Associated Wellbeing Limited

The Lighthouse

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

- Risk assessments had not been fully completed for all children. This meant that staff did not have all the necessary detailed information relating to children's risks.
- Safeguarding concerns had not been reported to the Care Quality Commission. This meant that there was limited oversight into safeguarding issues for external sources.
- Not all child safeguarding concerns had been reported to the local authority. This meant that there was a risk of children being put at further risk of harm.
- The service had blanket restrictions in place. There were no doors on children's en-suite bathrooms, which staff said was to manage risk. Children's privacy and dignity was impacted by this.
- Children's activity planners did not contain a full range of constructive activities and structure for children and staff to follow. There was no occupational therapy input to drive the quality of activities.
- There continued to be gaps in the effectiveness of their governance processes. For example, systems and processes had not captured gaps in risk assessment provision and gaps within safeguarding practices and procedures. In addition, many policies and processes were new and had not been fully embedded into the service.
- Independent child advocacy provision was limited. Independent advocates had not visited the service and links were weak. This meant that children did not have the opportunity to have their voices heard via a professional advocate.

However,

- The ward environments were safe and clean. There was now a nurse call system available to children to summon staff if required. This system was now audible to staff who could respond. The wards had enough nurses and doctors. There had been an improvement in staffing levels. This meant there were now enough suitably trained staff on shift at all times to keep children safe. Staff managed medicines safely.
- Staff minimised the use of restrictive practices. All physical interventions used by staff on children had been appropriately applied and met with national guidance. Policies and procedures had been updated to ensure that children who were high risk of requiring physical interventions would not be admitted to the service.
- Staff developed holistic, recovery-oriented care plans. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. All staff had now received training in positive behaviour support.
- The team included or had access to a range of specialists required to meet the needs of patients on the wards. However, there was no occupational therapist. Managers ensured that these staff received training, supervision and appraisal. Staff supervision was now of good quality and frequency. Staff described feeling supported. The staff worked well together as a multidisciplinary team and with those outside the service who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under Gillick competency and understood the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Children expressed that they felt involved in their care and that they understood the content of their care plans. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

- Some of the governance processes had improved. For example, all necessary recruitments checks were now embedded in practice and that all staff were trained in physical intervention prior to working with children. Policies relating to the admission of young people over 18 years of age had been amended. Young people over 18 years of age were would not now be admitted to the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to The Lighthouse

The Lighthouse is a four bed child and adolescent mental health unit based in Darwen, Lancashire. The service aims to provide step-down from child and adolescent mental health inpatient units as well as a placement for children to be admitted to during a crisis to avoid a hospital admission.

The service was registered in December 2019 and admitted its first child in January 2020.

The service is registered to provide the following regulated activities:

- Treatment for disease, disorder or injury
- Accommodation for persons who require personal and/or nursing care

At the time of inspection, a registered manager and a deputy manager had been in post for approximately four months.

This service has been inspected on three previous occasions. At the last comprehensive inspection in March 2021 the following requirement notices were issues and we told the provider:

- The service must ensure that all positive behaviour support plans are completed using functional assessments. Positive behaviour support plans must be developed so they do not include punishment strategies. Regulation 9(1)
- The service must ensure that restraint is always carried out safely, staff involved in restraint must be appropriately trained and there must be sufficient numbers of competent staff available to use restraint. Regulation 12(1).
- The service must ensure that a system is available to children and young people so where needed they can call for assistance. Regulation 12(1)
- The service must ensure that all staff have the correct disclosure and barring service checks prior to starting employment. Regulation 17(1)
- The service must ensure that there are systems and processes in place that capture any failures in governance. This must include ensuring all staff are appropriately trained and that the necessary employment checks are conducted prior to employment. Regulations 17(1)

A focused inspection was conducted in November 2021 in relation to the safe domain only and a warning notice was issued. A warning notice is issued when there has been a failure to meet relevant legal requirements in the past which has not been rectified, and/or that there has been a continuing failure to meet relevant legal requirements. We had told the provider:

- The service must ensure that there are enough competent and trained staff available on each shift to keep children safe. Staffing levels must match the required staffing establishments levels on each shift. Policies and practice should reflect nationally recognised best practice in de-escalation and restraint. (Regulation 18 (1))

At this focused inspection a requirement notice was also issued:

- The service must ensure that all police incidents are reported to the Care Quality Commission. (Registration regulation 18 (2) (f)

During this inspection we found that majority of the above breaches of regulation, including the warning notice had been met. At the time of this inspection, we were still reviewing the requirement notice issued in relation to failing to notify the Care Quality Commission of police incidents. We also issued a further breach of Registration Regulation 18 relating to the failure to report safeguarding concerns to the Care Quality Commission.

Summary of this inspection

The provider also owns another property across the road which had been used to accommodate children and at which staff had provided care and treatment prior to the last inspection. This property is not registered separately and following the last inspection, we informed the provider we considered this building to be an extension of The Lighthouse. We were concerned about the safety and suitability of this building and informed the provider we would inspect it as part of our next inspection. However, the provider had since changed the use of the building to a private rented property. This meant we were unable to cross the threshold at this inspection.

What people who use the service say

We spoke to three children who all stated they felt involved in their care and were aware of the content of their care plans. Children described staff as friendly and polite and that they felt safe in their environment. Children described enjoying activities outside of the service such as trampolining, bowling and shopping. Children said activities were not usually cancelled and went ahead as planned. Children explained they felt incidents were managed well and that staff were professional in utilising de-escalation techniques.

We spoke to one carer who was also very positive about the service. They felt the environment was clean and well maintained when they visited and that their child was doing well in the service. They described staff as welcoming and friendly and always professional and helpful during telephone conversations. They felt that they were as involved as they could be in their child's care and that they were updated when necessary regarding any future plans.

How we carried out this inspection

This was a comprehensive inspection focussing on all elements of the following key questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

This comprehensive inspection was brought forward due to whistle blower concerns relating to the safety of the service.

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

During the inspection visit, the inspection team:

- visited the service and observed how staff were caring for children and young people
- spoke with three children who were using the service
- spoke with the registered manager, deputy manager and clinical director
- spoke with three other staff members
- received feedback about the service from a local authority
- looked at four care and treatment records of children and young people
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke to one carer of a child using the service

Summary of this inspection

You can find more information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure that all children have a risk assessment completed on admission and that this is updated following any incident. (Regulations 12 (2) (a))
- The provider must ensure that there are robust structures in place for reporting and capturing safeguarding concerns and that they are acted upon promptly. (Regulations 13 (1) (2) (3))
- The provider must ensure that safeguarding concerns are reported to all relevant external agencies including the Care Quality Commission. (Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009)
- The provider must ensure that risk is managed on an individual basis and consider the impact that having no en-suite doors has on children's privacy and dignity. (Regulations 12 (2) (a))
- The provider must ensure that the governance system is robust to ensure it captures issues relating to gaps within risk assessment procedures and safeguarding pathways and that new policies and procedures are fully embedded into the service. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure that activity planners are fully completed with constructive and appropriate recovery activities. The provider should consider whether occupational therapy input is required.
- The provider should ensure that there are established links with independent advocacy services for children.
- The provider should ensure that care plans are written using collaborative language that clearly demonstrates children's input and captures their voice.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

The safe key question rating had previously been limited to inadequate due to a warning notice being issued. However, this warning notice has now been met.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all areas and removed or reduced any risks they identified. Staff checked the safety of the environment twice a day and reported any concerns appropriately.

Staff could observe children and young people in all parts of the ward. Bedrooms had en-suite bathrooms.

The service complied with guidance on mixed sex accommodation. There were measures in place to protect children. There was zonal observation of bedroom areas and all children were observed at 30-minute intervals as a minimum.

There were minimal potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. A ligature risk assessment was completed in November 2021 and was available to staff.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. The nurse call system had been repaired and could now be heard sufficiently for staff to respond.

We found no issues with children being able to access their bedrooms and all key fobs to access the bedrooms were in good working order.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. There had been recent fire risk assessments and legionella risk assessments conducted one month prior to the inspection. Both reports noted actions for improvement to the safety of the environment. This includes implementing weekly water temperature testing and recording, and implementing fire drills and establishing a general fire alarm process for staff to follow. An action plan had been developed and there was evidence of this being acted upon and delivered.

Staff made sure cleaning records were up-to-date and the premises were clean. The cleanliness of the service continued to be of a good standard.

Staff followed infection control policy, including handwashing. There were appropriate infection prevention measures in place such as hand sanitiser available and temperature checks for visitors. All staff were wearing masks.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

We found that although the clinic room temperature was being monitored; it was not always within the recommended ranges. The service was aware of this and were taking steps to manage the risk. There was a longer-term plan to install air conditioning.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The provider had been issued with a warning notice in December 2021 in relation to there not being enough competent and trained staff available on each shift to keep children safe. We told the provider; staffing levels must match the required staffing establishments levels on each shift and policies and practice should reflect nationally recognised best practice in de-escalation and restraint.

Findings from this inspection demonstrated that this warning notice had now been met.

There were more staff on each shift since the last inspection in November 2021. The staffing establishment level had been increased to four staff during the day (one qualified nurse with three nursing assistants) There were now three staff during the night (one qualified nurse and two nursing assistants).

The staffing rotas for November 2021 to present reflected or exceeded this establishment.

Requires Improvement

Child and adolescent mental health wards

A new admission and discharge policy had been drafted in February 2022 which stated that children who were a high risk of violence and aggression would now not be admitted to The Lighthouse.

The service had low and reducing vacancy rates. The service had two vacant posts for registered nurses. However, these had been recruited to and the new staff were awaiting employment checks and were due to start work soon.

The service had low and reducing rates of bank and agency nurses. Bank and agency nurses were only used to cover three shifts each week. Once new staff take up their positions this should reduce further.

The service had reducing rates of bank and agency nursing assistants. Bank and agency nursing assistance were used to cover 14 shifts each week. Two nursing assistants had recently been appointed and were awaiting to take up their positions.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Two new nursing assistants and two registered nurses had been employed and were due to start work imminently.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had introduced a safer recruitment tracker to ensure that inductions to the service were completed and documented.

There was a sufficient recruitment process in place to ensure that all staff had the appropriate disclosure and barring service checks in place prior to starting direct work with children.

The service had low and reducing turnover rates. The service had experienced a high turnover of staff in August 2021. Many new staff had been recruited between August and October 2021. Recruitment remains ongoing. Managers aimed for full recruitment soon.

Managers supported staff who needed time off for ill health. Staff had recently had absences from work due to the covid 19 pandemic restrictions. Staff reported that managers understood and were supportive of them.

Levels of sickness were low. There was one staff member who was on long term sick leave. Other staff had experienced short episodes of absence from work due to national measures relating to the Covid-19 pandemic.

Managers now accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. There was always a registered nurse on shift both day and night. Managers had increased the staffing ratio to four staff during the day and three staff during the night.

The registered manager could adjust staffing levels according to the needs of the children and young people. The number of healthcare assistants on each shift increased when needed to meet the needs of the children.

Children and young people had regular one to one sessions with their named worker. This often related to addressing behavioural change or improving independent living skills.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Children told us that escorted leave or activities were not cancelled and went ahead as planned.

The service now had more staff on each shift to carry out any physical interventions safely than at the previous inspection. Staffing ratios had been increased and these were being met. The service received a warning notice in December 2021 regarding having enough staff to carry out physical interventions safely. We saw evidence of improvements being made and the warning notice being met.

Staff shared key information to keep children and young people safe when handing over their care to others. Staff recorded discussions relating to children from handover sessions twice a day. However, there was no template for staff to follow.

Medical staff

A psychiatrist was available to attend multidisciplinary meetings and support the risk assessment process. For medical cover the service had access to community facilities such as GP and local hospitals. All children and young people were either registered with a local GP practice or remained at their former GP depending on preference. There was no out of hours medical cover. Children and young people had access to local hospitals and community services to meet any emergency medical needs.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All mandatory training modules, except for wound care, had been completed by staff and were compliant within an 81 to 100% compliance rate for each module. However, only 19% of staff had completed the wound care module. There was a plan for all staff to complete this soon.

The mandatory training programme was comprehensive and met the needs of patients and staff. There were 21 mandatory training modules for staff to complete. All modules were appropriate for the service.

Managers monitored mandatory training and alerted staff when they needed to update their training. A mandatory training tracker was available for managers to have oversight of staff training and prompted staff to complete training when necessary.

Assessing and managing risk to children and young people and staff

Staff mostly assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

A risk assessment had not been completed for one child and another risk assessment had not been updated following an incident.

Two children had fully completed risk assessments that had been completed following admission and reviewed at regular intervals and following any incident. There was a process in place for staff to complete risk assessments for each child and young person on admission, using a recognised tool. However, this had not been completed for one child.

Staff used a recognised risk assessment tool. All children should have been assessed by using the Short term Assessment of Risk and Treatability tool.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Although one risk assessment had not been completed, risks relating to this child were documented in other areas of the care record.

Staff did not always manage patient risk on an individual basis. The Lighthouse had a blanket restriction in place regarding the en-suite bathrooms, in that there were no en-suite bathroom doors. Staff told us this was to manage patient risk of self-harm, however this should be managed with an individual plan for each patient depending on their presenting risks. The current patient group did not present with significant risks of self-harm.

Staff identified and responded to any changes in risks to, or posed by, children and young people. However, one risk assessment had not been updated following an incident.

Staff followed procedures to minimise risks where they could not easily observe children and young people. All children were observed at 30-minute intervals as a minimum. Children had access to nurse call alarms if they needed to summon assistance. There was CCTV in communal areas.

Staff followed policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. This was only completed if there was a known risk and not done routinely. There was a policy in place for staff to follow.

Use of restrictive interventions

Levels of restrictive interventions were low. There had been three incidents of restraint in the last three months. These were low level arm holds. There had been no floor restraints.

The provider had been issued with a warning notice in December 2021 in relation to there not being enough competent and trained staff available on each shift to keep children safe. We told the provider that staffing levels must match the required staffing establishments levels on each shift and policies and practice should reflect nationally recognised best practice in de-escalation and restraint.

Findings from this inspection demonstrated that this warning notice had now been met.

The provider had drafted a new restraint policy in February 2022 which states that, “Face down/prone restraint must never be used. However, if the floor is used then this must be used for the shortest period of time and only for the purpose of gaining reasonable control. A sufficient number of staff members available who are trained and confident in safe and appropriate techniques and in alternatives to restrictive physical interventions and therapeutic holding of children and young people.”

The content of the restrictive interventions training remained the same and covered holds such as, safe location to the knees (level one), safe location to the knees (level two), unintentional prone (Nice 10), unintentional supine safety management, unintentional supine disengagement and scoop from the floor.

Requires Improvement

Child and adolescent mental health wards

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Restrictive interventions training had been approved by British Institute of Learning Disabilities. This complied with the Restraint Reduction Network training standards 2020.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. There was evidence of de-escalation practices being used within children's care records. Staff and children confirmed that de-escalation was always attempted prior to any physical intervention being used. All necessary staff were trained in restrictive interventions and de-escalation techniques.

Staff understood the Mental Capacity Act definition of restraint and worked within it. All current children were under 16. Staff understood the Gillick Competence guidelines.

Safeguarding

Staff had training on how to recognise and report abuse, however internal and external reporting of safeguarding was not robust. During the inspection process we noted one instance of child safeguarding. It was not clear from the notes what safeguarding actions had been taken. The provider later reported the incident following feedback from CQC to the local authority and the police. Two safeguarding concerns were reported to CQC retrospectively.

The service had a safeguarding lead who had undergone child safeguarding level five training.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were trained in child safeguarding level three. Two senior staff had completed child safeguarding level five.

Staff kept up-to-date with their safeguarding training. Compliance with safeguarding training was 100 per cent.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had received training in equality and diversity.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. The service was aiming to be paper-free. Clinical notes could be entered on handheld devices by each staff member. This was to ensure that notes were written at the time of the incident or observation.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

Records were mostly stored securely. The upstairs staff office had some archived notes that were not stored securely. However, they were in a non-patient area and the provider agreed to rectify this.

Requires Improvement

Child and adolescent mental health wards

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

The service ensured children and young people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service had systems and process in place to prescribe and administer medicines safely. All emergency medicines were in date and routinely checked by the service. Rapid tranquilisation policy and medicines policy were in place – both drafted in February 2022. However, the medicines policy still has review comments in place and was yet to be ratified by the board.

Staff completed medicines records accurately and kept them up to date. Drug stocks were checked daily by night staff. Current audits were present and correct. Staff were completing medicines audits.

Staff stored and managed all medicines and prescribing documents safely.

Track record on safety

Reporting incidents and learning from when things go wrong

The service mostly managed patient safety incidents well. Staff recognised incidents and reported them appropriately. However, there was one incident of physical intervention that had not been recorded in the providers restraint log in a timely way. Staff investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. There was an electronic incident reporting system that all staff knew how to use. Incidents such as children missing from home and violent and aggressive behaviour were reported by staff. A separate paper based restrictive intervention log was kept to capture any incidents of restraint. We found one incident of restraint that had not been added to the restrictive intervention log in a timely way.

Staff raised concerns and reported incidents and near misses in line with provider policy. There had been an improvement in relation to the reporting of police incidents. CQC had received notifications of all necessary police contacts. However, we found two safeguarding incidents that had not been reported to the CQC promptly and had been submitted retrospectively following CQC feedback.

Staff reported serious incidents clearly and in line with their policy. The service had not had any serious incidents since the last inspection. Historically when serious incidents had occurred staff had reported them appropriately.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. There was a duty of candour policy in place that staff could access and use for reference.

Requires Improvement

Child and adolescent mental health wards

Managers debriefed and supported staff and children after any incident. Children and staff were offered debriefs following incidents such as a restrictive intervention. This was clearly documented in the care records.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. Incidents were reviewed by managers as part of the incident reporting process. Managers had oversight of all incidents that occurred within the service and could identify themes.

Staff received feedback from investigation of incidents. There was a process in place to allow managers to feedback to staff results from investigations during staff meetings. The service had only experienced low level incidents in the last six months such as children not returning to the service promptly following unescorted leave or minor incidents of aggressive behaviour.

Staff met to discuss the feedback and look at improvements to patient care. There was a policy in place to guide staff how to implement changes following incidents. However, the service had only had low level incidents in the last six months and therefore opportunities for improvement were minimal.

There was evidence that changes had been made as a result of feedback. The service had experienced an increase in children being reported missing from the hospital. In response to this children's views were taken into account and clinical needs re-assessed. Feedback from children was responded to and there were new plans being considered by the service and the local authority.

Are Child and adolescent mental health wards effective?

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were, holistic and recovery-oriented. All care plans lacked the child's voice and did not demonstrate strong child collaboration.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. Children were assessed by senior managers prior to admission for their suitability for the service.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Care records demonstrated that children's physical health needs were assessed and met throughout their admission.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. Care plans contained enough information to reflect each child's needs and future goals.

Staff regularly reviewed and updated care plans when children and young people's needs changed. All care plans were up to date and reflected current needs.

Care plans were holistic and recovery-orientated but lacked detailed personalisation. Care plans contained all necessary information to meet the child's needs. However, it was not always clear that care plans had been completed collaboratively. The views of the child were not strongly evident within the record.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided care and treatment suitable for the children and young people in the service. Children currently had low risks and low clinical needs and therefore were not receiving much therapeutic mental health input. Most children's needs were behavioural and were being addressed by boundary setting and attempting structured routines. Children were offered sessions with the therapist and psychologist, but children were reluctant to engage. Children had regular sessions with their keyworkers to work on issues such as anger management, sleep hygiene and understanding emotions.

We reviewed children's weekly activity planners which did not contain much structure for the children. There were many hours of free time, relaxing and using games consoles. Whilst onsite we observed children staying asleep or in their bedrooms until late in the day.

Staff delivered care in line with best practice and national guidance. Staff had been trained in positive behaviour support methods. This was not currently being delivered. None of the current children had positive behaviour support plans in place. Positive behaviour support plans had not been required for the current children. There continued to be no further evidence of any punishment strategies being used within any of the care records.

Staff were being trained in dialectical behaviour therapy. There was a plan to admit children who required this therapy in the future when staff recruitment was complete, and therapies were embedded in the service.

Staff identified children and young people's physical health needs and recorded them in their care plans. Children with health risks had this clearly documented in their care records.

Staff made sure children and young people had access to physical health care, including specialists as required. Children were referred to physical health specialists in the local area. There was appropriate liaison between the service and the specialist as required.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. There were no children with special dietary needs currently admitted. Children were encouraged by staff to support the food shopping list each week where needs and preferences could be met.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Children were encouraged to cook their own food from fresh ingredients for healthier choices.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. A new psychologist had been employed who was planning to review the outcome measures.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. There was an administrator who completed audits to share with the team. Managers used results from audits to make improvements. There was a long term plan to be accredited by the Quality Network for Inpatient Child and Adolescent Mental Health Services. The service was working towards being fully compliant with the Safewards model of care. These aspirations had been delayed due to the change in management and high staff turnover in 2021.

Skilled staff to deliver care

The ward team included or had access to a range of specialists required to meet the needs of children and young people on the ward. Managers made sure they had staff with the range of skills needed to provide good quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a number of specialists to meet the clinical needs of the children and young people on the ward. The service had access to a psychologist, therapist, psychiatrist and mental health nurses and healthcare assistants. There was no occupational therapist. This meant that there was lack of opportunity to improve social skills and daily activities.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Staff were trained in a range of modules suitable for their role. This included positive behaviour support. Managers were, or were in the process of training in dialectical behaviour therapy. There was a plan for all staff to be trained in dialectical behaviour therapy and for the service to specialise in this type of therapeutic input.

Managers gave each new member of staff a full induction to the service before they started work. There was a process to record that all staff had received an induction prior to beginning work. This was updated regularly by the service administrator.

Managers supported staff through regular, constructive appraisals of their work. There was a process for all staff to receive an appraisal and for this to be recorded. Most staff were newly employed and had not yet undergone this process.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Clinical supervision records were of an appropriate quality and frequency. Staff described feeling supported. There was now a target for staff to have clinical supervision every four to six weeks.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. Minutes from meetings were emailed to all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers were continuing to complete leadership training and this was supported by the service. Staff were aware that they would eventually be trained in dialectic behavioural therapy.

Managers made sure staff received any specialist training for their role. Managers had all received dialectic behavioural therapy training. There were plans for this to be disseminated to the wider workforce. All staff had completed a mandatory training module relating to behaviours that challenge and positive behaviour support.

Managers recognised poor performance, could identify the reasons and dealt with these. The service had not had any poor performance in the last six months. Most staff were in new positions. Staff and children both remarked that a few staff had been employed who were not able to build good rapport with the children. Managers were aware of this, but the staff members resigned prior to this being addressed formally.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. There was a structure for internal weekly multidisciplinary meetings for each child. There were also regular meeting with external agencies to discuss progress and future plans.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Handover records contained relevant information about each child.

Ward teams had effective working relationships with external teams and organisations. External organisations attended regular meetings about each child. Feedback from local authorities highlighted that staff clearly communicated information about children in a professional manner and liaised with them regarding any issues as needed.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

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. All staff had received training in the Mental Capacity Act and consent.

There were no Court of Protection applications made in the last six months. None of the current children were under and restrictions set by the Court of Protection.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. The Mental Capacity Act policy contained information relevant information about how Mental Capacity Act and the Gillick Competency principles applied to children and young people.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew to liaise with senior managers regarding any issues with the Mental Capacity Act. When children have been subject to Court of Protection orders in the past, staff have liaised with the local authority regarding the implementation in practice of the orders.

Requires Improvement

Child and adolescent mental health wards

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so. All current children had mental capacity. However, staff were aware that children required information to be presented in different formats to support their understanding if there was concern relating to capacity.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Care records demonstrated that capacity had been considered during admission and at other intervals.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history. The service had not assessed a child as lacking capacity for over six months. However, their policy and process reflected that best interests needed to be considered.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. The service had not made any Deprivation of Liberty Safeguard orders. The service has cared for children who were subject to Court of Protection orders that were initiated by the local authority in the past.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. Staff were aware that Gillick competency related to all children currently admitted who were under 16.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this. Staff had a mental capacity and consent policy to refer to. Staff knew to raise issues with more senior managers for support.

Are Child and adolescent mental health wards caring?

Good

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people. All children acknowledged that staff were tactful in their approaches and interactions with them. Children said staff always knocked on their doors before entering and were professional in the language and manner.

Requires Improvement

Child and adolescent mental health wards

Staff gave children and young people help, emotional support and advice when they needed it. Staff were available to speak to children about their needs and any specific concerns they had. Staff were aware of the children's needs and offered advice and child friendly support regarding the topics of concern noted within care plans.

Staff supported children and young people to understand and manage their own care treatment or condition. Children were encouraged to engage in their care planning and all children stated they understood the content of their care plans. Care planning collaboration was not too evident in the care records, however, children confirmed this took place. Children were invited to and attended meetings about their progress with both internal and external partners.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Children and young people said staff treated them well and behaved kindly. All children reported that staff had good attitudes and were approachable and caring. Children reported that there had been some staff with poor attitudes but that they had recently left the service.

Staff understood and respected the individual needs of each child or young person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. All staff felt they could report any concerns to senior managers with confidence.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. However, access to independent advocacy services was limited.

Involvement of children and young people

Staff introduced children and young people to the service as part of their admission. Children were invited to visit the service prior to formally being admitted. There was an information booklet given to children about the service.

Staff involved children and young people and gave them access to their care planning and risk assessments. Children reported that they had been offered copies of their care plans and that they were familiar with the content.

Staff made sure children and young people understood their care and treatment. Children were invited to attend meetings and contributed to the discussions. Children were able to say what they were unhappy about and what they wanted to happen next.

Staff involved children and young people in decisions about the service, when appropriate. Children had been invited to support the staff recruitment process by being on the interview panel. However, currently children had declined this option.

Requires Improvement

Child and adolescent mental health wards

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Staff attempted to introduce community meetings for all children to attend. However, children were reluctant to attend. These discussions therefore occurred individually with children. There was a suggestions box available and a noticeboard to feedback actions completed.

Staff supported children and young people to make decisions on their care.

Access and promotion of advocacy services was limited. Advocacy services had not attended the service. The service had not developed any links with an external advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke to one family member who told us they felt involved in their child's care and were aware of care plans and received invites to relevant meetings. The family member reported feeling supported by staff who were respectful and polite to them.

Staff helped families to give feedback on the service. The family member reported that they were aware of how to give feedback on the service and that they felt staff would continue to treat them with respect and professionalism.

Staff gave carers information on how to find the carer's assessment. Staff reported that they would signpost carers to their child's social worker for information on carers assessments.

Are Child and adolescent mental health wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and children and young people children always had a bed following episodes of leave. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, children and young people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Managers made sure bed occupancy did not go above 100%. When children and young people went on leave there was always a bed available when they returned.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. One child had remained at The Lighthouse for approximately two years. Staff were liaising with the local authority to consider alternative options.

The service had no out-of-area placements. All children were from the North West of England. The provider's vision was that the service was for local children to retain local community and family links.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Discharges were usually planned over a number of weeks via liaison with partner agencies. There was a child who was discharged quickly in August 2021 due to her unsuitability for the service. The provider served notice on her admission.

Staff did not move or discharge children and young people at night or very early in the morning.

There was no psychiatric intensive care provision. If required, staff would liaise with commissioners to seek more intensive support from the NHS or other providers.

Discharge and transfers of care

The service had reported no delayed discharges in the past year. Most children had only been admitted for a few months. However, one child had been at the service for approximately two years. The local authority were looking at options for discharge while their progress at the service continues.

Staff carefully planned children and young people's admission and discharge and worked with local authorities to make sure this went well. We spoke to one local authority who spoke very positively of the service. They reported that there was good continuity of staff and effective communication. They also reported that the service prioritised talking through of any plans for children which were in depth and knowledgably. The service promptly forwarded any requested documentation to support moving on plans.

Staff supported children and young people when they were referred or transferred between services. Children reported that they felt supported through the admission process. Children were aware of what their moving on plan might be and staff discussed this with them.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support children and young people's privacy and dignity. Each child and young person had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

Each child or young person had their own bedroom, which they could personalise. All children had their own bedroom. There were no dormitories. Bedrooms contained personal items and children were encouraged to individualise their rooms.

The service did not always protect the privacy and dignity of children and young people. En-suite bathrooms did not have a door. Staff reported this was to manage risk of self-harm, but this meant that the privacy and dignity of children and young people was not protected.

Children and young people had a secure place to store personal possessions. Each bedroom had built in storage for children to put their belongings.

Requires Improvement

Child and adolescent mental health wards

Staff used a full range of rooms and equipment to support treatment and care. There was an activities room, a lounge, a meetings room and a sensory room that children could utilise. There was age appropriate games and equipment available.

The service had quiet areas and a room where children and young people could meet with visitors in private. There was a selection of rooms for the children to use as described above. Children could also access their bedrooms for quiet time if needed. The lounge had been used to accommodate family visits. There was no separate visitors' room.

Children and young people could make phone calls in private. Children had access to mobile phones which they could use in their bedrooms for privacy.

The service had an outside space that children and young people could access easily. There was a small courtyard with increased fencing to prevent absconding and to provide some privacy.

Children and young people could make their own hot drinks and snacks and were not dependent on staff. There was a drinks fridge in the lounge for children to access. Although on the day of our visit this was empty. Children could access the kitchen with staff supervision for food and hot drinks.

The service offered a variety of good quality food. Children described the food as being of good quality. Children were asked to contribute to the meal planning process. We saw evidence of children cooking appropriate meals.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and work, and supported them. Children attended a mixture of local schools or received remote education via online resources. Staff liaised with education providers appropriately to support children through their education. Children were awarded certificates for skills awarded by the Assessment and Qualifications Alliance in areas such as cooking and selfcare.

Staff helped children and young people to stay in contact with families and carers. Children went on regular home leave where this was safe and appropriate. Families reported that the service promoted good relationships between families and children. There was no formal family therapy in place.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Children were encouraged to attend local youth groups and football teams to establish broader peer relationships.

Meeting the needs of all people who use the service

The service met the needs of most children and young people – including those with a protected characteristic. Staff helped children and young people with communication, and cultural and spiritual support.

Requires Improvement

Child and adolescent mental health wards

The service could only make limited adjustments for disabled people due to the layout of the building. The building was over three floors with no lift access. Children with high physical needs would not be admitted to the service. Children with communication needs or other specific needs were assessed for their suitability for the service on an individual basis.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. Children were given a welcome pack during the admission process which outlined information on the local area, complaints process, any other relevant information.

The service had information leaflets available in languages spoken by children, young people and the local community. Leaflets were available in English but could be translated to other languages if necessary.

Managers made sure staff, children and young people could get help from interpreters or signers when needed. The service had not required an interpreter or signer for any child or staff member. However, if required the service had links with an organisation who could provide this.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. Food options were planned each week, taking into account any individual needs. Children were encouraged to participate in deciding food options.

Children and young people had access to spiritual, religious and cultural support. Staff were aware to signpost children and young people to local places of worship in the community.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. Children and their families reported that they were aware of how to complain and that they were confident to do so.

The service clearly displayed information about how to raise a concern in patient areas. There was a comments box for children to raise any issue. All children had a welcome pack which outlined the complaints process. There was information on walls in communal areas about how to raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff described knowing how to deal with a complaint and who to escalate a complaint to if needed.

Managers investigated complaints and identified themes. There had not been any complaints in the last six months. However, managers had a policy to follow and were aware to consider and act on any themes relating to complaints.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment. Although the service had not received any complaints in the last six months, staff had a policy to follow which outlined how to protect children from discrimination and harassment.

Requires Improvement

Child and adolescent mental health wards

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. There was a process for staff to acknowledge complaints and feedback to children and families following an investigation.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Child and adolescent mental health wards well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

A new registered manager and a deputy manager had been in post for approximately four months. There were two clinical directors who knew the service well and had oversight of the systems and processes. Managers demonstrated a good understanding of the service and of the needs of each of the children. A new service manager had been appointed but had yet to take up her role. There was a plan that the new service manager would oversee much of the day to day clinical management arrangements, leaving the clinical directors to embed governance plans. All children, families and staff described the management team as approachable. Over the last two months the service had acknowledged feedback from staff that the registered manager and deputy manager were not as visible in patient areas. Both managers had agreed to be added to the daily duty allocation plan and complete clinical tasks alongside staff. Clinical directors attended the service at least weekly to contribute to senior management meetings.

At the last focussed inspection in November 2021 the provider disclosed that they had been using another building to accommodate and deliver regulated activities to children from April 2021 to August 2021. This building was nearby to The Lighthouse at 251 Blackburn Road, Darwen, Lancashire. The Care Quality Commission were concerned about the safety and suitability of the environment at 251 Blackburn Road and told the provider not to accommodate any more children in the building. CQC also confirmed that 251 Blackburn Road would be classed as an annex of the hospital and would be included in the next planned inspection. However, in December 2021 the provider placed an adult with a tenancy agreement into 251 Blackburn Road who was also receiving outreach support. This meant that CQC were unable to inspect 251 Blackburn Road.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff understood that the service had undergone significant change and that the new management team were invested in improving the service for the benefit of the children. Staff described feeling engaged with the change process and positive about the future of the service.

Requires Improvement

Child and adolescent mental health wards

Staff acknowledged that eventually the service will be orientated towards delivering more in-depth therapeutic care such as dialectic behaviour therapy and positive behaviour support. At present children had been admitted who had low risk and low clinical needs, whilst the staff team was being trained and therapies and interventions being embedded.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff reported that they felt supported in their roles and that the service respected and valued their input. Staff remarked that managers were available to offer formal and informal support when necessary. Changes had been made in response to staff feedback. Staff and managers reported a trusting relationship that was open and transparent.

Staff were able to choose shifts to fit around childcare arrangements as much as possible.

Staff were offered further training opportunities to enhance career progression.

Governance

Our findings from the other key questions demonstrated that governance processes were not fully effective at team level and that performance and risk were not always managed well. New governance leads were in place and new process were being implemented, however many of these were not embedded yet. The service had altered its model of care to only currently admitting children with low risks and clinical need. However, there was a plan to admit more complex children in the future.

Systems and processes were not fully effective in identifying gaps in the risk assessment provision and external notifications of safeguarding concerns. One child did not have a risk assessment. Another child did not have their risk assessment updated following an incident. One safeguarding concern had not been reported to the local authority and two safeguarding concerns had not been reported to the Care Quality Commission. Care plans not containing the child's voice and poor quality activity planners had not been identified within care records audits. Governance checks had not captured these shortfalls.

However, other governance arrangements remained in place. There were now two clinical directors who were responsible for ensuring good governance. New key performance indicators had been introduced and a new weekly care records audit.

Governance processes had improved in relation to disclosure and barring service checks, police incident reporting to the CQC and restraint training for staff. New spreadsheets had been developed that gave managers better oversight of these measures.

The necessary board and committee meetings were in place. There was a process for information from ward level to meet board level if needed. Meetings were held regularly, and the appropriate assurances were sought for any issues raised.

The service had an administrator who conducted audits and other quality checks. This information was shared with the senior management team. There were plans to add more audits to her schedule in the future.

The service was in the process of updated all its policies and procedures. A company had been appointed to draft these policies. Some policies had not been fully ratified by the service and needed further work. There was a plan for the policies to be ratified by the board during March 2022 and introduced in practice in April 2022.

A shared electronic drive had been introduced so all staff could access policies, procedures and other provider information as needed.

Management of risk, issues and performance

There was a risk register in place that captured relevant and current service level risks. There were actions in place to mitigate these risks and timeframes for completion.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers had access to data such as mandatory training, clinical supervision rates, incident reports, and care plan audits. Managers used this information to target any areas of concern.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers regularly met and liaised with local authority social workers regarding the needs of the children and ongoing care planning. Managers liaised with local health partners where necessary in relation to children's physical health needs. This includes GP's, specialist outpatient consultants and dentists.

The service had been recently commissioned to provide community outreach work to children with mental health conditions in Lancashire. This was being funded by the local authority and the clinical commissioning group.

Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities. The service was working towards accreditation by the Quality Network for Inpatient Child and Adolescent Mental Health Services. The service was also working towards being fully compliant with the Safewards model of care. These aspirations had been delayed due to the change in management and high staff turnover in 2021. The service had also joined the Restraint Reduction Network and had developed a restraint reduction plan.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that governance systems were robust to capture issues relating to gaps within risk assessment procedures and safeguarding pathways and that new policies and procedures were fully embedded into the service. (Regulation 17)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured there were robust structures in place for reporting and capturing safeguarding concerns and that they were acted upon promptly. (Regulations 13 (1) (2) (3))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed to ensure that all children had a risk assessment completed on admission and that this was updated following any incident. (Regulations 12 (2) (a)). The provider failed to ensure that risk was managed on an individual basis. The provider had not considered the impact of having no en-suite doors on children's privacy and dignity. (Regulations 12 (2) (a))

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not ensure that safeguarding concerns were reported to all relevant external agencies including the Care Quality Commission. (Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009)