patient's admission or detention.

Are services caring?

We rated caring as **inadequate** because:

- Staff did not always treat patients with kindness, dignity and respect when in seclusion. Except for Brook ward, none of the seclusion rooms included furnishings such as a bed, pillow, mattress or blanket. We reviewed 13 episodes of seclusion where staff had not provided patients with a mattress or chair. Observation records for nine episodes of seclusion detailed 28 entries describing the patient sitting or lying on the floor. It was the inspection teams view that this practice was uncaring, undignified and disrespectful.
- Staff, on one occasion, did not ensure female staff supported a female patient when the need arose for the patient to change into rip proof clothing. This did not protect the patient's privacy and dignity.
- Staff did not always engage with and support carers. Five out of 12 carers spoken with expressed that communication from staff on Maple ward was poor. There were significant delays in addressing concerns raised by families about the treatment of their loved ones.

However:

Inadequate



Summary of this inspection

- Patients told us that most staff treated them well and behaved appropriately, although some agency staff were not as kind as regular staff. We observed staff being polite and caring towards patients. Patients told us that staff supported them to understand and manage their care, treatment or condition.
- Patients told us that they were invited to their own multidisciplinary review meetings, involved in their care plans and staff gave them a copy of their care plan. We observed a multidisciplinary meeting which confirmed this.
- Seven carers reported positive experiences with the service, telling us that staff were kind, brilliant, amazing, and the hospital was the best their child had been in. The service provided accommodation on site and money towards travel costs for families who had long distances to travel to visit their child.

Are services responsive?

We rated responsive as **good** because:

- Staff and patients had access to an extensive range of rooms and equipment to support treatment and care. This included activity rooms, games rooms and courtyards on each ward. Within the secure perimeter of the building there were family visiting rooms, numerous sports facilities, an animal courtyard, a tranquillity garden, a horticultural garden, sensory rooms, music, art and craft rooms, a hairdresser, a café, social areas, therapy kitchens, a multi-faith area. There were enough treatment rooms and conference rooms for tribunals and care and treatment reviews. All patients and carers spoken with reported that the environment and facilities were very good.
- Patients had access to the provider's college for educational activities. Each patient had an individualised timetable to meet their needs. There was a specially designed classroom for patients with autistic spectrum disorders. Patients had opportunities for voluntary work experience at a local charity shop, this included upcycling furniture and selling it. Other patients operated the mobile toiletry trolley and worked in a pop up coffee shop. Patients were also able to access the provider's on site light industry workshop.
- Staff ensured that patients had access to appropriate spiritual support. The service had a multi faith area and access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.

Good



Are services well-led?

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

Inadequate



Summary of this inspection

- Governance arrangements did not always operate effectively. For example, governance systems had not always identified that staff practices were sometimes in breach of the Mental Health Act Code of Practice. The provider had not addressed issues raised by the CQC on 12 previous occasions, across different locations, in relation to restrictive practices or action points previously issued by the CQC Mental Health Act reviewer, and while staff undertook a range of audits across the service, these audits had failed to address the issues with restrictive practices.
- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. Staff practices were not always caring in relation to patient's in seclusion and when using restrictive interventions. Staff applied blanket restrictions without justification. Managers at all levels told us that staff recorded the impact of blanket restrictions in patients' records. There was no evidence of this in the records we reviewed.
- Managers did not always deal with risk issues appropriately or in a timely way. Although the provider had carried out work to rectify hazards, it was incomplete. We asked senior managers who checked and signed off work carried out on the wards and they advised that ward managers were responsible for this. The provider did not have a system to check that the maintenance team had completed required works satisfactorily.
- The provider had not always reported notifiable incidents to CQC. There had been two incidents involving the police that staff had not reported to CQC.

However:

- Leaders were visible in the service and approachable for patients and staff. Staff we spoke with told us that the operational leads and clinical leads for the service were visible on the wards. Staff also told us that the new chief executive officer visited regularly and had been particularly supportive to staff on one ward who had been dealing with a difficult situation.
- All staff spoken with told us they felt respected, supported and valued. The provider had a relatively new leadership team in place developing and changing the culture. Staff said the management culture had changed for the better and there was no longer a blame culture. Overall, staff felt proud and positive about working for the provider and their team despite the high levels of media coverage and scrutiny from external organisations in recent months.

Summary of this inspection

- A confidential trauma nurse and the occupational health service supported staff with any physical and emotional health needs. The provider had invested in a programme of support to promote staff wellbeing. This included the provider training staff being in mental health first aid (to support colleagues), staff wellbeing events, massage and Zumba classes.
- The provider recognised staff success within the service through staff awards. The provider issued values based awards on a monthly and quarterly basis, which then culminated in an organisation wide annual awards ceremony for the overall winners. Bracken ward had won team of the year in 2018.
- Staff had opportunities to participate in research, this included staff on Meadow ward working with a university researching genetic approaches to the treatment of psychosis, and staff working with a student from another university researching the positive impact of physical activity in adolescents with mental health problems. Innovations were taking place in the service. These included the introduction of behavioural family therapy and the physiotherapist using virtual reality equipment to support patients with dyspraxia.

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.

- The majority (93%) of staff had completed Mental Health Act training.
- Staff did not always follow the Mental Health Act Code of Practice in relation to restrictive practices, including the application of blanket restrictions, seclusion and long-term segregation.
- Staff had access to the provider's Mental Health Act administrators.
- The provider had relevant policies and procedures that reflected the most recent guidance.
- Staff had easy access to local Mental Health Act policies and to the Code of Practice.
- Patients had easy access to information about independent mental health advocacy and advocates visited the wards on a weekly basis.
- Staff had not always explained to patients their rights under the Mental Health Act. We reviewed the care records of 25 patients detained under the Mental Health Act. In 18 records, staff had provided patients with information about their legal position and rights, at the point of the patient's admission and, or detention and periodically thereafter, as required under section 132 of the Mental Health Act. However, in the remaining seven records (two records on Brook ward, two records on Bracken ward, two records on Acorn ward and one record on Maple ward) it was not evident that staff had provided patients with this information. In one record on Brook ward, staff had not provided the patient with information about their legal position and rights for six months after the patient had initially not understood this information.
- In 17 of the 25 records, we noted the patients' detention had been considered and renewed (under section 20 of the MHA). In five of these records, we saw that staff had provided the patient with information about their position and rights at the time of detention. However, this was not evident in the remaining 12 records (three records on Brook ward, three records on Fern ward, two records on Maple ward, three records on Acorn ward and one record on Bracken ward).
- Staff and patients told us that section 17 leave was not always able to be taken due to staff shortages, and two patients daily care notes confirmed this.
- Staff requested an opinion from a second opinion appointed doctor when necessary, for patients who lacked capacity to consent to treatment.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- We reviewed 25 sets of Mental Health Act detention papers. These related to the patients' current period of detention including, where applicable, section 19 (authority for transfer from one hospital to another under different managers) and section 20 (renewal of authority for detention). The detention papers were complete and appeared to be in order, in relation to the patients' detention under the of Mental Health Act.
- The service does not accommodate informal patients.
- Managers told us that regular audits were completed to ensure that the Mental Health Act was being applied correctly. However, we identified that staff were not following the Mental Health Act Code of Practice in relation to restrictive practices, including the application of blanket restrictions, seclusion and long-term segregation.

Mental Capacity Act and Deprivation of Liberty Safeguards






- The provider reported that 93% of staff had completed Mental Capacity Act training, and staff we spoke with demonstrated knowledge of the Mental Capacity Act, including Gillick competency and Fraser guidelines, applicable to children and adolescents. The Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them

Detailed findings from this inspection

safe. Staff were able to explain that once a patient was 16, the Mental Capacity Act would apply and they were required to gain consent to share information with parents.

- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff supported patients to make decisions. When necessary, staff would hold best interest meetings for patients and where required would involve parents or the local authority for looked after children.
- The service had arrangements to monitor adherence to the Mental Capacity Act and had recently conducted an organisation wide audit of capacity and consent.

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate 

Safe and clean environment

- Managers had not ensured that they consistently identified or addressed safety concerns quickly enough. We found safety hazards and blind spots in some seclusion rooms and extra care suites. The top of the door frames between the seclusion room and en suite area were sharp in one seclusion room on Sycamore ward, two seclusion rooms for Fern and Berry wards, three seclusion rooms for Marsh and Meadow wards and three seclusion rooms for Maple and Acorn wards. The top of the door frames within the extra care suites in Fern ward, Marsh ward, Sycamore ward, Maple ward and Willow ward were sharp and/or damaged. A Mental Health Act reviewer had raised this with the provider during previous visits on seven separate occasions. However, there had been no reported incidents of patients harming themselves on the door frame edges. The thumb-turn mechanism to the louvre window control was missing on lounge door of the extra care suite on Maple ward and on Berry ward. This exposed a sharp piece of metal. The paintwork was damaged in the seclusion rooms on Sycamore, Fern, Berry, Marsh, Meadow and Brook wards. Although all seclusion rooms and en suite areas had closed-circuit television, we found blind spots in all seclusion rooms.
- All wards operated a cutlery checking process to ensure patients did not take cutlery out of the dining area. The provider's process required staff to count cutlery out

and back in, checking against the total amount of cutlery there should be and signing and dating the form. We found that staff did not always follow this process. On Sycamore, while staff had completed the form, there was no information detailing how many items of cutlery there should be. On Fern, staff had completed the forms but had not signed them and there was no information detailing how many items of cutlery there should be. On Marsh, staff had not dated and signed all the forms and the numbers of cutlery items did not correlate with list of what there should be. Staff had scribbled out and rewritten the numbers on list several times making it difficult to read. On Maple, staff had not dated and signed all the forms and there was no information detailing how many items of cutlery there should be.

- Managers had completed up to date ligature audits and risk assessments identifying all potential ligature points. A ligature point is a fixed point which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Managers had displayed ligature 'heat maps' in each ward office highlighting high risk areas on the wards. Ligature cutters were located throughout the ward areas in secure boxes.
- All wards were single sex and therefore compliant with guidance on eliminating mixed-sex accommodation.
- The provider had not fitted call alarms in patients' bedrooms. Staff advised they would increase observations of patients' if there were concerns for their physical or mental health. However, we did not find any evidence that staff had completed risk assessments detailing how patients would summon help.
- Staff had ensured ward areas were clean and the majority were well maintained with good furnishings. However, Sycamore ward had a ripped chair and patch of carpet missing in the lounge area. We saw evidence

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that the provider had submitted a request for the carpet to be repaired and the chair to be replaced. We also found two unlabelled and out of date food items in the fridge on Marsh ward and unlabelled, opened food items in the fridges on Willow and Brook wards.

- We looked at 13 seclusion rooms. Fern and Berry wards shared three seclusion rooms, however, one room was out of use on the day of our visit. Marsh and Meadow wards shared three seclusion rooms. Bracken and Willow wards shared three seclusion rooms. Maple and Acorn wards shared three seclusion rooms. Sycamore and Brook wards each had one seclusion room. We did not view the seclusion facilities on Oak ward. Each seclusion room had: a robust door which opened outwards; a robust, reinforced window providing natural light; an intercom which allowed for communication with the patient when the patient was in the room and the door was locked; a clock which was visible to the patient; externally controlled lighting, including a main light, subdued lighting for night time and mood lighting (offering a range of different colours); an audio input point (outside the room), where the patient's music device could be plugged in, allowing the patient to listen to music, through speakers in the seclusion room; externally controlled heating, enabling staff observing the patient to monitor the room temperature; and, en suite facilities of a hand-basin, toilet and shower.
- We looked at all 11 clinic rooms, staff had fully equipped them with accessible resuscitation equipment and emergency drugs. However, on Marsh and Acorn wards staff had not checked the emergency bag in line with the provider's policy which states staff are to carry out checks weekly. Since December, staff on Marsh ward had only carried out two checks. On Acorn ward, staff had only completed eight checks over the 14 weeks prior to the inspection.

Safe staffing

- Managers had not always ensured established staffing levels were met. The provider used a recognised staffing tool to set safe and optimum staffing levels. Although the required optimum number of staff were on shift during the inspection, this had not been the case prior to the inspection.
- Managers had not filled 13% of shifts between 1 and 31 March 2019. Permanent staff had filled 40% of available shifts, bank staff 23% and agency staff 24%. However,

some of the bank shifts had been covered by permanent staff working additional hours. The ward with highest rate of unfilled shifts was Bracken ward with 19%. The ward with the lowest number was Acorn ward with 6%.

- From 01 September 2018 to 30 November 2018 the provider covered 3,392 shifts with bank staff from its own bureau, 3,949 shifts by agency staff and 1,198 shifts were unfilled across all wards.
- The wards that used highest numbers of bank staff were Bracken (774 shifts), Brook (765) and Acorn (368).
- The wards that had the highest use of agency staff were Fern (1,147), Brook (781) and Meadow (759). Fern ward manager told us that they had a high use of agency staff due to a specialist agency that had been providing a team of staff to support one patient.
- Staff on Fern, Maple and Willow wards told us that the high use of bank and agency staff impacted on patient care as risk events increased due to inconsistencies in patient care.
- The wards that reported the highest unfilled shifts rates were Fern (353), Meadow (325) and Willow (253).
- The provider had establishment levels of 263 whole time equivalent staff across all wards as of 30 November 2018. The provider reported a vacancy rate of 13% as of 30 November 2018. Bracken reported the highest vacancy rate at 30% as of 30 November 2018 with Brook reporting the lowest at -1%.
- Ward managers could adjust staffing levels daily to take account of case mix. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. When agency and bank nursing staff were used, they received an induction and were familiar with the ward. Managers had block booked agency staff to cover vacant posts to ensure continuity of care. We observed that a qualified nurse was present in communal areas of the wards during our inspection. Four wards now had two qualified staff on duty at night. A duty nurse, allocated to the building, supported wards which had one qualified staff on duty at night.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse.
- Staff shortages had recently resulted in staff cancelling escorted leave, appointments or ward activities. We reviewed the record of a patient on Fern ward, who had a medical appointment cancelled as there were no regular staff to provide support. We reviewed the records for one patient on Maple ward whose planned

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leave was cancelled on nine occasions between 9 January 2019 and 17 March 2019 due to staff shortages. Staff on Fern, Maple, Acorn and Brook wards told us that staff shortages impacted on patients accessing escorted leave and activities.

- There were usually enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely. The provider reported that 98% of staff had completed Management of Actual and Potential Aggression training.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency, although doctors were not attending to complete all seclusion reviews as required.
- Staff had received and were up to date with appropriate mandatory training. Overall, staff in this service had undertaken 92% of the various elements of training that the provider had set as mandatory. There were no mandatory courses with a compliance rate below 75%.

Assessing and managing risk to patients and staff

- Staff had completed a risk assessment for each patient and updated them regularly and after any incident.
- Staff used the provider's comprehensive risk assessment tool. Staff considered historical and current risk information to determine how best to care for patients.
- Staff identified and responded to changing risks to, or posed by, patients. We observed staff responding quickly and effectively to a patient presenting with risk behaviours during our visit.
- Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. Staff were conducting searches of patients in side rooms, unless the patient had requested staff searched them elsewhere.
- We found that staff were applying blanket restrictions without justification. Mental Health Act reviewers had raised the application of blanket restrictions on eight previous visits. All wards had imposed set snack times for patients. These were four times a week at set times and days. On Willow ward this included restricting mints to snack times, with a poster displayed advising that "patients are not to have mints at any other time". Blanket restrictions on other wards included; Marsh ward, staff limited patients to spending a maximum of £10 a month on a takeaway and only allowing patients one main dish and one side dish. Staff told us that they imposed these restrictions on the advice of the dietician and in line with National Institute of Health and Care Excellence guidance; four wards restricted access to drinks. Acorn, had recently restricted access to drinks due to the medical condition of one patient; Meadow ward's manager advised that they had disallowed drinks bottles on the ward because patients had urinated in them and then thrown them at staff. To counteract this the manager advised they had requested an in-built water dispenser for the ward. Other wards had made drinks available either in jugs or by allowing patients to have their own drinks bottles without lids. Meadow and Willow wards had restricted patients from taking their shoes onto the ward. Staff gave different reasons for this restriction, including infection control and risk issues, while managers told us the patients had requested to not have shoes on the ward as they did not want dirt brought in on people's shoes. However, staff and visitors were wearing shoes on the ward. On Willow ward staff told us that the patients' en suites were kept locked all the time and opened on request.
- We discussed blanket restrictions with senior managers, who advised that staff had recorded the impact of the restrictions in individual patient records. However, in the records we reviewed there was no evidence of this. Managers also told us that patients had requested set snack times and to not have shoes on certain wards and that staff had recorded this in community meeting minutes. Staff provided minutes of community meetings, however only records for Meadow and Bracken wards indicated patient agreement.
- The wards in this service participated in the provider's restrictive interventions reduction programme. Staff told us that they would use de-escalation methods before resorting to restrictive interventions. Staff told us about different de-escalation methods they would try, for example, weighted blankets and use of ice cubes to distract from self harm urges to avoid using restrictive interventions. However, we reviewed one incident on Maple ward, when staff had restrained the patient and changed them into rip proof clothing when the patient was presenting as calm and compliant.
- Staff adhered to best practice when implementing a smoke free policy.
- All patients at this service were detained under the Mental Health Act.

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- There were 326 episodes of seclusion over six months across all wards between 01 July 2018 and 31 January 2019. These were highest on Fern ward with 88 seclusions, followed by Willow (67) and Brook (65). The provider reported 65 episodes of seclusion per 1000 occupied bed days in May 2017 and 60 per 1000 occupied bed days in February 2019.
- From 01 July 2018 to 31 January 2019 there were 1,754 episodes of restraint. These were highest on Meadow ward with 546 restraints for 15 different patients, followed by Willow with 486 for 14 different patients and Fern with 436 for 11 different patients. The provider reported an overall decrease in use of restraint from 541 per 1000 occupied bed days in May 2017 to 441 per 1000 occupied bed days at the time of inspection. Over the same period there were 161 episodes of prone restraint. These were highest on Willow (51), Fern (44) then Meadow (24). This was a significant decrease from the figures provided in 2016, when the provider reported 578 episodes of prone restraint over six months. Managers advised the high use of prone restraint on Willow had been in relation to one patient who had presented with frequent episodes of violent and aggressive behaviours. Managers advised that staff used prone (face down) restraint only when the patient had gone into that position and moved the patient to the supine (face up) position as soon as possible. Staff recorded all incidents of prone restraint, even if the duration was for less than a minute.
- The provider reported 34 uses of rapid tranquilisation from 01 July 2018 to 31 January 2019. These were highest on Fern (24), then Meadow (7), Willow (2) and Brook (1). All other wards reported zero use of rapid tranquilisation. This was a significant decrease from the figures provided in 2016, when the provider reported 352 uses of rapid tranquilisation over six months.
- Staff did not follow best practice when using seclusion. We reviewed 21 episodes of seclusion. Medical reviews had not taken place within an hour in six episodes on Willow, Meadow and Brook wards. Two nurses had not carried out nursing reviews in nine records on Fern, Willow, Meadow, Marsh and Brook wards. Doctors had not completed continuing medical reviews every four hours in six episodes of seclusion on Bracken, Meadow and Brook wards. Internal multidisciplinary team reviews had not taken place in two out of six episodes. Independent multidisciplinary team reviews had not taken place for a patient on Brook ward. Staff had not recorded details of who undertook scheduled nursing reviews, their assessment, and a record of the patient's condition and recommendations in seven episodes of seclusion on Fern, Willow, Meadow and Brook wards. Staff had not recorded details of who undertook scheduled medical reviews, their assessment and a record of the patient's condition and recommendations in two out of three episodes of seclusion on Meadow and Brook wards. Staff had not recorded details of who undertook the scheduled multidisciplinary team reviews, their assessment and a record of the patient's condition and recommendations in two out of four episodes of seclusion on Brook ward.
- Staff had not developed care plans for the patient's episode of seclusion in nine of the 21 episodes. There were no care plans for two episodes of seclusion on Fern ward, one on Meadow ward and five on Brook ward. Completed care plans did not always contain the information required by the Mental Health Act Code of Practice. This information was not complete in three care plans on Willow ward, two on Brook ward and one of both Sycamore ward and Marsh ward. Staff had secluded a patient, intermittently, in their bedroom on Fern ward between 24 January 2019 to 29 January 2019, but had not implemented seclusion processes and as such staff had not protected the patient's rights in line with the Mental Health Act Code of Practice. We found evidence that staff did not end seclusion at the earliest opportunity for three patients. Staff had secluded one patient on Fern ward and recorded that they were settled in the 15 minute observations for two hours and 45 minutes before seclusion was terminated. Staff had secluded the second patient on Bracken ward for eight hours and three minutes. Staff had made a total of 32 observation entries during the length of the seclusion, none of which described the patient presenting with challenging or disturbed behaviour. Staff had secluded the third patient on Willow ward for three hours and 38 minutes. Staff had recorded the patient as relaxed or asleep in the 15 minute observation records throughout the episode of seclusion.
- However, in 21 episodes, there was documentation to indicate who had authorised the seclusion, the date and time of commencement of seclusion and the reason(s) for seclusion. In 20 episodes, staff had documented what the patient took into the seclusion room. In 19 episodes, staff had documented if and when a family

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member, carer and/or advocate was informed of the use of seclusion. Staff had recorded the date and time seclusion ended and details of who determined that seclusion should come to an end in 20 episodes.

- Staff had not followed best practice when using long-term segregation. We reviewed four episodes of long-term segregation, one patient on Bracken ward, one on Acorn ward, and two patients on Brook ward. An approved clinician (who may or not be a doctor) did not formally review the patient's situation at least once in any 24-hour period. For example, for one patient's long-term segregation on Brook ward, only 12 reviews out of a possible 75 had taken place between 04 January and 18 March 2019. For another patient on Acorn ward, only eight reviews out of a possible 30 had taken place between 18 February and 20 March 2019.
- While the full multidisciplinary team formally reviewed the patient's situation at least weekly on Bracken ward and Acorn ward, this had not happened for two patients on Brook ward. One patient on Brook ward, had only three out of a possible 11 multidisciplinary team reviews recorded since January 2019 and another patient had only three out of a possible six reviews between February and March 2019. Staff did not record independent mental health advocate involvement, and we were unable to establish, from the care records, whether staff had made the local safeguarding team aware of any patient being cared for in long-term segregation.
- However, in each record, we saw the clinical judgement was that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. Staff had, wherever appropriate, considered the views of the patient's family and carers.
- Patients in long-term segregation were in environments that were no more restrictive than was necessary. Patients had access to secure outdoor areas and activities of interest and relevance to the patient. A minimum of two members of staff cared for each patient under long-term segregation. Staff created treatment plans aiming to end the patient's long-term segregation. Staff caring for patients in long-term segregation made written records, on an hourly basis, about the patients' condition. We saw evidence of the outcome of all reviews and the reasons for continued segregation recorded and staff informing the responsible

commissioning authority of the outcome. Staff had clearly stated in each patient's treatment plan the reasons why long-term segregation was required. Where successive multidisciplinary team reviews determined that the patients' long-term segregation continued to be required, information was available to demonstrate its necessity and explain why the patients could not be cared for in a less restrictive manner.

Safeguarding

- Most staff (82%) were trained to level three in safeguarding children, knew how to make a safeguarding alert, and did that when appropriate.
- Social workers, allocated to individual wards, were responsible for overseeing safeguarding alerts during normal office hours. Outside of these hours staff would contact the local authority duty worker.
- The service had a named child protection lead and managers had displayed this information on the wards.
- Staff followed safe procedures for children visiting the ward. There were visiting areas located outside of the wards which staff used to facilitate families visiting with children.

Staff access to essential information

- Staff used an electronic record system for patient records, with some records also available in paper format, for example, positive behaviour support plans.
- All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form.

Medicines management

- Staff on seven of the nine wards followed good practice in medicines management. However, on Marsh ward we found five out of date drug testing kits and on Acorn ward staff had not tested the fridge temperature on five days in February and March 2019. Staff had stored aftershave in the medicines cupboard on Acorn ward.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute of Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

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- The provider reported 22 serious incidents from January 2018 to January 2019. The highest number were on Fern ward (eight) and then Meadow ward (seven).
- The most common incident type was self harm, with a total of 12.
- We reviewed 21 incidents, staff had recorded most of these appropriately, with referrals made to the local authority safeguarding team where necessary. However, we found two incidents involving the police that staff had not reported to the CQC.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. However, there was one example where staff recorded details of an incident that did not accurately reflect what took place. This was highlighted throughout the course of an investigation where senior managers reviewed closed circuit television camera footage. Managers did not communicate accurate facts to the relatives regarding the incident.
- Staff understood the duty of candour, they were usually open and transparent and gave patients and families a full explanation when things went wrong. However, we spoke with one carer who told us this had not been the case.
- Staff received feedback from the investigation of incidents, both internal and external to the service. Feedback was provided in team meetings, supervisions and via 'red top alerts', which were emailed to all staff across the organisation.
- Managers had made changes in response to learning from incidents, including removing access to certain items on certain wards at certain times following incidents of self harm. For example, on one ward, staff managed all pens in such a manner that patients only have directly supervised access to them due to the risk of patient's passing them to a peer who is intent on swallowing pens. On some wards, staff have had to restrict individual access to lithium batteries due the risk of patient's ingesting them.
- Managers acted following the previous inspection to make some changes to improve the safety of the environment. This included the installation of self closing doors throughout the building.
- Staff on Sycamore and Willow wards told us that there were high levels of violence and aggression on the

wards and patients injured staff frequently. However, staff on all wards told us managers supported and debriefed them following incidents, including staff assaults.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Staff had completed comprehensive mental health assessments in the 14 patient records reviewed.
- Staff had completed assessments of patient's physical needs in a timely manner after admission.
- Staff had developed care plans to meet the needs identified during assessment. These included 'Positive Behaviour Support' plans for most of the patients. We reviewed 58 'Positive Behaviour Support' plans, all were holistic, personalised and recovery orientated. They included a communication plan and the patients' strengths, likes and dislikes. Hard copies of the plans were available on the ward to enable staff to access them quickly. Staff had also developed additional care plans to meet specific needs, these included sensory plans, physiotherapy plans, plans to support transitioning patients and nasogastric feeding plans. The team on Bracken ward had been on an away day to discuss one very complex patient on the ward and developed a plan that clearly detailed each staff member's role in supporting the patient. However, staff had not completed care plans for one patient on Marsh ward, who had been admitted in February 2019.
- Staff had updated the majority of general care plans when necessary, although they had not always completed seclusion care plans when required.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence. Interventions included a full dialectical behavioural therapy programme, cognitive behavioural therapy, behavioural

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family therapy, sensory integration, 'reinforce appropriate implode disruptive' approach, transition to the family environment therapy, work on psycho-social skills, autism groups, trauma work and cognitive development.

- The service included an Ofsted registered college, rated as outstanding, which provided educational and vocational opportunities to patients. These included General Certificates of Secondary Education, A levels, access courses, the Duke of Edinburgh award, citizenship activities and access to work experience.
- Staff assessed patient's needs for food, drink and specialist nutrition and hydration. Staff assessed patient's needs for food, drink and specialist nutrition and hydration. There were several patients with 'disordered eating', some of which required nasogastric feeds at times. There were 21 staff trained within the adolescent's service to provide nasogastric feeds. In addition to this the provider had a list of nasogastric feeding trained staff across the Northampton site and would ensure one of these staff was always available. However, we reviewed the records for one patient on Fern, who had a nasogastric feeding plan. The dietician had recorded in the patient's notes that staff were not completing the required food and fluid charts to ascertain if staff needed to provide nasogastric feeds. This patient was at risk of not receiving sufficient nutrition.
- Staff supported patients to live healthier lives through healthy eating advice and support to access physical activities.
- Staff used recognised rating scales to assess and record severity and outcomes. These included Health of the Nation Outcome Scales for Children and Adolescents, the Short Term Assessment of Risk and Treatability, Structured Assessment of Violence Risk in Youth and Children's Global Assessment Scale, Autism Diagnostic Observation Schedule, Autism Diagnostic Interview, Wechsler Intelligence Scale for Children and Assessment of Motor and Process Skills.
- Staff participated in clinical audits, including audits against National Institute of Health and Care Excellence standards, Prescribing Observatory for Mental Health audits, high dose antipsychotics, polypharmacy, consent to treatment, benzodiazepines, controlled drugs, opiate use, sodium valproate in females and clozapine.

Skilled staff to deliver care

- The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, teams included or could access occupational therapists, technical instructors, physiotherapists, clinical psychologists, social workers, pharmacists, speech and language therapists and dieticians.
- Staff had the experience, qualifications, skills and knowledge to meet the needs of the patient group.
- Managers provided new staff with appropriate induction. This included the corporate induction, followed by a two day specific adolescents induction then a week of shadowing on the ward. The provider had employed a member of staff to support new staff, including support to complete the care certificate.
- All staff had received an appraisal within the last 12 months.
- The provider had reported clinical supervision rates above their target of 85% on all wards, apart from Willow ward, which reported 77%. Managers and staff told us that they received monthly clinical supervision and quarterly management supervision. We reviewed 21 paper copies of clinical supervision records. All records only detailed the date, time, names and signatures. The provider's policy stated that the supervisor will take minutes and provide a copy to both parties. The supervisor should also record issues and actions. When we raised this with the provider, they advised that supervisors kept records electronically.
- In addition to supervision, staff had the opportunity to attend reflective practice sessions with the psychologist. Staff on Brook ward reported that they did not always have time to attend. The clinical nurse lead on Acorn ward had started providing 30 minute catch ups with each staff member once a month. The nurse used these sessions to communicate training, hospital information and share lessons learnt.
- Managers identified the learning needs of staff within the annual appraisal and management supervision and provided them with opportunities to develop their skills and knowledge. Health care assistants had the opportunity to train to become a registered mental health nurse.
- Managers ensured that staff received the necessary specialist training for their roles. Staff told us that they

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had accessed courses in personality disorders, the 'reinforce appropriate, implode disruptive' approach, dialectical behavioural therapy, autism and sensory integration and coaching.

- Managers dealt with poor staff performance through the management supervision process, with support from the provider's human resources team when required.

Multidisciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings. We observed a multidisciplinary ward round which the social worker, consultant, associate specialist, psychologist, senior staff nurse and the patient attended. The meeting was well organised and everyone contributed. Staff updated the patient's care plan and gave a copy to the patient. The team discussed the patient's diagnosis, therapies, early warning signs, communication aids, level of aggression, medication, sleep hygiene and referral to other specialists.
- We observed a bed management meeting attended by ward managers, operational lead, consultants, clinical lead and a customer accounts team member. The team discussed issues including current bed numbers, potential transfers, delayed discharges, and plans for those patients approaching 18. The team agreed that Willow ward would not be accepting any new admissions at present due to the high acuity of current patients. In addition, the meeting discussed current risk and risk management plans, patients on enhanced observations, those in long term segregation, and the reintegration of patients in extra care as well as consideration of least restrictive options. The team also discussed availability of treatment, acuity levels, outcomes from referral assessments, incidents, lessons learnt, de briefs, transgender issues, safeguarding and communication with external organisations.
- Staff shared information about patients at effective handovers between each shift.
- The ward teams had effective working relationships within the service and with external agencies, including local authorities and commissioners. Staff told us that they used to have a good relationship with the police, but the service no longer has a dedicated police liaison officer and this has resulted in a less positive relationship.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Most (93%) staff had completed Mental Health Act training.
- Staff did not always follow the Mental Health Act Code of Practice in relation to restrictive practices, including the application of blanket restrictions, seclusion and long term segregation.
- Staff had access to the provider's Mental Health Act administrators.
- The provider had relevant policies and procedures that reflected the most recent guidance.
- Staff had easy access to local Mental Health Act policies and to the Code of Practice.
- Patients had easy access to information about independent mental health advocacy and advocates visited the wards on a weekly basis.
- Staff did not always explain to patients their rights under the Mental Health Act. We reviewed the care records of 25 patients detained under the Mental Health Act. In 18 records, staff had provided patients with information about their legal position and rights, at the point of the patient's admission/detention and periodically thereafter, as required under section 132 of the Mental Health Act. However, in the remaining seven records (two records on Brook ward, two records on Bracken ward, two records on Acorn ward and one record on Maple ward) it was not evident that staff had provided patients with this information, at the point of the patient's admission/detention. In one record on Brook ward, staff had not provided the patient with information about their legal position and rights for six months after the patient had initially not understand this information. Staff had considered and renewed the patient's detention (under section 20) in 17 records. In five of these records, staff had provided the patient with information about their position and rights, as required under section 132 of the Mental Health Act. However, staff had not done this in the remaining 12 records (three records on Brook ward, three records on Fern ward, two records on Maple ward, three records on Acorn ward and one record on Bracken ward).
- Staff and patients told us that patients were not always able to take section 17 leave due to staff shortages. Two patient records confirmed this.
- Staff requested an opinion from a second opinion appointed doctor when necessary.

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- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- We reviewed 25 sets of Mental Health Act detention papers. These related to the patients' current period of detention including, where applicable, section 19 (authority for transfer from one hospital to another under different managers) and section 20 (renewal of authority for detention). The detention papers were complete and in order, in relation to the patients' detention under the of Mental Health Act.
- The service did not accommodate informal patients.
- Managers told us that they completed regular audits to ensure that staff were applying the Mental Health Act correctly. However, we identified that staff were not following the Mental Health Act Code of Practice in relation to restrictive practices, including the application of blanket restrictions, seclusion and long term segregation.

Good practice in applying the Mental Capacity Act

- Most (93%) of staff had completed Mental Capacity Act training. This included training on the Gillick competency and Fraser guidelines, applicable to children and adolescents.
- Staff we spoke with demonstrated knowledge of the Mental Capacity Act, Gillick competency and Fraser guidelines. Staff explained that once a patient was 16, the Mental Capacity Act would apply and patients would have to consent to staff sharing information with parents.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff supported patients to make decisions. When necessary, staff would hold best interest meetings for patients and where required would involve parents or the local authority for looked after children.
- The service had arrangements to monitor adherence to the Mental Capacity Act and had recently conducted an organisation wide audit of capacity and consent.

Are child and adolescent mental health wards caring?

Inadequate 

Kindness, privacy, dignity, respect, compassion and support

- Staff did not always treat patients with kindness, dignity and respect when in seclusion. Except for Brook ward, none of the seclusion rooms included limited furnishings such as a bed, pillow, mattress and blanket or covering. Staff gave us conflicting information about reasons for this. Staff reasons included providing furniture after seclusion commenced, furniture was an infection control risk, patients had access to furniture after 15 minutes. When we checked patients' seclusion records, it was evident that there were 13 episodes of seclusion when staff had not provided patients with a mattress or chair (one episode on Fern ward, one episode on Sycamore ward, one episode on Meadow ward, one episode on Maple ward, three episodes on Willow ward, two episodes on Oak ward -sleeping over from Brook and four episodes on Acorn ward). Observation records for nine episodes of seclusion detailed 28 entries describing the patient sitting or lying on the floor. In one episode of seclusion staff recorded the patient as sitting or lying on the floor for two hours and 15 minutes. In another episode staff recorded the patient as sitting or lying in the floor for one hour and 14 minutes. Staff had also recorded entries describing the patient as eating their lunch and supper whilst sat on the floor.
- Staff, on one occasion, did not ensure that female staff supported female patients when it was required, for their safety, to change into different clothing. An incident took place where four male staff were present in the room whilst a female patient was changed into rip proof clothing. Despite investigation, the provider could not offer any assurance that this was not the case and why this had occurred. This did not uphold the dignity of the patient during a distressing situation.
- Staff had stopped the practice of conducting pat down searches in the corridor and carried searches out in private side rooms, unless otherwise requested by the patient.

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- Patients told us that staff treated them well and behaved appropriately, although some agency staff were not as kind as regular staff. We observed staff being polite and caring towards patients.
- Patients told us that staff supported them to understand and manage their care, treatment or condition.
- Staff demonstrated a good understanding of patients' individual needs, including their personal, social, cultural and religious needs.
- Staff told us they would raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes.
- Staff maintained the confidentiality of information about patients.

Involvement in care

- Staff used the admissions process to inform and orientate patients to the ward and service.
- Patients told us that staff invited them to multidisciplinary meetings, involved them in their care plans and provided them with a copy. We observed a multidisciplinary meeting which confirmed this.
- Staff communicated with patients to help them understand their care plan, including finding effective ways to communicate with patients with communication difficulties. An example of this was the use of social stories.
- Patients on the mental health wards were involved in the recruitment of staff, patients sat on the recruitment panel and were involved in the decision of which staff to recruit.
- Staff enabled patients to give feedback on the service received in community meetings, which staff recorded. We observed a community meeting on Acorn ward, four patients and five staff attended. Discussions included responses to action points and praise for patient achievements. On Maple ward staff told us that there was a log of actions from the community meetings, however staff were not able to find this.
- Staff ensured that patients could access advocacy.
- We spoke with 12 carers. Six carers had children on Maple ward. Five of these carers expressed that communication from nursing staff on the ward was poor. Some of the carers advised that their children had been on other wards within the service previously and staff communication had been very good on those wards. Three carers told us that staff shortages impacted on their child getting leave and attending

activities. Two carers told us that staff were inconsistent. One carer told us that staff had not followed her child's care plan which had resulted in her child experiencing distress and punching a wall. This resulted in injury to her child's hand requiring hospital attention. There were significant delays in one case of addressing concerns raised by a parent about their child's care. All carers told us that the environment and facilities were very good. Other carers reported positive experiences with the service, telling us that staff were kind, brilliant, amazing, and the hospital was the best their child had been in.

- The provider had conducted a carers' survey in 2018. The results were mostly positive with 94% of carers strongly agreeing that they feel welcomed and 92% strongly agreeing that they are treated with dignity and respect. 77% of carers said they would recommend the provider.
- The service provided accommodation on site for families who had long distances to travel to visit their child. The service also provided funds towards the cost of fuel for families travelling.
- The service facilitated monthly carers meetings and two big carers events each year.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

- The service provided a national service, with patients from all parts of the United Kingdom and from Ireland.
- There was always a bed available when patients returned from leave.
- Staff did not move patients between wards during an admission episode unless clinically justified and in the interests of the patient.
- When staff moved or discharged patients, this happened at an appropriate time of day.
- The provider reported that there were 15 delayed discharges currently in the service. Twelve were patients who were over 18. The provider started work with commissioners to discharge patients who were due to turn 18 well in advance of this. The wards with the highest number of delayed discharges were Bracken

Child and adolescent mental health wards

and Acorn. Managers told us that all the delayed discharges were due to a lack of suitable move on accommodation. Managers told us that they had arranged numerous assessments with other providers for patients, but that providers would not accept the patients when they became aware of the risk issues and resources required. The provider was working closely with commissioners to find suitable alternative placements.

- Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital.
- The provider only supplied average length of stay data for two wards; Bracken reported 206 days for patients discharged over the last 12 months and Acorn reported 390 days.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms, which they had personalised.
- Patients had somewhere secure to store their possessions.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. This included activity rooms, games rooms and courtyards on each ward. Within the secure perimeter of the building there were two gyms, a large sports hall, an outdoor multi sports area, an outside gym area, an animal courtyard, a tranquillity garden and a horticultural garden. In addition to two sensory rooms, a music room, an arts studio, a craft room, a hair salon, a café, a social area with a pool table, three therapy kitchens, a multi-faith area (including a wudu for bathing), and treatment rooms. There were two conference rooms for tribunals and care and treatment reviews and the college for educational activities.
- Each ward had a quiet room and meeting rooms located just outside the main ward area that staff used to facilitate patients' family visits.
- Each ward had a phone room where patients could make phone calls. There were also additional phones located in the meeting rooms just off the wards, which patients could also use.
- Each ward had an outside courtyard area that provided patients' access to outside space.

- Patients had to request hot drinks on all wards and cold drinks on four wards. Staff only allowed patients to have snacks at set times.

Patients' engagement with the wider community

- Patients had access to the provider's college for educational activities. Each patient had an individualised timetable to meet their needs. There was a specially designed classroom for patients with autistic spectrum disorders. The room had individual work stations, clearly labelled items and social areas to encourage interaction.
- Patients had opportunities for voluntary work experience at a local charity shop, this included upcycling furniture and selling it. Other patients operated the mobile toiletry trolley and worked in the pop up coffee shop.
- Patients were also able to access the provider's on site light industry workshop.
- Staff supported patients to maintain contact with families through visits and video conferencing.

Meeting the needs of all people who use the service

- The service made adjustments for patients with a disability – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs. The provider had equipped wards with assisted bathrooms. Staff had devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients.
- Managers ensured that staff and patients had easy access to interpreters and/or signers.
- Staff offered patients a choice of food to meet the religious and cultural dietary requirements. This included vegetarian, vegan, halal and kosher meals.
- Staff ensured that patients had access to appropriate spiritual support. The service had a multi-faith area and access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.
- Staff were supporting a number of transgender patients during our visit. Staff had ensured these patients were sensitively supported to be the gender they identified as. Staff had completed training and accessed support from specialist organisations to support patients with lesbian, gay, bisexual and transgender needs.

Child and adolescent mental health wards

Listening to and learning from concerns and complaints

- The provider reported that they had received 26 complaints in the 12 months prior to the inspection. The provider had upheld two of these complaints, partially upheld six, not upheld 15 and advised that three were ongoing. The provider had not had any complaints referred to the ombudsman. Maple and Meadow wards received the most complaints, with seven each, followed by Fern ward with four. The common themes of complaints were staff attitude, clinical treatment and staff availability.
- Patients spoken with told us they knew how to complain, however one patient told us that staff had not provided any feedback about their complaint. The provider had a complaints team, which patients could contact directly from the patient telephones on the wards.
- Staff spoken with knew how to handle complaints appropriately.
- Managers provided feedback about complaints in team meetings.

Are child and adolescent mental health wards well-led?

Inadequate 

Leadership

- Leaders had the skills, knowledge and experience to perform their roles.
- Leaders had a good understanding of the services they managed, however they were not all aware that the default position of staff was not to provide a mattress, chair or bedding to patients in seclusion.
- The service had been operating as two integrated practice units since April 2018. One unit specialised in children and adolescent's mental health and the other unit specialised in developmental disorders. Each unit had an operational lead and a clinical lead.
- Leaders were visible in the service and approachable for patients and staff. Staff spoken with told us that the operational leads and clinical leads for the service were visible on the wards. Staff told us that the chief executive officer visited regularly and had been particularly supportive to staff on one ward that had

been dealing with a difficult situation. Staff also told us that members of the board would visit the service and some board members were befrienders for patients. The befriender role involved visiting patients on the ward and taking them out for walks in the grounds.

- Leadership development opportunities were available, including opportunities for staff below team manager level. Managers told us that the service held six monthly leadership days for managers and staff in lead roles. New managers had attended training to develop leadership skills.

Vision and strategy

- The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were: Compassion: Be supportive; understand and care for our patients, their families and all in our community. Accountability: Take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well.
- Staff knew and understood the provider's vision and values and how they applied them in their work.
- The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.
- Staff told us that the change of model within the service had enabled them to have more influence on decisions within the service. Ward managers told us they have more autonomy.
- Operational leads were responsible for the budget for their unit. The leads explained that they aimed to provide the best value service.

Culture

- All staff spoken with told us that they felt respected, supported and valued. The provider had a relatively new management team who were developing and changing the culture. Staff told us that the management culture had changed for the better and there was no longer a blame culture. Staff gave us examples of managers supporting them to work flexibly to improve their well-being. This included a reduction in hours worked and flexibility in shift patterns. One healthcare assistant told us the provider was supporting them to improve their English to enable them to complete their nurse training.

Child and adolescent mental health wards

- Overall, staff felt proud and positive about working for the provider and their team. The staff survey of 2018 reported the following results; 88% of staff agree that we look after our patients with compassion, 85% of staff are willing to give extra effort to help meet our goals, 83% of staff agree that their team constantly look for ways to do their jobs better. The top three concerns identified in the survey were; reward and recognition, communication and staffing.
- The service had been subject to high levels of media coverage and scrutiny from external organisations in recent months. Staff had continued working in a positive manner throughout this, despite the stress and pressure caused. However, some staff on Fern and Maple wards told us that they felt burnt out and exhausted.
- Staff felt able to raise concerns without fear of retribution.
- Staff knew how to use the whistle-blowing process.
- Managers dealt with poor staff performance when needed, with support from the provider's human resources team.
- Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Staff appraisals included conversations about career development and how the provider could support this. The provider supported healthcare assistants to train as registered mental health nurses.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider had an active lesbian, gay, bi-sexual and transgender group, which was sponsored by the acting Director of Nursing. There was also an equality and diversity team that supported staff, including with career progression. The provider has been in the Top 100 Employer in the Stonewall Work Equality Index for 2016, 2017 and 2018 and reported female representation to be 64% at management level, 33% at executive level and 33% at board level. Black, Asian, minority ethnic representation at management level has increased to 11%.
- The provider reported a staff sickness rate of 5% for the service between 01 September 2018 and 30 November 2018. Acorn ward reported the highest rate at 13%, followed by Sycamore and Maple wards at 7%.
- Occupational health services and a trauma nurse supported staff physical and emotional health needs.

The provider had invested in a programme of support to promote staff well-being. This included training staff in mental health first aid (to support colleagues), staff wellbeing events, massages and Zumba classes.

- The provider recognised staff success within the service through staff awards. The provider issued awards based on their values on a monthly and quarterly basis, which then culminated in an organisation wide annual awards ceremony for the overall winners. Bracken ward had won team of the year at the annual ceremony in 2018.

Governance

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. Staff were secluding patients in environments that did not meet the standards required by the Mental Health Act Code of Practice in relation to access to furnishings and bedding. It was the inspection team's view that this practice was uncaring. Staff, had on three occasions, secluded patients for longer than required. We had raised this issue following the last inspections of the Adolescents location and another of the provider's locations. Staff were applying blanket restrictions without consideration of the impact on individual patients. The CQC Mental Health Act reviewer had issued the provider with action points in relation to blanket restrictions on eight separate occasions. The provider's response at the time had been that the multi-disciplinary team would review blanket restrictions, patients would be individually risk assessed and care plans put in place in relation to any restrictions. Managers at all levels told us that staff had recorded the impact of blanket restrictions in patients' records. There was no evidence of this in the records we reviewed.
- The arrangements for governance did not always operate effectively. Governance arrangements had not always identified that staff practices were sometimes in breach of the Mental Health Act Code of Practice. Senior managers were unaware that the default position was not to provide furnishings to patients in seclusion. The provider had not addressed previous issues raised by the CQC on 12 separate occasions, across different locations, in relation to restrictive practices or actions points issued by the CQC Mental Health Act reviewer. We identified inconsistencies in the delivery of services at a provider level.

Child and adolescent mental health wards

- Managers did not always deal with risk issues appropriately or in a timely way. We found hazards in seclusion rooms and extra care suites. A CQC Mental Health Act reviewer had previously raised the issue of sharp door frame edges with the provider on seven separate occasions. Whilst the provider had completed work to remove the sharp edges on the side of the door frames, the top of the door frames were still sharp. There were no recorded incidents of patients harming themselves on these edges. Senior managers advised that ward managers were responsible for signing off any work completed on their wards in relation to risk issues. The provider had no assurance system in place to check that the maintenance team had completed required works satisfactorily.
- The provider undertook a range of audits across the service. However, these audits had failed to address the issues with seclusion and long term segregation practices.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk issues and performance

- Ward managers told us they could add items to the service or organisational risk register.
- The provider's risk register for the service had identified the following red rated risks; patient and staff safety and recruitment and retention of qualified staff.
- Staff concerns matched those on the risk register.
- The service had business continuity plans to manage emergency situations, for example, adverse weather events.

Information management

- The provider used systems to collect data from wards that were not over burdensome on staff.
- Staff had access to the equipment and technology they needed to do their work.
- The provider used key performance indicators to support managers to gauge the performance of their teams, including compliance with training, supervision and reduction in restrictive interventions.

- Staff made referrals to the local authority safeguarding team as required, however the provider had not notified the CQC about two incidents involving the police.

Engagement

- Staff had access to up to date information about the work of the provider through the intranet, emails and newsletters.
- Patients and carers had opportunities to feedback about the service through questionnaires and meetings. The provider employed a dedicated involvement lead to oversee this work.
- Staff had opportunities to meet the providers senior leadership team through 'drop in' sessions. Staff told us they had met the new chief executive officer when they had visited the service.
- Senior leaders engaged with external stakeholders, for example NHS England and clinical commissioning groups.

Learning, continuous improvement and innovation

- Managers offered staff the opportunity to give feedback on services and input into service development.
- Staff had opportunities to participate in research, this included staff on Meadow ward working with a university researching genetic approaches to the treatment of psychosis and staff working with a student from another university researching the positive impact of physical activity in adolescents with mental health problems.
- Innovations were taking place in the service. These included the introduction of behavioural family therapy and the physiotherapist using virtual reality equipment to support patients with dyspraxia.
- Brook ward was a member of the Quality Network for Inpatient Child and Adolescent Services and peers carried out annual reviews. The last review was in April 2018 and identified that that the ward needed to improve in the following areas; appropriate use of the seclusion room; having sufficient skilled staff, involving young people more and improving governance input.

Outstanding practice and areas for improvement

Outstanding practice

The service provided an impressive range of therapies within excellent facilities. The environment was well designed and spacious which allowed staff to facilitate therapies, education and activities in both group and 1:1 settings.

The service provided outstanding support for patients with lesbian, gay, bi-sexual and transgender needs. The provider also encouraged staff diversity through promotion of lesbian, gay, bi-sexual, transgender, black, Asian and minority ethnic rights.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure staff treat patients with kindness, respect and dignity. They must ensure patients comfort when using seclusion rooms as required by the Mental Health Act Code of Practice. They must ensure patients privacy and dignity is upheld at all times.
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and blanket restrictions.
- The provider must ensure safety concerns are identified and addressed in a timely manner and that staff follow procedures in relation to checking cutlery, food hygiene and the checking of emergency bags and medical equipment.

- The provider must ensure sufficient staff of the right experience to deliver patient care and facilitate access to leave and other activities.
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues.

Action the provider **SHOULD** take to improve

- The provider should ensure that all patients have their rights explained to them under the Mental Health Act as required by the Code of Practice.
- The provider should ensure all staff engage and communicate with carers appropriately.
- The provider should ensure that all notifiable incidents are reported to the CQC in a timely manner.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- Staff did not always treat patients with kindness or respect when in seclusion. Eleven of the 15 of the seclusion rooms did not include furnishings such as a bed, pillow, mattress or blanket. We reviewed nine episodes of seclusion when the patients had not been provided with a mattress or chair. We reviewed observation records for a further two episodes of seclusion on Acorn ward and found nine entries describing the patient sitting or lying on the floor.
- Staff did not always uphold patients' dignity. Four male members of staff remained present when a young female patient was changed into rip proof clothing.

This was a breach of regulation 10

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Managers had not ensured that they consistently identified or addressed safety concerns quickly enough. We found sharp door frames in seclusion rooms and extra care suites. We found blind spots in seclusion rooms and sharp metal in extra care suites. Staff did not always follow safety procedures in relation to cutlery checks and food hygiene. Staff did not always check emergency equipment and medicines.
- Staff did not follow best practice when using seclusion and long term segregation. Medical, nursing and

Enforcement actions

multi-disciplinary reviews had not taken place as required by the Mental Health Act Code of Practice. Staff had not always completed seclusion care plans for patients, involved advocacy or informed the local authority when required.

- Staff were applying blanket restrictions without justification. All wards had imposed set snack times for patients. Other restrictions included access to drinks and takeaways, shoes being banned and en suites being locked. Managers told us that patients had requested set snack times and to not have shoes on wards and that this was recorded in community meeting minutes. Staff provided minutes of community meetings, however only records for two wards indicated patient agreement.
- Managers had not always ensured established staffing levels on all shifts. Managers had not filled 13% of shifts between 1 and 31 March 2019. Managers had used bank and agency staff to cover 47% of shifts. Staff shortages sometimes resulted in staff cancelling escorted leave, appointments or ward activities. Staff on Fern, Maple and Willow wards told us that the high use of bank and agency staff impacted on patient care as risk events increased due to inconsistencies in patient care.
- Staff did not always follow safety procedures. Wards operated a cutlery checking process to ensure patients did not take cutlery out of the dining area. We found that staff did not always follow this process on four wards. Staff did not always check emergency and medical equipment. On Marsh and Acorn wards staff had not checked the emergency bag in line with the provider's policy which states checks are to be carried out weekly. On Marsh ward we found five out of date drug testing kits and on Acorn ward staff had not tested the fridge temperature on five days in February and March.
- The provider had not fitted or supplied call alarms in patient bedrooms. Staff had not completed risk assessments detailing how patients would summon help.

This was a breach of regulation 12

This section is primarily information for the provider

Enforcement actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- Staff kept three patients in seclusion for longer than required.
- We reviewed one incident on Maple ward, when staff had restrained the patient and changed them into rip proof clothing when the patient was presenting as calm and compliant.

This was a breach of regulation 13

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care in relation to the comfort of patients in seclusion and the application of blanket restrictions.
- The arrangements for governance did not always operate effectively. Governance arrangements had not always identified that staff practices were sometimes in breach of the Mental Health Act Code of Practice. The provider had not addressed actions points previously raised by the CQC, across different locations, and action points issued by the CQC Mental Health Act reviewer. Provider audits had failed to address the issues with restrictive practices.
- Managers did not always deal with risk issues appropriately or in a timely way. Although the provider had carried out work to rectify hazards, it was incomplete. The provider did not have a system to check that the maintenance team had completed required works satisfactorily.

This was a breach of regulation 17