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?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We have not previously rated this service. We rated it as requires improvement because:

- Young people did not receive care and treatment in a manner that safeguarded them from potential abuse. Positive behaviour support plans were not based on functional assessments. Positive behaviour support plans contained strategies which included the use of punishments which were not in keeping with the therapeutic ethos.
- Disclosure and barring service checks were not always conducted robustly. Staff had started employment without having the appropriate checks in place which ensured they could work with children as well as adults.
- Restraint was not safe. Staff involved in restraint had not always undertaken the providers restraint training. This meant staff could potentially use different methods of restraint which could result in the young people being physically harmed.
- Children and young people requiring assistance did not have a way to alert staff if they needed assistance quickly. Whilst hand held equipment was available in the unit to enable communication in an emergency, this was rarely being made available to the young people.
- There was no target for staff supervision. This meant that there was not a measurable target for the service to work towards.
- Staff did not use child friendly approaches with children and young people to engage them in decisions about their individual care and treatment. This meant children and young people felt uninvolved.
- There were gaps in the governance processes that did not identify there were issues with disclosure and barring service checks and restraint training for staff.

However:

- Infection prevention control measures had improved following prompting by the Care Quality Commission. Staff were now wearing masks and following national guidance.
- Staffing at night had improved since the last inspection. Registered nurses were employed to work at night. This meant that children and young people had access to registered nurses at all times.
- The service sought to ensure that children and young people had access to the appropriate therapies and treatment. Alternative therapies were sourced and funded by the service where necessary.
- Community meetings were held regularly. Children and young people were asked of their opinions and changes were made based on their feedback.
- The service had sought input from external bodies such as the Restraint Reduction Network, Safewards and was working towards Quality Network for Inpatient Child and Adolescent Mental Health Services accreditation.

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 	We have not previously rated this service. We rated it as requires improvement. See overall summary.

Summary of findings

Contents

Summary of this inspection

Background to The Lighthouse

The Lighthouse is a four-bedded child and adolescent inpatient service based in Darwen, Lancashire. The service provides mental health care to children of either gender from aged eight to eighteen. The service model is based on providing step-down care for children who are ready to leave a tier four child and adolescent mental health ward but require extra support before returning to the community. The service also provides crisis admissions for children and young people who need extra support to avoid requiring a tier four bed.

There was a registered manager in post at the time of our inspection. The Lighthouse was registered for the following regulated activities:

- Treatment for disease, disorder or injury
- Accommodation for people who require nursing or personal care

The service was registered in December 2019. The service had a focussed inspection of elements of the safe and well-led domains in May 2020. Following this inspection, the following requirement notices were issued:

- Regulation 11 HSCA (RA) Regulations 2014 Need for consent. Staff were not trained in the Mental Capacity Act. The Mental Capacity Act policy was not suitable for the purpose of working with children and was unclear. The consent policy also lacked specific detail. Staff had signed for consent on behalf of a young person who was able to consent.
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Staff were not trained appropriately in restraint despite the service having high levels of restraint. Staff had received different models of restraint training. This meant that restraint practices were unsafe.
- Regulation 17 HSCA (RA) Regulations 2014 Good governance. Overall systems and processes were not robust. There were gaps in the mandatory training schedule that meant staff were not skilled to deliver safe care and treatment. The approach to training was inconsistent with previous training being accepted. Many policies were poor and required review. The risk register did not clearly identify risk associated with the service. Areas for improvement within the service had not been identified by governance measures.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing. Suitably qualified staff were not deployed to meet the needs of children and young people. There were no qualified nurses working at night.

These breaches of regulation were reviewed during the inspection process and have now been met.

We were prompted to complete this comprehensive inspection during the Covid 19 pandemic due to whistle-blowing concerns raised to us involving:

- Unsafe restraint
- Lack of disclosure and barring service checks
- Poor infection prevention control measures

What people who use the service say

All children we spoke to described feeling unsure of what care is being delivered to them and that they felt uninvolved in decisions about their care. Children and young people felt they had no input into their care plans or future decisions. However, children were invited to meetings about their care and information shared with them. We saw evidence of patients feeling that staff really cared and that they felt safe at The Lighthouse.

Summary of this inspection

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?

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 during the day and in the evening
- spoke with all four children who were using the service
- spoke with the two registered managers
- spoke with seven other staff members, this included employed staff and agency staff
- received feedback about the service from two local authorities
- looked at three 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 three carers of children and young people who use the service
- conducted specific observations of child and staff interactions

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:

We told the service that it must take action to bring services into line with legal requirements.

- 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)

Summary of this inspection

Action the service SHOULD take to improve:

We told the service that it should take action to improve services.

- The service should ensure children and young people are supported in a child friendly way to participate in the care planning process to ensure children and young people feel involved in their care and future decisions.
- The service should ensure they have clear oversight of the quality and frequency of staff supervision.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Inadequate

This service had not previously been rated. We rated safe as inadequate because:

- Children were unable to summon assistance should they need support quickly from staff. Staff had access to radios to communicate with each other. Children and young people who were at higher risk of self-harm were given a radio to communicate with staff. However, in practice this rarely occurred. Children and young people were encouraged to seek support directly if needed. Staffing levels were high to mitigate any challenges in the building layout. There was CCTV in communal areas. Young people did not receive care and treatment in a manner that safeguarded them from potential abuse. Positive behaviour support plans were unsafe for children due to the wrong model of care being applied. Positive behaviour support plans contained negative punishments strategies such as the removal of items or a planned activity was denied. This meant that children who had suffered abuse or neglect were at risk of being re-traumatised. There were plans for the psychologist to support the implementation of positive behaviour support plans and for this to be completed by May 2021.
- Not all restraint was carried out safely and according to the organisations policy. Some staff were involved in a restraint without having completed the necessary restraint training. It was not clear from the records what each child or young person's individual de-escalation plan was although staff could describe this verbally. However, there was evidence that de-escalation techniques had been attempted prior to the restraint and that restraint was used as a last resort. Staff used restraint only after attempts at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.
- Patients were not always safeguarded in line with national guidance. Some staff were employed without having been background checked to work with children as well as adults by the disclosure and barring service. A police incident was not notified to the Care Quality Commission. However, staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had a named safeguarding lead and a deputy safeguarding lead. Three staff had been trained to level five in safeguarding children.

However:

- Following intervention by the Care Quality Commission the service had now implemented good infection prevention control measures in relation to the Covid 19 pandemic. There was regular testing of children, staff and visitors. The correct Personal Protective Equipment (PPE) was now being used and there were systems in place to ensure any outbreak was minimised. The service was clean, well furnished and well maintained.

Requires Improvement

Child and adolescent mental health wards

- The service now had enough nursing and multidisciplinary staff. Registered nurses were now working at night so children and young people had access to registered staff at all times. Nurses working at night were employed by an agency. However, two agency nurses had been recruited into permanent staff posts and were due to start in the next few weeks. There remained one registered nurse vacancy and all other posts were filled. All staff knew the patients well and had received basic training to keep patients safe from avoidable harm. This now included restraint training approved by the British Institution of Learning Disabilities and focussed on using positive approaches to challenging behaviour.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. The service had introduced a new electronic recording system that was easy to navigate.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. Children and young people's medicines were reviewed weekly and changes made to stop or reduce any medicine that was unnecessary and replaced with therapeutic interventions where appropriate.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are Child and adolescent mental health wards effective?

Requires Improvement

We have not rated this service before. We rated effective as requires improvement because:

- Positive behaviour support plans were of a poor quality. They had been completed without being based on a functional assessment or formulation. Care plans and positive behaviour support plans did not always reflect the correct therapeutic language or approach. Positive behaviour support plans were not effective in supporting staff to engage appropriately with children.

However:

- Care plans were extensive and varied. They covered all developmentally appropriate risk factors. They were reviewed regularly and updated.
- Staff assessed the physical and mental health of all patients on admission. Children and young people were given a screening assessment prior to admission. During the initial 12-week period a more detailed assessment and formulation were developed by the multidisciplinary team.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. The service had introduced a dialectic behavioural therapy model. Staff had received inhouse training in this approach. Children and young people whose needs could not be met using this therapeutic model received specialist therapeutic interventions sourced from outside of the service. Children and young people had received privately sourced play therapy and an autistic spectrum disorder assessment funded by the service. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. Staff used outcome measures including recovery star, health of the nation outcome score for children and adolescents and strengths and difficulties questionnaire. Staff also participated in clinical audit, benchmarking and quality improvement initiatives.
- The staff team included or had access to the full range of specialists required to meet the needs of children and young people on the ward. The service employed a consultant psychiatrist, a psychologist and a teacher. All had specialisms in working with children. Managers made sure they had staff with a range of skills needed to provide high quality care.

Requires Improvement

Child and adolescent mental health wards

Some support staff were not experienced of working with children but had completed two modules specifically relating to working with children and young people. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. The service did not have a target for staff supervision. This meant it was difficult to measure. However, staff said they felt supported and we saw evidence of supervision records that were adequate. Managers provided an induction programme for new staff.

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Feedback from local authorities was positive. Children's social workers reported that the service was professional, caring, and open and honest in relation to treatment options and incidents.
- Staff understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Are Child and adolescent mental health wards caring?

Requires Improvement

This service had not previously been rated. We rated caring as requires improvement because:

- The service was not caring enough to ensure that staff were appropriately vetted to work with children, that the correct therapeutic approach was used, or that staff had been trained in the safe use of restraint.
- Children and young people felt uninvolved in their care and treatment. All children reported they felt uninvolved in their care and that decisions were made without their input. The service had not used child centred approaches to ensure children felt involved in their care and treatment. Children were regularly invited to meetings about their care but often declined to attend. However, there were weekly community meetings where children and young people could give feedback. The service ensured that patients had easy access to independent advocates. They linked with an advocacy provider and children were receiving telephone calls to discuss any issues they had.

However:

- Staff respected children and young people's privacy and dignity. Children and young people reported staff always knocked on their doors before entering.
- Staff informed and involved families and carers appropriately. Staff provided family therapy and weekly updates to parents and carers.

Are Child and adolescent mental health wards responsive?

Good

This service had not been previously rated. We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Requires Improvement

Child and adolescent mental health wards

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to education throughout their time on the ward. Children and young people accessed external community schools wherever possible. Three children were attending school and one child was receiving online lessons. The service were creative with sourcing alternative educational solutions such as a mechanics apprenticeship at college and a hairdressing course. The service had also recently been accredited by the Assessment and Qualifications Alliance which allows children and young people to study towards qualifications on site.
- Each child had an activity planner which detailed individual activities children and young people could access each day. This planner included formal education, leisure activities and life skills sessions.
- The food was of a good quality. Children helped choose the meal plan each week and were encouraged to make healthy choices. Food and drinks were always available.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service was responsive to the needs of children and young people and sourced external resources where necessary at no extra cost to the commissioner. For example, play therapy and an autistic spectrum disorder assessment were provided to children privately. This meant there was no delay to children and young people receiving the correct care and treatment at the right time.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. We saw evidence of complaints being addressed and resolved. However, not all risks were addressed sufficiently. One complaint did not fully address the need to always have enough trained staff to safely manage restraint.

Are Child and adolescent mental health wards well-led?

Requires Improvement

This service had not been previously rated. We rated well-led as requires improvement because:

- Our findings from the other key questions demonstrated that governance processes still required further improvement. We found concerns regarding; disclosure and barring checks, restraint being undertaken by staff not adequately trained, not all police contacts reported to the Care Quality Commission, no target for staff supervision to be monitored by and three policies referred to Children's Homes regulations rather than/ as well as Care Quality Commission guidance.
- Leaders were gaining skills, knowledge and experience to perform their roles, but this was in development. Leaders had sought input from a specialist in governance to help develop and understand the governance structures although further progress was needed.
- Leaders were unable to provide assurance that all staff had undergone a disclosure and barring check for children and systems were not in place to provide evidence of when disclosure and barring checks had been carried out.
- Staff were unclear of the provider's exact vision and values but understood the providers drive for excellent care and treatment. Staff spoke of feeling inspired by the providers passion for better outcomes for children and young people. The provider confirmed the vision and values could be made more obvious and were considering ways to address this.

However:

Requires Improvement

Child and adolescent mental health wards

- Staff felt respected, supported and valued. Staff spoke very highly of the service and its leadership team. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. The clinical directors were on a rota to be onsite every day. Staff and children and young people described them as available and supportive. We observed positive interactions between leaders, staff and children and young people.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. Policies were available on the electronic system for staff to access. There was a monthly prize quiz on each policy to promote staff understanding.

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 working towards being fully compliant with the Safewards model of care. 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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person centred care** **The service failed to ensure that all positive behaviour support plans were completed using functional assessments. Positive behaviour support plans included negative punishment strategies that was detrimental to children's wellbeing. Regulation 9(1)**

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 **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **The service failed to ensure that restraint was always carried out safely. Staff involved in restraint were not appropriately trained and there was not sufficient numbers of competent staff available to use restraint. Regulation 12(1).** **The service failed to ensure that a system was available to children and young people so where needed they can call for assistance. Regulation 12(1)**

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

This section is primarily information for the provider

Requirement notices

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service failed to ensure that all staff had the correct disclosure and barring service checks prior to starting employment. Regulation 17(1)

The service failed ensure that there were systems and processes in place that captured any failures in governance. This included not checking all staff were appropriately trained and that the necessary employment checks were conducted prior to employment. Regulations 17(1)