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?	Requires improvement
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

This service was placed in special measures on 06 June 2019. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking 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 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 Edward Baker
Chief Inspector of Hospitals

Overall summary

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

- Patients were at risk of continuing harm. The service did not always manage patient safety incidents well. Managers had not investigated incidents thoroughly, or in a timely manner. Staff did not always use approved restraint techniques, which resulted in staff dragging patients along the floor or physically injuring patients during restraint. Senior staff told us they observed CCTV footage of these incidents and were concerned that other staff present had not acted to intervene. Staff did not always keep patients safe from harm whilst on enhanced observations. The provider reported 212 incidents of patients' self harming whilst on enhanced observations between 1 September 2019 and 30 November 2019. Staff did not always make sure they shared clear information about patients and any changes in their care. Staff did not always complete required safety checks in line with the providers policy and procedures.
- Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others. We found staff on enhanced observations for the same patient for between three to ten hours. We found staff completed observations continually throughout a shift for up to three different patients. Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety. We found examples of staff not completing observation records.
- Staff did not always treat patients with kindness, dignity and respect on four wards. Staff referred to a patient who identified as male as her/she, this upset the patient and continued after the patient complained. We found staff recorded an incident of bullying behaviour between patients as "a bit of fun". We found examples of a punitive culture on some wards. Staff criticised and sanctioned patients, without justification, for talking to other patients and cooking different meals to those planned.
- The leadership, governance and culture did not always support the delivery of safe, high quality, person centred-care. Leaders did not always understand the issues, priorities and challenges the service faced. The provider's governance processes had not addressed staff failures to follow the provider's procedures. There was no evidence that the provider undertook regular and effective audits of these issues. We were not assured that the provider acted to keep patients safe from harm. The provider did not oversee patient risks effectively. We found that evidence to support serious incident investigations was not preserved. There was a lack of leadership during serious incidents. Investigations into serious incidents were not completed in a timely manner.

Summary of findings

- We were concerned about the culture within the organisation in relation to the perception of the regulator and the message leaders relayed to staff and patients. Comments made in board papers downplayed the significant concerns raised in the last Adolescents inspection. A senior leader requested wording in a safeguarding report was changed from 'dragged' to 'moved along' in relation to use of non-approved restraint techniques.
- Use of restraint and seclusion had significantly increased since the last inspection. The provider reported 2,266 incidents of restraint from 01 February 2019 to 31 July 2019. This was an increase of 29% since the last inspection. Use of prone restraint increased by 44% since the last inspection. Use of seclusion increased by 79% since the last inspection.
- The service did not have enough nursing and support staff to keep patients safe. We reviewed four incidents where staff shortages impacted on patient safety. Between 01 May 2019 and 31 July 2019 managers were unable to fill 17% of shifts, bank staff filled 50% of shifts and agency staff 35% of shifts.
- Staff did not always identify and meet patients' needs. Staff had not completed physical health assessments on admission for three patients reviewed and two patients had no care plan. Staff had not taken action to meet the physical healthcare needs of three patients.
- Although staff compliance with the Mental Health Act Code of Practice in relation to seclusion and long term segregation had improved, we found 21 examples where practice did not meet the code in 22 records reviewed, for example, staff not recording their role in review records and care plans lacking detail.

However:

- The provider made improvements since the last inspection. They introduced a new leadership team, ensured safe environments and made significant changes to blanket restrictions. The service had been working with external partners, including NHS trusts with outstanding ratings to help the service improve.
- Staff and patients had access to an extensive range of rooms and equipment to support treatment and care. Patients had access to the provider's school for educational activities. Each patient had an individualised timetable to meet their needs. Staff ensured that patients had access to appropriate spiritual support. Staff supported patients to access a range of leave activities, including football matches and horse riding.
- Staff completed comprehensive mental health assessments for patients. Staff provided a range of care and treatment interventions suitable for the patient group. The teams included or had access to the full range of specialists required to meet the needs of patients on the ward.
- Senior leaders were visible in the service and approachable for patients and staff. Staff spoken with told us that the operational lead 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 following the last inspection.
- Staff involved patients in decisions about the service. The provider introduced a new recruitment process, which involved patients as equal partners in deciding on staff to recruit.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	Start here...

Summary of findings

Contents

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 school, 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. Three of the wards were closed during this inspection. There were 58 patients at the service during our inspection.

St Andrew's Healthcare Adolescents service has been inspected 11 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 March and April 2019. The service was rated inadequate overall and placed into special measures. The service was rated inadequate for safe, good for effective, inadequate for caring, good for responsive and inadequate for well led.

We took enforcement action for breaches of the following regulations:

Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 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.

Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 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 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

Summary of this inspection

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.

Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 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.

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 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.

We found that the provider had addressed some, but not all of the issues from the last inspection. We found further issues of immediate concern during the inspection and issued an urgent Notice of Decision, imposing conditions on the provider. These concerns related to the lack of safe care and treatment, which may result in a serious risk to any person's life, health or wellbeing, lack of safeguarding patients from abuse and improper treatment and a lack of good governance. Details are in the enforcement section of the report.

Our inspection team

Team leader: Victoria Green

The team that inspected the service comprised two CQC inspection managers, three CQC inspectors, two CQC Mental Health Act reviewers, two specialist advisors including a doctor and a nurse, and one expert by experience.

Why we carried out this inspection

We inspected this service to check on improvements made following it being rated inadequate and placed in special measures in June 2019.

Summary of this inspection

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 all eight wards that were open at the hospital, including early morning and night visits, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 21 patients who were using the service and reviewed two comments cards;
- spoke with eight carers:
- spoke with the registered manager, operational lead, clinical director, specialist nurse and managers for six of the wards;
- spoke with 25 other staff members; including doctors, nurses, occupational therapists, psychologists, healthcare assistants, social workers and technical instructors.
- attended and observed three episodes of care, three community meetings, one governance meeting and one recruitment assessment.
- looked at 32 care and treatment records of patients and 21 seclusion records;
- carried out a specific check of the medication management on all wards;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- reviewed feedback received from five stakeholders, including commissioners, local authority and advocacy services.

What people who use the service say

We spoke with 21 patients. Most patients were positive about their experience of the service and told us that staff were respectful, kind and helpful. However, two patients told us that there were some staff who were rude.

One patient was upset about the negative publicity the service received and told us that they had made great progress.

Three patients told us that the food was horrible.

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?

Inadequate 

We rated safe as **inadequate** because:

- Patients were at risk of continuing harm. The service did not always manage patient safety incidents well. Managers had not investigated incidents thoroughly, or in a timely manner, and did not always involve patients, families or staff in their investigations. We reviewed 13 incidents and found eight delayed investigations, including for safeguarding incidents, and one investigation of poor quality.
- Staff did not always use approved restraint techniques. We found nine examples of staff using non approved restraint techniques, which resulted in staff dragging patients along the floor or physically injuring patients during restraint incidents. Five of these incidents occurred on Meadow ward. Senior staff told us they observed CCTV footage and were concerned that other staff present had not acted to intervene.
- Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations. The provider reported 212 incidents of patients' self harming whilst on enhanced observations between 1 September 2019 and 30 November 2019. The ward with the highest number of incidents was Fern with 79.
- Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We found issues on five of the eight wards visited. We found staff on enhanced observations for the same patient for between three to ten hours. We found staff completed observations continually throughout a shift for up to three different patients. This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations are less likely to maintain the levels of concentration required to maintain patient safety. We found examples of staff not completing observation records on Fern, Brook, Marsh and Meadow wards.
- Use of restraint and seclusion significantly increased since the last inspection. The provider reported 2,266 incidents of

Summary of this inspection

restraint from 01 February 2019 to 31 July 2019. This was an increase of 29% since the last inspection. Use of prone restraint increased by 44% since the last inspection. Use of seclusion increased by 79% since the last inspection.

- The service did not have enough nursing and support staff to keep patients safe. We reviewed four incidents where staff shortages impacted on patient safety. Between 01 May 2019 and 31 July 2019 managers were unable to fill 17% of shifts, bank staff filled 50% of shifts and agency staff 35% of shifts.
- Staff did not always complete safety checks in line with the providers policy and procedures. We found gaps in the checklists on Maple, Willow, Fern and Marsh wards.
- Although staff compliance with the Mental Health Act code of practice in relation to seclusion and long term segregation had improved, we found 21 examples of poor practice in 22 records reviewed, for example, staff not recording their role in review records and care plans lacking detail.

However:

- Managers ensured safe environments and addressed issues with sharp door frames and blind spots following the last inspection.
- Managers made significant changes to blanket restrictions, removing snack restrictions and introducing positive and safe champions and restrictive practice logs across the wards.
- Staff completed detailed risk assessments for patients, which they regularly reviewed.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Staff did not always make sure they shared clear information about patients and any changes in their care. Staff did not always complete handovers in line with the provider's policy and procedures. We found examples of staff not handing over important risk information and lack of, or poor record keeping of handovers.
- Staff did not always identify and meet patients' physical health needs. Staff on Fern ward had not completed physical health assessments on admission for three of the four patients reviewed. Staff on Maple ward had not completed the required physical health monitoring for one patient and missed three nasogastric feeds for another patient. Nasogastric feeds consist of delivering liquid nutrients through a tube passing through the nose and into the stomach.

Summary of this inspection

- Staff recorded for one patient on Brook ward, that the patient lacked capacity and that a best interest meeting was required, however there was no capacity assessment to support this decision.
- On Acorn and Brook wards staff had not completed a care plan for one patient on each ward.

However:

- Staff completed comprehensive mental health assessments for patients and developed care plans to meet identified needs. These included 'Positive Behaviour Support' plans for all patients and, SPELL (Structure, Positive approach, Empathy, Low arousal, Links) plans and trauma informed care plans for some patients. Staff created holistic, personalised and recovery orientated plans. Staff 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 meetings we observed.

Are services caring?

Inadequate

We rated caring as **inadequate** because:

- Staff did not always treat patients with kindness, dignity and respect on four wards. Some staff referred to a patient who identified as male as her/she, this upset the patient and continued after the patient complained.
- Staff did not always take bullying incidents between patients seriously. We found staff recorded in handover an incident of bullying behaviour between patients as "a bit of fun".
- We found examples of a punitive culture on some wards. Staff criticised and sanctioned patients, without justification, for

Summary of this inspection

talking to other patients and cooking different meals to those planned. Staff told one patient they had to be risk free for 72 hours before they could visit the on-site hair salon, when their plan advised risk free behaviour for 24 hours.

However:

- Staff involved patients in decisions about the service. The provider introduced a new recruitment process, which involved patients as equal partners in deciding on staff to recruit.

Are services responsive?

Good

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 and a multifaith area. There were enough treatment rooms and conference rooms for tribunals and care and treatment reviews.
- Patients had access to the provider's school 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. Patients were also able to access the provider's on site light industry workshop. Staff supported patients to access a range of leave activities, including football matches and horse riding.
- Staff ensured that patients had access to appropriate spiritual support. The service had a multifaith area and access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.

Are services well-led?

Inadequate

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

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations, handovers and safety checks. There was no evidence that the

provider undertook regular and effective audits of these issues. We were not assured that the provider acted to ensure staff were not using unapproved restraint techniques, resulting in patients being dragged or injured.

- Leaders did not always understand the issues, priorities and challenges the service faced. We were concerned about the culture within the organisation in relation to the perception of the regulator and the message leaders relayed to staff and patients. We reviewed comments in board meeting minutes that downplayed the significant concerns raised in the last Adolescents inspection, which resulted in a rating of inadequate and the service being placed in special measures. We were informed that a senior leader requested the local authority changed wording in a safeguarding report, relating to an incident of a patient being dragged during restraint, from 'dragged' to 'moved along.' This did not accurately reflect the severity of the incident reported or provide assurance that leaders took this incident seriously.
- The provider did not oversee patient risks effectively. We found that evidence to support serious incident investigations was not preserved as a matter of course, for example CCTV footage. We were unable to identify any robust senior leadership during an 'organisational disturbance' incident and CCTV footage showed a lack of clear direction for staff to follow to resolve the incident to keep patients and staff safe from harm.
- Leaders had not ensured managers completed investigations into serious incidents in a timely manner. We reviewed 13 incidents and managers had not completed eight investigations in a reasonable timeframe.

However:

- Senior leaders were visible in the service and approachable for patients and staff. Staff spoken with told us that the operational lead 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 following the last inspection.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider ran several patient and staff events including their first Trans-inclusion Healthcare conference, St Andrews Pride, Mental Health Awareness Week, Black History Month and International Women's Day. The provider was an NHS Diversity & Inclusion Partner and facilitated workshops for 150 inclusion allies and partnered with an external agency to run trans awareness workshops.

Summary of this inspection

- The service had been working with external partners, including NHS trusts with outstanding ratings to help the service improve.

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.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of 04 December 2019, 95% of the workforce in this service had received training in the Mental Health Act. The training compliance reported during this inspection was higher than the 93% reported at the last inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and the provider recently changed its approach to advocacy, whereby patients have to opt out from advocacy support, rather than opting in. However, we received feedback from the local advocacy service that they experienced delays in receiving requested information and staff did not always invite them to relevant meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed the Mental Health Act 1983 detention paperwork of 21 patients. The detention paperwork was complete and appeared to be in order. We found outline reports by the approved mental health professional, where required, were present.

The service did not accommodate informal patients.

The provider completed an audit in August 2019 to ensure that staff were applying the Mental Health Act correctly. Staff adherence to the Mental Health Act significantly improved since the last inspection. However, we identified 21 occasions when staff did not follow the Mental Health Act Code of Practice in relation to seclusion and long term segregation, for example, staff not recording their role in review records and care plans lacking detail.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. As of 04 December 2019, 95% of the workforce in this service received training in the Mental Capacity Act. The training compliance reported during this inspection was higher than the 93% reported at the last inspection.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed a ward round on Maple ward where capacity was discussed.

Staff recorded for one patient on Brook ward,that the patient lacked capacity and that a best interest meeting was required, however there was no capacity assessment.

Detailed findings from this inspection

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. The service was part way through an audit of 'National Institute of Clinical Excellence decision making and mental capacity' and completed an audit of consent.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to patients 16 to 18 and where to get information and support on this.

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards, however staff were aware of blind spots and mitigated these through observations.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers displayed a ligature heat map on each ward which identified high risk areas.

Patients did not have nurse call alarms in their bedrooms. The provider launched a trial of tamper proof call alarms in patients' bedrooms on two wards during the inspection.

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Staff did not always follow safety procedures in relation to food hygiene. We found opened, unlabelled food items in fridges on Willow and Meadow wards.

We inspected all 11 seclusion rooms at the service. None of the seclusion rooms were occupied on the day of the inspection. Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. Staff displayed information outside the seclusion rooms. This included: a poster about the process, roles and responsibilities for initiating seclusion; a flowchart about initiating, reviewing and observing a patient being cared for in seclusion; an explanatory key to the seclusion procedure; an aide-memoir entitled "Using seclusion?", with a series of questions for staff to consider; a lessons learnt bulletin about strong clothing and a red top alert about seclusion furniture; a poster, within eyesight of the patient, entitled "things I need to be offered", including music, drinks and furniture. A checklist, for staff to check the furnishings, was available outside the seclusion rooms. However, we observed that the seclusion clock on Oak ward was an hour slow.

We inspected the extra care suites on Meadow ward, Fern ward, Maple ward, Marsh ward, Willow ward, Acorn ward, Bracken ward, Brook ward and the non-operational Oak ward. Although Oak ward was closed, staff would nurse patients from other wards in the extra care suite. Overall, the areas in which staff cared for patients in long-term segregation met most of the requirements of the Mental Health Act 1983 Code of Practice. For example, patients in long-term segregation had access to a lounge, bedroom with en suite facilities (including a toilet, hand-basin and shower) and secure area in which they could access fresh air. However, we noted some of the extra care suites did not

have tables fitted and patients would have to eat their meals on their laps. Patients chose whether to personalise their extra care areas, in line with their individual risk assessments.

There was some damage to the plaster work on a wall (at the top of a door frame), within the extra care suite of Meadow ward. In Acorn ward's extra care suite, we found remnants of food on the patient's bed linen. The shower room was unclean. We saw evidence of vomit in the lounge area of the extra care suite.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and support staff to keep patients safe.

We reviewed two incidents on Fern ward, where there were not enough staff trained in management of actual and potential aggression to provide physical interventions to keep patients safe from harm. In one incident a patient was subjected to physical abuse by another patient as staff were not able to intervene to stop the assault. This was despite the provider reporting that 98% of staff completed Management of Actual and Potential Aggression training.

During our first day on site we identified that there were not enough staff trained in management of actual and potential aggression allocated to the night shift on Fern ward. We raised this with a senior staff member who advised they would adjust the rota. We were provided with evidence following the inspection that this had been done.

We reviewed two incident reports for Marsh ward which cited staff shortages and lack of experienced staff as a reason for escalation of incidents, that could have been avoided if regular staff had been on duty.

We reviewed the report for an incident on Maple ward, where a patient missed a nasogastric feed due to staffing issues resulting in information not being handed over to night staff.

This service has reported a vacancy rate for all staff of 18% as of 31 July 2019. This was higher than the rate reported at the last inspection of 13% (as of 30 November 2018).

This service reported an overall vacancy rate of 31% for registered nurses as of 31 July 2019.

This service reported an overall vacancy rate of 15% for nursing assistants.

The provider advised that as of 30 November 2019 the service was 7% over establishment for nursing assistants.

Between 1 May 2019 and 31 July 2019, of 15,898 total shifts, 33% were filled by bank staff to cover enhanced support, sickness, absence or vacancy. The highest use was on Brook (1283) and Bracken (884).

In the same period, agency staff covered 11% of available shifts for staff. The highest use was on Fern (464) and Brook (362).

The main reasons for bank and agency usage for the wards were to provide enhanced support to patients, cover staff vacancies and sickness.

The provider reported 17% of available shifts were unable to be filled by either bank or agency staff, the highest was on Fern (417) and Willow (272).

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 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. A duty nurse, allocated to the building, supported wards which had one qualified staff on duty at night.

This service reported 38 (14%) staff leavers between 1 August 2018 and 31 July 2019. This was higher than the 13% reported at the last inspection (as of 30 November 2018).

Managers supported staff who needed time off for ill health.

The sickness rate for this core service was 6% between 1 August 2018 and 31 July 2019. This was the same as the sickness rate of 6% reported at the last inspection in March 2019.

Staffing levels allowed patients to have regular one-to-one time with their named nurse.

Patients on Maple, Marsh and Acorn wards told us that staff shortages occasionally resulted in staff cancelling escorted leave.

Staff received and were up to date with appropriate mandatory training. Overall, staff in this service had undertaken 95% of the various elements of training that the provider set as mandatory. There were no mandatory courses with a compliance rate below 75%.

The mandatory training programme was comprehensive and met the needs of staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed these regularly.

Staff did not always act to prevent or reduce risks to patients and staff. We observed an incident on Meadow ward on CCTV, which the local authority designated officer described as an "organisational disturbance". This serious incident involved several patients and staff and included multiple and protracted patient restraints and serious staff assaults. We observed patients seriously assaulting one staff member whilst other staff focused on clearing mattresses and blankets from the corridor. This exposed the staff member to ongoing and significant risk of harm. Colleagues did not relieve the staff member from the restraint to seek medical attention.

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We found issues on five of the eight wards visited.

We found examples of staff not completing observation records on Fern, Brook, Marsh and Meadow wards. Examples included staff not recording observations for 11 hours for one patient on Fern ward and for eight hours on three different days for another patient on Fern ward. On Marsh ward staff completed one patient's observation record ahead of time. In other records staff had not recorded details of the patient's presentation.

We found that shift leads allocated staff to complete enhanced observations for the same patient for up to ten hours at a time on Brook ward, on three occasions, in December 2019. We found that shift leads allocated staff to observe the same patients' for between three to eight hours on 36 occasions in December 2019 on Brook, Fern and Willow wards.

We found that shift leads allocated staff to complete observations continually throughout a shift for up to three different patients. This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

We also found discrepancies in the level of observations required for one patient in their care and treatment records on Meadow ward, staff recorded the required level of observations as 1:1 in one plan and as 2:1 in another.

Staff did not always keep patients safe from harm whilst on enhanced observations. The provider reported 212 incidents of patients' self harming whilst on enhanced observations between 1 September 2019 and 30 November 2019. The ward with the highest number of incidents was Fern with 79. We reviewed a self-harm incident for one patient on Fern ward; staff allocated to their enhanced observations left the patient unobserved and the patient tied a ligature which staff removed with ligature cutters. A patient on 2:1 arm's length observation, on Willow ward was able to engage in sexual activity with two other patients.

We reviewed two incidents on Maple ward, where a patient inserted objects into a wound whilst on enhanced observations.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff did not always complete safety checks in line with the providers policy and procedures. We found gaps in the checklists on Maple, Willow, Fern and Marsh wards.

The provider made significant changes to the use of blanket restrictions. All wards had a reducing restrictive practice champion and all wards, apart from Meadow and Fern, had restrictive practice logs, which evidenced staff and patient discussions about any restrictions in place.

Staff spoken with demonstrated varying levels of understanding of the concept of least restrictive practice and senior managers acknowledged that this was a work in progress.

Staff did not always use approved restraint techniques. We found nine examples of staff using non approved restraint techniques, which resulted in staff dragging patients along the floor or physically injuring patients during restraint incidents. Five of these incidents occurred on Meadow ward. Senior staff told us they observed CCTV footage and were concerned that other staff present had not acted to intervene. Although the provider reported these incidents appropriately and suspended staff pending investigation, we were concerned that there had been no further action taken to provide assurance that these incidents were not more widespread.

Levels of restraint significantly increased since the last inspection. The provider reported 2,266 incidents of restraint from 01 February 2019 to 31 July 2019, these were highest on Willow with 691, Meadow with 613 and Fern with 424. This was an increase of 29% since the last inspection. The provider supplied more recent data covering 01 September 2019 to 30 November 2019 and reported 1,394 incidents of restraint, which indicated a continuing increase.

There were 232 incidents of prone restraint from 01 February 2019 to 31 July 2019 which accounted for 10% of total restraints, the highest on Willow with 87, Meadow with 58 and Fern with 49. This was an increase of 44% since the last inspection. Managers told us that the use of restraint had increased due to the acuity of patients. However, there were 58 patients using the service during this inspection, compared to 77 at the last inspection.

Staff followed National Institute of Clinical Excellence guidance when using rapid tranquilisation.

There were 39 prone restraints that resulted in rapid tranquillisation, these were highest on Fern with 22 and Meadow with 10. This was an increase of 14% since the last inspection.

There were no instances of mechanical restraint over the reporting period.

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.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

There had been 582 episodes of seclusion from 01 February 2019- 31 July 2019, the highest on Brook with 161, Willow with 159 and Meadow 74. This was an increase of 79% since the last inspection when the provider reported 326 seclusion episodes over six months.

We reviewed 22 seclusion records. The seclusion records met most of the requirements of the Mental Health Act 1983 Code of Practice. However, we found three examples on Fern, Meadow and Brook wards, where it was not clear if registered nurses completed nursing reviews. We found two examples on Fern ward of staff recording patients as settled for between three to four hours before staff terminated seclusion. We found one example on Fern ward, where a doctor had not recorded an entry for their review of the patient. On Brook ward, staff had not specified in the seclusion care plan, the gender of staff required to observe a patient who chose to be naked. On Meadow ward, staff recorded in a patient's seclusion care plan that staff supporting should be female, however, it was not clear from the records if this was the case. On Willow ward, we found one example where staff had not contacted the patient's family to inform them of a seclusion incident.

There had been 24 episodes of long-term segregation from 01 February 2019- 31 July 2019, the highest on Willow with five.

Staff cared for ten patients in long-term segregation at the time of our visit. On each ward, a member of staff provided an explanation as to why they were caring for patients under long-term segregation. We saw nine of the ten patients in long-term segregation. We spoke with two of these patients.

The records relating to long-term segregation met most of the requirements of the Mental Health Act 1983 Code of Practice. However, on Brook ward, one patient's long-term segregation commenced two hours after the patient's admission, whilst the patient was on section 2 of the Mental Health Act. The responsible clinician and nurse manager made the decision to commence the long-term

segregation. At the time of the long-term segregation commencing, there was no evidence that staff informed the local safeguarding team, independent mental health advocate or patient's family. It was unclear as to why staff admitted the patient directly under long-term segregation and why staff had not considered the use of seclusion as an alternative option. There was no evidence of a comparison or evaluation as to whether the long-term segregation and integration was working.

We found blank or incomplete hourly observation records for five patients on Marsh, Bracken, Brook, Meadow and Fern wards.

We found clinicians had not always completed daily reviews for four patients on Meadow, Fern, Brook and Acorn wards.

On Brook ward, one patient's long-term segregation plan was vague and did not evidence why other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period. Staff admitted this patient directly to a non-operational ward, which they shared with another patient. Staff did not allow the patient to mix freely which amounted to long-term segregation. Despite this, staff did not develop a long-term segregation care plan for the patient until six days later.

On Meadow ward staff nursed one patient under long-term segregation for two days before devising a long-term segregation care plan.

The provider ensured patients had access to education when in long term segregation. We spoke with a teacher, who talked to us about bespoke education programmes for patients in long-term segregation.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. All staff completed level one safeguarding children and adults training and 91% of staff completed level three safeguarding children and adults training.

At the time of the inspection the service had a backlog of safeguarding investigations awaiting completion. However, the provider recruited a locum social worker to help address this issue.

We found that the quality of safeguarding investigations was sometimes poor, the lead social worker escalated this issue and new investigation training was planned for January 2020.

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 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 knew how to make a safeguarding referral and who to inform if they had concerns.

This service made 17 safeguarding referrals between 31 October 2018 and 31 October 2019.

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 followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Inadequate

Child and adolescent mental health wards

Decision making processes were in place to ensure staff did not control patients' behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance.

However, we found out of date blood collection bottles on Marsh and Acorn ward, one out of date urine analysis kit on Bracken ward and two out of date burn soothe packs on Marsh ward.

Track record on safety

Between 01 August 2018- 31 July 19 there were 31 serious incidents reported by this service, the highest on Willow with ten and Meadow with five. Of the total number of incidents reported, the most common type of incident was self harm meeting serious incident criteria with 13.

The number of serious incidents reported during this inspection was higher than the 22 reported at the last inspection.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well.

Managers had not investigated incidents thoroughly, or in a timely manner, and did not always involve patients, families or staff in their investigations. Patients were at risk of continuing harm.

We reviewed 13 incidents and found eight delayed investigations, including for safeguarding incidents, and one investigation of poor quality. We reviewed a safeguarding incident on Fern ward which staff reported in August 2019, with further concerns reported by staff and a relative in October 2019 and November 2019. At the time of the inspection, the investigation had recently been reallocated to an investigator from another location and was due to start in January 2020. The patient's commissioner had issued the service with a performance improvement notice in relation to this incident.

Over the past six months the provider reported nine incidents of staff dragging, physically harming patients or using inappropriate techniques during restraint incidents. This exposed patients and staff to the risk of significant injury. The provider reported these incidents across four of the eight wards. The first reported incident was 29 July 2019 and the most recent was 28 October 2019. We were informed that managers requested the local authority to change wording in the safeguarding report from 'dragged' to 'moved along'. This did not accurately reflect the severity of the incident reported or provide assurance the provider took this incident seriously.

We were concerned that staff were not reporting all incidents that they should. We found a record where a staff member asked senior staff whether they should report an incident and they were told to report it 'if they felt like it'. We reviewed the record of a patient on Fern ward, CCTV recorded an agency staff member physically assaulting the patient, however staff had not recorded this incident in the patient's care notes.

Staff did not always understand the duty of candour. We reviewed two incidents, one on Willow ward and one on Fern ward which managers identified as duty of candour, however there was no evidence of staff sending duty of candour letters.

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, examples included an alert issued following an incident at another location where a patient swallowed batteries from a Christmas jumper. We saw that staff signed to confirm they had read these alerts.

Managers acted following the previous inspection to make changes to improve the safety of the environment. This included removing sharp edges from door frames and rectifying blind spots in seclusion rooms.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Inadequate

Child and adolescent mental health wards

Staff on Fern ward had not completed physical health assessments on admission for three of the four patients reviewed. On the other wards, patients had their physical health assessed soon after admission.

On Acorn and Brook wards staff had not completed a care plan for one patient on each ward. On the other wards, staff developed a comprehensive care plan for each patient that met their mental health needs.

Staff developed 'Positive Behavioural Support' plans with patients on all wards. These were personalised, holistic and recovery-orientated. On Fern ward staff developed trauma informed care plans, which were very detailed and included 'me on a good day', history, understanding difficulties, functions of behaviour and discharge planning.

Staff developed 'SPELL' plans (Structure, Positivity, Empathy, Low arousal, Links) on Brook, Acorn and Bracken wards. These were plans designed specifically to support patients with autistic spectrum disorders. The plans were very detailed and included positive approaches and expectations, warning signs and self-regulation.

Staff regularly reviewed and updated care plans when patients' needs changed.

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 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 school, 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 did not always identify patients' physical health needs and record them in their care plans. On Maple ward staff had not completed the required physical health monitoring for a patient following administration of anti-psychotic medication.

Staff mostly met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. There were several patients with 'disordered eating', some of which required nasogastric feeds at times. There were staff trained to provide nasogastric feeds. Nasogastric feeds consist of delivering liquid nutrients through a tube passing through the nose and into the stomach. However, we reviewed a patient on Maple ward, who had not eaten for a week following admission. Staff assessed the patient as requiring nasogastric feeding, however the patient missed three nasogastric feeds, one due to equipment not being available, one was 'unsuccessful' and another due to information not being handed over to staff. This meant that the 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 of high dose antipsychotics and obesity in children and young people. Managers had taken action to improve monitoring the use of high dose antipsychotic medication through implementation of high dose antipsychotic medication care plans.

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.

Managers supported staff through regular, constructive appraisals of their work. All staff received an appraisal within the last 12 months.

Managers supported staff through regular, constructive clinical supervision of their work. The provider's target of clinical supervision for non-medical staff is 85% of the sessions required. Between 01 August 20198 and 31 July 2019 the average rate across all wards in this service was 92%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. This included training in SPELL- Structure, Positive approach, Empathy, Low arousal, Links; trauma informed care; sensory integration; dialectical behaviour therapy; Autistic Spectrum Disorder; relational security and Reinforce Appropriate, Implode Disruptive. The provider trained a number of support staff to be dialectical behaviour therapy coaches to offer support to patients outside of formal therapy sessions. These staff wore green lanyards to identify themselves to patients.

Managers recognised poor performance, could identify the reasons and dealt with these. As of 31 July 2019, eight staff were suspended pending investigation and four staff were working under supervision.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two ward rounds and one care programme approach conference call. They were all well attended and discussed all aspects of the patients' care and treatment.

Staff did not always make sure they shared clear information about patients and any changes in their care. Staff did not always complete handovers in line with the provider's policy and procedures. We found examples of staff not handing over important risk information and lack of or poor record keeping of handovers. We found issues with handovers on all wards except Brook ward. We observed a handover on Marsh ward and four staff arrived late. Senior managers advised that they carried out handover audits, however these were provider wide and did not specify which wards had been audited.

Ward teams had effective working relationships within the service and with external agencies, including local authorities and commissioners.

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of 04 December 2019, 95% of the workforce in this service received training in the Mental Health Act.

The training compliance reported during this inspection was higher than the 93% reported at the last inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and the provider had recently changed its approach to advocacy, whereby patients have to opt out from advocacy support, rather than opting in. However, we received feedback from the local advocacy service that they experienced delays in receiving requested information and staff did not always invite them to relevant meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Inadequate

Child and adolescent mental health wards

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed the Mental Health Act 1983 detention paperwork of 21 patients. The detention paperwork was complete and appeared to be in order. We found outline reports by the approved mental health professional, where required, were present.

The service did not accommodate informal patients.

The provider completed an audit in August 2019 to ensure that staff were applying the Mental Health Act correctly. Staff adherence to the Mental Health Act significantly improved since the last inspection. However, we identified 21 occasions when staff did not follow the Mental Health Act Code of Practice in relation to seclusion and long term segregation. Examples included staff not recording their role in review records and care plans lacking detail.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

As of 04 December 2019, 95% of the workforce in this service received training in the Mental Capacity Act.

The training compliance reported during this inspection was higher than the 93% reported at the last inspection.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed a ward round on Maple ward where capacity was discussed.

Staff recorded for one patient on Brook ward that the patient lacked capacity and that a best interest meeting was required, however there was no capacity assessment.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. The service was part way through an audit of 'National Institute of Clinical Excellence decision making and mental capacity' and had completed an audit of consent.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to patients 16 to 18 and where to get information and support on this.

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 on Meadow, Willow, Marsh and Bracken wards.

We reviewed the records for a patient who identifies as male, but staff refer to him as she/her in their notes. The patient complained that staff calling him 'she' makes him angry, however one staff member continued to do this. Staff recorded a further incident in December when staff upset the patient by referring to them as 'she' and the author wrote up the incident using female pronouns.

We reviewed handover records of an incident on Marsh ward when a patient threw cooked chicken at another patient who was vegetarian. Staff recorded "It's ok- it was funny. I would do something like that. Bit of fun".

Although these may have been isolated incidents, we were also concerned that other staff present had not intervened.

We found examples of a punitive culture on three wards. Staff criticised and sanctioned patients, without justification.

On Willow ward we reviewed one patient record where the patient planned to go for a hair appointment at the service based salon and was told they were not allowed to go as they were required to display 72 hours of risk free behaviour, despite being previously told they had to display 24 hours of risk free behaviour; the same patient

was criticised by staff for making chips and a smoothie as this had not been agreed by the nurse in charge; on Bracken ward staff criticised a patient for "loitering in the corridor" when they were chatting with another patient.

However, we observed care delivered by staff that demonstrated staff knew the needs of their patients. We saw several examples of staff de-escalating patients at times of distress and supporting them with needs and requests.

Following our last inspection, the provider implemented care plans that detailed patients' preferred gender of staff when being changed into rip proof clothing.

Staff made plans with patients to ensure they had activities or leave over Christmas. Staff arranged for one patient on Meadow ward to spend Christmas with their family in accommodation on the hospital site.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said most staff treated them well and behaved kindly. However, two patients told us that some staff were disrespectful and rude.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate. The provider introduced a new recruitment process, which we observed part of, which involved patients as equal partners in deciding on staff to recruit. Patients told us that if they said a candidate was not suitable, the service would not offer them the job.

One patient on Marsh ward told us that they were involved in a steering group which was redesigning the service information leaflet.

The provider introduced a service user group for all wards, this had initially been well attended, however, attendance reduced with only two wards represented at the most recent meeting.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed two ward rounds and one care programme approach conference call and staff involved patients. Patients chaired weekly or twice weekly community meetings on all wards. We observed these meetings on three wards and all were well attended with evidence of active patient involvement.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services.

We received mixed feedback from carers about the service. Two carers told us that staff did not value or trust their opinion. In one case this resulted in staff caring for a patient in seclusion on an almost daily basis for 14 months, before staff changed the care and treatment plan based on the parent's feedback on what worked for the patient previously. Since this change the patient had made positive progress.

All but one carer spoken with told us that staff were kind and caring. Three carers told us that the service was outstanding, great and the best they had experienced. However, two carers said that communication with them was poor and one was very unhappy with the care and treatment provided to their relative.

Senior staff told us that they were working to improve communication with and involvement of carers. The service is aiming to have communication plans for all carers, tailored to what they need and are encouraging carers to attend ward rounds.

The provider facilitated a monthly carers group at the weekend. Senior managers have started to attend in rotation at the request of carers.

The service hosts twice yearly carers days and young children are now able to attend.

There is a carers centre located on site.

Inadequate

Child and adolescent mental health wards

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

Good

Access and discharge

The service was commissioned to provide a national facility, with patients from all parts of the United Kingdom, Ireland and Gibraltar.

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.

Staff completed discharge plans for patients.

The provider reported that there were nine delayed discharges between January 2019 and July 2019. Managers told us that the main reason for delayed discharges was a lack of suitable move on accommodation. The service engaged in a weekly teleconference with NHS England colleagues to discuss any delayed discharges and transition blockages in the service and worked to resolve these issues and escalate matters.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital.

The provider reported that the average length of stay for patients discharged over the previous twelve months was 400 days, the highest on Fern (655) and Bracken (549).

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms, which they 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 school 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. The provider fitted cold drinks dispensers in the lounge areas.

The provider removed set snack times following our last inspection and all patients had their own snack box. However, patients on Marsh ward told us that staff only allowed 'good' snacks and the doctor on Willow ward directed staff not to provide any fruit to patients after supper.

Patients' engagement with the wider community

Patients had access to the provider's school 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.

Inadequate

Child and adolescent mental health wards

Staff supported patients to access a variety of on site and leave activities, including football matches, trampolining, cinema, parks, Pride colour run, horse-riding, 'Eid' meal cook, 'greenfest', bike maintenance, indoor climbing and a visit to a safari park.

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 equipped wards with assisted bathrooms. Staff devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients. We saw examples of this on Brook ward.

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 were responsive to patients' needs. Staff on Maple ward supported one patient with autism, who did not like different foods to touch each other, by ordering meals on a sectioned plate.

Staff on Bracken ward supported a patient with sensory needs, by ordering coloured balls that the patient said they found helped them to express their feelings.

Staff on Bracken ward also involved patients in designing the sensory room and choosing sensory items.

Staff ensured that patients had access to appropriate spiritual support. The service had a multifaith 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 completed training and accessed support from specialist organisations to support patients with lesbian, gay, bisexual and transgender needs. However, we found one example of staff not supporting a patient to be the gender they identified as.

Listening to and learning from concerns and complaints

The provider reported they received 43 complaints in the 12 months prior to the inspection. The provider had not provided information on whether the complaints were upheld or not. The provider had no complaints referred to the ombudsman. Meadow ward received the most complaints, with 15. The common themes of complaints were staff attitude and behaviour, communication and information and privacy and dignity.

Patients spoken with told us they knew how to complain. The provider completed an organisation wide survey in 2018/19 and 79% of patients responded that they knew how to complain. 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.

The provider reported they received 67 compliments in the 12 months prior to the inspection. Meadow received the highest (14) followed by Fern with 12.

Are child and adolescent mental health wards well-led?

Inadequate

Leadership

Leaders did not always understand the issues, priorities and challenges the service faced. We were informed that a senior leader requested the local authority changed wording in a safeguarding report, relating to an incident of a patient being dragged during restraint, from 'dragged' to 'moved along.' This did not accurately reflect the severity of the incident reported or provide assurance that leaders took this incident seriously.

We were not provided with assurance that leaders had taken action to prevent further incidents of patients being dragged during restraints. However, the provider had referred a senior nurse implicated in one of these incidents to the Nursing and Midwifery Council.

Inadequate

Child and adolescent mental health wards

Leaders were reactive rather than proactive in their response to issues, this was demonstrated by the delay in responding to concerns raised and the delay in completing investigations into serious incidents.

Senior leaders were visible in the service and approachable for patients and staff. Staff spoken with told us that the operational lead 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 following the last inspection.

The provider was making changes to improve the management of the service. Leaders recently combined two operational lead posts into one and transferred a senior manager from another location into this post. The provider seconded a child and adolescent mental health nurse specialist from an outstanding rated NHS trust to help make improvements to the service.

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 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.

Although the provider's senior leadership team successfully communicated the provider's vision and values to the frontline staff in this service, staff did not always embed them in practice.

Staff told us that the service model enabled them to have more influence on decisions within the service. Ward managers told us they have autonomy.

The operational lead was responsible for the budget for the service. The leads explained that they aimed to provide the best value service.

Culture

We were concerned about the culture within the organisation in relation to the perception of the regulator and the message leaders relayed to staff and patients. We reviewed board meeting minutes which included comments, including, "if the report is actually read without seeing the ratings, then it would not be seen as an inadequate report" made by the chief executive that downplayed the significant concerns raised in the last Adolescents inspection, which resulted in the service being placed in special measures. During the most recent inspection, staff commented that the provider made changes because the CQC said they had to, rather than an understanding that we were highlighting non-adherence to the Mental Health Act.

Staff reported that managers supported them well and they were confident to raise concerns. However, a senior staff member shared concerns about staff, including in lead roles, not reporting incidents where they observed colleagues mistreating patients.

The provider introduced 'Speak Up Guardian' champions across their locations.

Overall, staff felt proud and positive about working for the provider and their team. The most recent 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 provider implemented a bi-annual staff wellbeing week in response to concerns raised previously about staff wellbeing.

Managers did not always identify poor performance; however, when poor performance had been identified, we saw managers dealt with it, with support from the provider's human resources team.

Senior leaders expressed concerns about how well teams worked together due to the shift system in place that separated staff into two teams that never worked together. This impacted on patient care as teams were not working cohesively and consistently.

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.

Inadequate

Child and adolescent mental health wards

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider appointed their first female chief executive officer, internally promoted the first female chief finance officer, appointed their first Black, Asian minority ethnic executive medical director and first female chief nurse. The provider set up an Inclusion Steering Committee and employee support groups for black, Asian minority ethnic; lesbian, gay, bi-sexual and transgender plus; disability and a support group for women. Each group has an executive as their sponsor. Almost 20% of staff are black, Asian, minority ethnic and 30% of senior managers are black, Asian, minority ethnic. The provider reported a median gender pay gap of zero. The provider ran several key patient and staff events including their first Trans-inclusion Healthcare conference, St Andrews Pride, Mental Health Awareness Week, Black History Month and International Women's Day. The provider was an NHS Diversity & Inclusion Partner and facilitated workshops for 150 inclusion allies and partnered with an external agency to run trans awareness workshops for over 100 staff.

The provider reported a staff sickness rate of 6% for the service between 01 August 2018 and 31 July 2019. Acorn ward reported the highest rate at 10%, followed by Sycamore (now closed) at 9%.

Occupational health services and a trauma nurse supported staff physical and emotional health needs. The provider 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.

Governance

The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations, handovers and safety checks. There was no evidence that the provider undertook regular and effective audits of these issues.

We were not assured that the provider acted to ensure staff were not using unapproved restraint techniques, resulting in patients being dragged or injured. The provider reported nine of these incidents between July and October this year.

The provider did not oversee patient risks effectively. We found that evidence to support serious incident investigations was not preserved as a matter of course, for example CCTV footage. The 'organisational disturbance' incident we viewed on CCTV, clearly showed the incident was not contained solely in the bedroom corridor. However, this area of the ward was the only area of CCTV footage preserved. The provider had not ensured that adequate CCTV evidence would be available to support the investigation and identify learning. We were unable to identify any robust senior leadership during the incident and CCTV footage showed a lack of clear direction for staff to follow to resolve the incident to keep patients and staff safe from harm.

Leaders had not ensured investigations into serious incidents were completed in a timely manner. We reviewed 13 incidents and eight investigations had not been completed in a reasonable timeframe.

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 identified the following red rated risks for the service; damage to reputation; lack of capacity to address safeguarding expectations; lack of staff personal alarms; procurement CQC ratings impact; recruitment and retention of staff; patient and staff safety; decline in referrals; enhanced support demands.

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.

Inadequate

Child and adolescent mental health wards

The provider introduced a 'patient safety dashboard', managers used this to review incidents and use of restrictive interventions.

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 and notifications to CQC as required.

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.

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.

The service had been working with external partners, including NHS trusts with outstanding ratings to help the service improve.

Innovations were taking place in the service. The provider introduced quality methodology in its projects and for all wards in the service, using the plan-do-study-act (PDSA) cycle to identify and evaluate an activity that they feel supports a positive and safe culture. One example was the introduction of a new piece of equipment to reduce the length of time in restraint, reduce injury to staff, reduce trauma for the patient and increase comfort. The provider trained staff in compassion focused therapy and launched compassion focused therapy more widely during the staff health and wellbeing week in November 2019.

Marsh 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 2019 with an overall score of 96%.

Outstanding practice and areas for improvement

Outstanding practice

The service provided an impressive range of therapies, education and activities 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 provider continued to develop it's therapeutic offering to patients through the development of trauma informed care.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues.
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff to meet service users' needs and to undertake service users' observations as prescribed.
- The provider must undertake a review of all service users' observation records and ensure that the level of service user observations prescribed throughout a 24-hour period are individualised, detail specifically when levels of observations should reduce or increase and are based on individual risk assessments, including mitigation of any risks identified.
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures and that all service user observations are recorded in line with provider's policy.
- The provider must ensure investigations are completed in a timely manner.
- The provider must review and have an adequate system and process(es) in place to investigate safeguarding incidents.
- The provider must ensure that staff use approved restraint techniques in line with the provider's policy and protocol.
- The provider must ensure there is adequate oversight of incidents of restraint and appropriate action taken when approved restraint techniques are not used.
- The provider must review the use of restrictive interventions and take action to reduce the use of restraint and seclusion.
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion and long term segregation.
- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including during restraint incidents and when supporting transgender patients.
- The provider must ensure that robust and effective handovers take place, between staff shifts, to ensure that information about risk and service users' care is communicated between relevant teams, to support service user safety.
- The provider must ensure that handovers are recorded in line with policy.
- The provider must ensure staff complete physical health assessments for all patients and meet patients' physical healthcare needs.
- The provider must ensure all patients have a care plan.

Action the provider SHOULD take to improve

- The provider should ensure that staff complete capacity assessments for those patients that require one.
- The provider should continue to review blanket restrictions and ensure any restrictions are clearly justified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Staff referred to a patient who identified as male as her/she, this upset the patient and continued after the patient complained. We found staff recorded an incident of bullying behaviour between patients as “a bit of fun”. • We found examples of a punitive culture on some wards. Staff criticised and sanctioned patients, without justification, for talking to other patients and cooking different meals to those planned. Staff told one patient they had to be risk free for 72 hours before they could visit the on-site hair salon, when their plan advised risk free behaviour for 24 hours. This was a breach of regulation 10.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff did not always complete safety checks in line with the providers policy and procedures. We found gaps in the checklists on Maple, Willow, Fern and Marsh wards. • Use of restraint and seclusion significantly increased since the last inspection. The provider reported 2,266 incidents of restraint from 01 February 2019 to 31 July 2019. This was an increase of 29% since the last inspection. Use of prone restraint increased by 44% since the last inspection. Use of seclusion increased by 79% since the last inspection.

This section is primarily information for the provider

Requirement notices

- Although staff compliance with the Mental Health Act code of practice in relation to seclusion and long term segregation had improved, we found 21 examples of poor practice in 22 records reviewed.
- Staff did not always make sure they shared clear information about patients and any changes in their care. Staff did not always complete handovers in line with the provider's policy and procedures. We found examples of staff not handing over important risk information and lack of, or poor record keeping of handovers.
- Staff did not always identify and meet patients' physical health needs. Staff on Fern ward had not completed physical health assessments on admission for three of the four patients reviewed. Staff on Maple ward had not completed the required physical health monitoring for one patient and missed three nasogastric feeds for another patient. Nasogastric feeds consist of delivering liquid nutrients through a tube passing through the nose and into the stomach.
- On Acorn and Brook wards staff had not completed a care plan for one patient on each ward.

This was a breach if regulation 12.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patients were at risk of continuing harm. The service did not always manage patient safety incidents well. Managers had not investigated incidents thoroughly, or in a timely manner, and did not always involve patients, families or staff in their investigations. We reviewed 13 incidents and found eight delayed investigations, including for safeguarding incidents, and one investigation of poor quality. • Staff did not always use approved restraint techniques. We found nine examples of staff using non approved restraint techniques, which resulted in staff dragging patients along the floor or physically injuring patients during restraint incidents. Five of these incidents occurred on Meadow ward. Senior staff told us they observed CCTV footage and were concerned that other staff present had not acted to intervene. • Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations. The provider reported 212 incidents of patients' self harming whilst on enhanced observations between 1 September 2019 and 30 November 2019. The ward with the highest number of incidents was Fern with 79. • Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We found issues on five of the eight wards visited. We found staff on enhanced observations for the same patient for between three to ten hours. We found staff completed observations continually throughout a shift for up to three different patients. This is not in accordance with

Enforcement actions

the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety. We found examples of staff not completing observation records on Fern, Brook, Marsh and Meadow wards.

- The service did not have enough nursing and support staff to keep patients safe. We reviewed four incidents where staff shortages impacted on patient safety. Between 01 May 2019 and 31 July 2019 managers had not filled 17% of shifts, bank staff filled 50% of shifts and agency staff 35% of shifts.

This was a breach of regulation 12.

Regulated activity	Regulation
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 • Over the past six months the provider reported nine incidents of staff dragging or physically harming patients or using inappropriate techniques during restraint incidents. We were not assured that the provider acted to ensure staff were not using unapproved restraint techniques, resulting in patients not being safeguarded from abuse or improper treatment. This was a breach of regulation 13.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	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. The providers governance processes

Enforcement actions

had not addressed staff failures to follow the provider's procedures on enhanced observations, handovers and safety checks. There was no evidence that the provider undertook regular and effective audits of these issues. We were not assured that the provider acted to ensure staff were not using unapproved restraint techniques, resulting in patients being dragged or injured.

- Leaders did not always understand the issues, priorities and challenges the service faced. We were concerned about the culture within the organisation in relation to the perception of the regulator and the message leaders relayed to staff and patients. We reviewed comments in board meeting minutes made by the chief executive that downplayed the significant concerns raised in the last Adolescents inspection, which resulted in a rating of inadequate and the service being placed in special measures. We were informed that a senior leader requested the local authority changed wording in a safeguarding report, relating to an incident of a patient being dragged during restraint, from 'dragged' to 'moved along.' This did not accurately reflect the severity of the incident reported or provide assurance that leaders took this incident seriously.
- The provider did not oversee patient risks effectively. We found that evidence to support serious incident investigations was not preserved as a matter of course, for example CCTV footage. We were unable to identify any robust senior leadership during an 'organisational disturbance' incident and CCTV footage showed a lack of clear direction for staff to follow to resolve the incident to keep patients and staff safe from harm.
- Leaders had not ensured managers completed investigations into serious incidents in a timely manner. We reviewed 13 incidents and managers had not completed eight investigations in a reasonable timeframe.

This was a breach of regulation 17.