

Elysium Healthcare No.2 Limited

Potters Bar Clinic

Inspection report

190 Barnet Road
Potters Bar
EN6 2SE
Tel: 01707858585
www.elysiumhealthcare.co.uk

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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 | | Good |  |
| Are services safe? | | Good |  |
| Are services effective? | | Good |  |
| Are services caring? | | Good |  |
| Are services responsive to people's needs? | | Good |  |
| Are services well-led? | | Good |  |

Summary of findings

Overall summary

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. The use of restrictive practices was reducing, medicines were managed safely, and staff followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of young people and in line with national guidance about best practice. Staff engaged in audits to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and supervision. Staff worked well together as a multidisciplinary team.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They actively involved young people in their care.
- Staff planned and managed discharge well.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- There were high vacancy rates for qualified nursing staff.
- Staff did not always appropriately record and store consent to treatment forms.

Summary of findings

Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|--|--|------------------------------|
| Child and adolescent mental health wards | Good  | |

Summary of findings

Contents

| | |
|--|-------------|
| Summary of this inspection | Page |
| Background to Potters Bar Clinic | 5 |
| Information about Potters Bar Clinic | 6 |
| <hr/> | |
| Our findings from this inspection | |
| Overview of ratings | 7 |
| Our findings by main service | 8 |
| <hr/> | |

Summary of this inspection

Background to Potters Bar Clinic

Potters Bar Clinic is an independent hospital that provides services to adults who have needs related to their mental health and Child and Adolescent Mental Health Services (CAMHS) Tier 4 low secure services for young people aged 13 to 18 years with a wide range of disorders and complex needs. Young people may be detained under the Mental Health Act or may be voluntarily staying at the hospital.

Potters Bar Clinic is provided by Elysium Healthcare No 2. Limited. There are 2 CAMHS wards:

- Jasper ward is a mixed gender CAMHS ward with 11 beds on the ground floor.
- Opal ward is a mixed gender CAMHS ward with 7 beds on the ground floor.

Potters Bar Clinic is registered to carry out the following legally regulated activities:

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

At the time of the inspection there was a registered manager in place who was the hospital director.

This location was most recently inspected in December 2019. At this inspection we did not identify any breaches of the Health and Social Care Act (2014) for Child and Adolescent Mental Health Services.

We carried out this unannounced inspection because we received information giving us concerns about the safety and quality of the services. We visited the service during the day and on another occasion, during the night time shift.

What people who use the service say

We spoke with 5 young people that were using the service and 3 carers:

Young people told us:

- Staff were mostly caring, helpful, and supportive, especially the day-time staff.
- They felt listened to by staff.
- They felt actively involved in their care.
- However, 3 young people felt that agency night staff quickly resorted to applying restrictive practices such as restraint, rather than using other interventions first.
- One young person told us that night-time staff sometimes spoke in their own language.

Carers told us:

- They were invited to ward rounds and mostly felt involved in care.
- One carer told us staff communication could be improved.
- Two carers told us the service should offer more autism training for staff.

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- visited both wards during a day shift on 25 July 2023 and a night shift on 3 August 2023
- toured the clinical environments, including clinic rooms and reviewed emergency equipment.
- reviewed the medicine management on the wards, including a review of 8 medication cards.
- spoke with 5 patients that were using the service.
- spoke with 3 family members or carers.
- interviewed fifteen staff, including ward managers, clinical services manager, nurses, healthcare assistants, and social worker.
- reviewed 6 patient care records.
- reviewed 10 observation charts.
- observed a handover from day to night shift and reviewed 5 staff allocation sheets.
- Observed staff and patient interactions.
- reviewed minutes of various meetings, policies and procedures, data and documents relevant to the running of the service

You can find 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 is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD:

- Continue to work towards reducing vacancy rates for qualified nursing staff.
- Continue to monitor and reduce physical interventions (restraints).
- Ensure that staff record and store consent to treatment forms appropriately.

Our findings

Overview of ratings

Our ratings for this location are:

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

Child and adolescent mental health wards

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

Is the service safe?

Good 

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

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 risk assessments of all wards areas and removed or reduced any risks they identified. Staff undertook regular ligature risk assessments of the wards. The assessments identified potential ligature points, and clearly stated the mitigation of these. Managers had carried out a recent ligature audit in June 2023. At the time of inspection 92% of eligible staff had received mandatory use of ligature cutters training.

Staff could observe children and young people in all parts of the wards with the aid of mirrors and installed closed circuit television (CCTV.) Staff knew and understood where areas of risk were on the wards.

The wards complied with guidance and there was no mixed sex accommodation. There were gender specific lounges and all bedrooms had ensuite bathroom facilities.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. All clinical staff carried personal alarms and summoned help in a timely way when needed. Young people had easy access to a nurse call system if required. Security checks were completed appropriately including alarm checks, and recording when alarms were taken in and out of the wards.

Maintenance, cleanliness and infection control

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

Child and adolescent mental health wards

Staff kept cleaning records up to date and demonstrated that ward areas were cleaned regularly. We saw both the wards were clean and well maintained during our visits. However, Opal ward was tired and in need of some redecoration. Managers had made attempts to brighten the environment with colourful paintings in corridors. Staff followed infection control policy, including handwashing. Staff participated in regular infection control audits and infection control was a standing agenda item at clinical governance meetings.

Seclusion room (if present)

Both wards had a seclusion room. Staff were able to clearly observe young people using the seclusion room and there was two-way communication. They had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records of emergency bag checks and clinic room checks demonstrated this.

Staff checked, maintained, and cleaned equipment. We observed green clinic stickers on equipment dated the day we visited the wards demonstrating cleaning had occurred. Cleaning records showed regular cleaning of equipment with managerial monitoring and oversight of this.

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 service had enough nursing and support staff to keep children and young people safe.

We reviewed staffing rotas during the period January 2023 to July 2023. Staffing data showed that there had been a reduction in the number of shifts where planned staffing numbers were not met. Most unfilled shifts were in January and March 2023.

For Jasper ward during this time there were 6 occasions when planned staffing numbers were not met on a day shift and 2 occasions when planned staffing numbers were not met on a night shift. However, of the 6 occasions when planned staffing numbers were not met, 5 of these were between January and March 2023. The 2 occasions when planned staffing numbers were not met on a night shift, 1 took place in January and 1 in July 2023.

For Opal ward during this time there were 30 occasions when planned staffing numbers were not met on a day shift and 12 occasions when planned staffing numbers were not met on a night shift. However, of the 30 occasions when planned staffing numbers were not met on a day shift 24 of these were between January and March 2023. For the 12 occasions when planned staffing numbers were not met on a night shift 10 took place between, January and March 2023.

On all occasions where planned staffing numbers were not met, the wards were supported by ward managers, night coordinators, nurses in charge and staff from other wards in the hospital stepping in to fill the gap.

Child and adolescent mental health wards

On 4 occasions between January to March 2023 managers mitigated low staff numbers by staff taking reduced breaks. However, there had been no occasions since March 2023 where staff were required to reduce their breaks to ensure the wards ran safely. Staff we spoke with told us they always took their breaks.

The service used bank and agency staff to fill shifts. Managers booked regular bank and agency staff and wherever possible, requested staff that were familiar with the needs of the young people. We spoke with agency staff during the inspection, and they described the needs of young people on the wards. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had a high number of vacancies for qualified nursing staff and support workers. At the time of inspection, the service had a 50% vacancy rate for registered nurses (10 vacant posts out of 20) and a vacancy rate of 18% for support workers (9 vacant posts out of 48).

Managers told us they block booked agency staff to cover the vacancy shortfall and had implemented strategies to improve staff retention and recruitment. For example, new starter bonuses had been introduced for qualified staff, and retention bonuses for all other staff, agency staff had been recruited into permanent roles and a new approach to interviewing support workers as part of a two-hour group interview process, run fortnightly, had been introduced. The service had an ongoing active recruitment campaign for qualified nurses and support workers including recruitment events, job fairs and Universities.

The service had reducing turnover rates. For the most recent complete month, July 2023 staff turnover was 36% compared with July 2022 at 43%.

Managers supported staff who needed time off for ill health and gave example of how staff on long term sick were supported.

Levels of sickness were reducing. We reviewed data from January to July 2023 and sickness rates had reduced from a maximum of approx. 6% in both February and March to approx. 3% in May, June and July. April had the lowest sickness rate at 1.4%

The ward managers could adjust staffing levels according to the needs of the children and young people. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers adjusted staffing levels daily to meet the needs of the young people. Each ward had set minimum staffing numbers which depended upon occupancy and if young people were nursed under enhanced observations, additional staff were provided.

Children and young people had regular one to one sessions with their named nurse.

Children and young people rarely had their escorted leave, or activities cancelled.

The service had enough staff on each shift to carry out any physical interventions safely. Managers told us and we reviewed staffing rotas to show that there were always enough staff on the wards. In the event of incidents or occasions where the wards were short-staffed staff from other wards in the hospital could assist.

Staff shared key information to keep children and young people safe when handing over their care to others. We observed a handover from the day shift to the night shift. Staff clearly described young people's risks and gave updates on incidents that may have occurred during the day shift.

Child and adolescent mental health wards

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the wards quickly in an emergency. The service had an on-call rota system to ensure that a doctor was always contactable and available, if required, to attend the ward in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

The medical team included Child and Adolescent Psychiatrists who are medically qualified doctors who specialise in working with young people with mental health problems and their families.

Mandatory training

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

Managers monitored mandatory training on a weekly basis and alerted staff when they needed to update their training. We reviewed training compliance data and found that staff had completed and kept up-to-date with their mandatory training. The mandatory training compliance rate overall was 90%. Compliance rates for individual mandatory training course ranged from 75% to 100%.

Assessing and managing risk to children and young people and staff

Staff 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 and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment and management of patient risk

Staff completed risk assessments for each child and young person on admission / arrival, using recognised tools, and reviewed this regularly, including after any incident.

We reviewed 6 patient records. Staff assessed and managed risks to young people and themselves well. Staff completed a risk assessment of each young person upon, or shortly after admission, and updated these appropriately. The provider used recognised risk assessment tools. Staff updated risk assessments following incidents.

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. We observed a handover where staff shared clear information about young people's risks and any changes in their care.

At the day of inspection we found that not all staff we spoke with knew which staff member had been allocated the role of the emergency responder. We were concerned that this could mean that staff may not always respond to emergency incidents if they were not clear who was allocated to this role. However, we observed 5 allocation sheets and saw this role had been allocated. When we returned to visit the nightshift we observed this role was allocated in the handover

Child and adolescent mental health wards

meeting, and staff we spoke with knew who the emergency responder for the shift was. Following our onsite visit, we spoke to further staff virtually, who were all aware of the role of the emergency responder. Following our onsite feedback, the provider has ensured all staff are clear on the role of the emergency responder and that this role is always allocated to staff.

Staff identified and responded to any changes in risks to, or posed by, children and young people.

Staff could observe children and young people in all areas of the wards, with the aid of mirrors and installed closed circuit television (CCTV) and followed procedures to minimise risks when they were carrying out observations. The service had a policy for observations in place and staff could describe the different levels of observations. We viewed 10 patient observation records and found all were fully completed.

Staff followed safe policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. There was an allocated security nurse who undertook searches.

Use of restrictive interventions

Levels of restrictive interventions were reducing.

Managers kept a log of restrictive practices. We reviewed restrictive interventions data for a two-week period in July 2023. During this time there had been 97 episodes of physical intervention on Jasper ward and 92 episodes on Opal ward. However, data showed that staff recorded a range of all levels and types of physical interventions.

Of these interventions, 2 episodes on Jasper ward and 1 episode on Opal ward resulted in restraint in the prone position. There had been 10 episodes of the use of rapid tranquilisation on 3 young people on Jasper ward and 2 episodes of rapid tranquilisation on 2 young people on Opal ward. Staff followed NICE guidance when using rapid tranquilisation. Managers compiled and reviewed monthly audits for the use of rapid tranquilisation.

Managers regularly reviewed and analysed restrictive interventions data and the service had a reducing restrictive interventions policy. Data for June 2023 across both wards showed a 37% decrease in physical restraints from 119 in May to 75 in June. From July 2002 to June 2023 data showed there was a continuous reducing trend in the number of physical interventions falling from 110 incidents a month to 75 incidents.

Following restraint incidents managers reviewed CCTV footage of the incidents to ensure this was managed safely. Managers held debrief sessions with staff and young people and sometimes undertook a review of CCTV footage with them. We viewed the service CCTV and debrief log.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed or when necessary to keep the child, young person or others safe as part of planned care. Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating and de-escalating violence and aggression. Staff were trained in how to manage potential conflict, with emphasis upon the least restrictive approach. Staff we spoke with described how they used verbal de-escalation, distraction techniques, and applied positive behavioural support plans where appropriate. Training data showed that 81% of staff were up to date with mandatory conflict resolution training and breakaway and 80% of staff were up to date with safe and therapeutic management of violence and aggression training. Managers told us that agency staff were booked onto refresher prevention and management of violence and aggression training.

Child and adolescent mental health wards

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

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. We reviewed minutes from the last 2 reducing restrictive practice meetings. Staff did not apply blanket restrictions unnecessarily on patients. Restrictions in place were the minimum necessary to provide the care and treatment required safely.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed the service's seclusion register. Within the last 6 months there had been 17 episodes of seclusion (14 for Jasper ward and 3 for Opal ward). Each episode of seclusion was recorded appropriately along with the reason for the seclusion and duration of the episode.

Managers compiled and reviewed monthly audits of episodes of seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. We reviewed the service's long term segregation register. Within the last 6 months there had been 1 episode of long-term seclusion on Jasper ward.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been fifteen safeguarding incidents reported during the previous month, June 2023.

Staff knew how to recognise adults and children at risk of or suffering harm and how to work with other agencies to protect them. Staff we spoke with were able to give examples such as how they would identify physical abuse, financial abuse and psychological abuse.

At the time of inspection, 87% of eligible staff were up to date with safeguarding adults and children. The service's mandatory induction programme included safeguarding training.

The safeguarding lead regularly met with young people and would investigate all concerns and allegations of abuse. This included a fact-finding exercise involving speaking with young people, staff and reviewing CCTV. The senior management team would immediately review all safeguarding incidents and agree and take actions to safeguard young people. The service regularly liaised with the local authority safeguarding team and had named contacts to be able to do this.

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 followed clear procedures to keep children visiting the wards safe.

Staff access to essential information

Child and adolescent mental health wards

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 staff could access electronic records easily. All information needed to deliver care was available to all relevant staff (including bank and agency) when they needed it.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

At the time of inspection 95% of eligible staff had received mandatory record keeping training.

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.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At the time of inspection 88% of eligible staff had received mandatory safe administration of medicines training.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines.

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

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

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

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Track record on safety

Between July 2022 and June 2023 there had been 14 serious incidents requiring investigation. Eleven of these incidents related to self-harm; 2 security incidents and 1 incident of aggression and violence.

Data from the most recent month showed a total of 140 incidents reported within the Child and Adolescent Mental Health Service in June 2023, with 45 incidents occurring on Jasper ward and 87 incidents on Opal ward. Of these incidents there were 2 incidents reported that had resulted in high harm (these incidents occurred on Opal ward). There had been no incidents reported that had resulted in severe harm. The service had no never events, these are serious incidents that are wholly preventable.

Child and adolescent mental health wards

Reporting incidents and learning from when things go wrong.

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 children and young people honest information and suitable support.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff knew what incidents to report and how to report them.

Staff we spoke to knew what situations required reporting as an incident. The ward used electronic recording systems to record incidents and staff knew how to use the system and knew who to contact if they needed support. We saw that incidents were recorded in patient notes.

Staff reported all incidents to external bodies including safeguarding incidents, and incidents notifiable to the Care Quality Commission.

Staff we spoke with told us how they referred to positive behaviour plans to support de-escalation and prevention of incidents.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents. They met to discuss the feedback and look at improvements to patient care.

Managers reviewed, analysed and categorised incidents. They identified themes and trends and escalated these appropriately and shared lessons with staff. Staff discussed each incident at daily handover meetings and in supervisions. Staff and young people were given debriefs after incidents and staff discussed incidents and learning in supervisions. Staff, including night-time staff, had the opportunity to further discuss incidents at reflective practice sessions.

Managers routinely checked CCTV following incidents. They had introduced 'Keeping Lessons Learnt Alive' (KLLA) sessions where CCTV footage was viewed as part of lessons learnt and incidents discussed where learning had taken place to keep staff aware of any lessons learnt. Staff were asked to complete feedback forms to review the effectiveness of the sessions and identify any areas that need to be changed to ensure that the sessions were beneficial.

We reviewed the serious incident log and saw evidence of lessons learned. There were lessons learnt posters.

Staff and patients were given debriefs after incidents and staff discussed incidents and learning in supervisions.

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.

Child and adolescent mental health wards

Is the service effective?

Good 

Our rating of effective stayed the same. 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 personalised, holistic and recovery-oriented.

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

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the wards.

We viewed 6 patient records, The records showed that patients had their mental health and physical health assessed on admission. Care records showed that a physical examination had been undertaken at admission or soon after and there was ongoing monitoring of physical health. Monthly audits were conducted for food and fluid and the physical health National Early Warning Score and Paediatric Early Warning Score tools. Managers reviewed and analysed the results of these audits.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs.

Care plans were personalised, holistic and recovery orientated. There were comprehensive plans for all patients' physical health; personal care and wellbeing, leave, keeping safe, keeping connected, my mental health all of which were all personalised to the individual. Staff regularly reviewed and updated these when young peoples' needs changed.

Patients participated in co-producing their care plans as much as they wanted to. We read through care plans and could see the patient voice throughout. Patients were offered copies of their care plans and we saw this recorded in care records.

Staff completed positive behaviour support plans for patients, so that staff were made aware of what triggers patients may have that led to challenging behaviours and what individualised interventions to use to support patients to prevent and manage behaviours.

Best practice in treatment and care

Child and adolescent mental health wards

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 a range of care and treatment suitable for the children and young people in the service including psychological therapies and a range of activities. Therapies focused on 4 areas, mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Staff aimed to equip young people with coping skills to increase resilience, reduce self-harm and enable them to monitor, regulate and manage their emotions.

There was a broad timetable of meaningful activity run by a well-staffed therapy team including, psychologists, occupational therapists, activity coordinators, family therapists and an art therapist.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. NICE)

Staff identified children and young people's physical health needs and recorded them in their care plans. We reviewed 6 care plans and found staff appropriately recorded physical healthcare needs and there was evidence of ongoing monitoring of physical health.

Staff made sure children and young people had access to physical health care, including specialists as required. Young people had access to an on-site physical health nurse, dietician and a GP and there were weekly physical health checks at the service. Staff escorted young people to local hospitals to access specialist physical healthcare when required.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. Staff sought support and guidance from their neighbouring hospital for any young people with disordered eating needs. We saw in care records that several young people were on food and fluid balance monitoring. Staff completed regular food and fluid audits and reviewed and analysed the results.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Young people had the opportunity to engage in appropriate therapeutic programmes such as family and trauma therapy. Young people took part in activities such as fitness, music, social club and cooking.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes including HoNOS (Health of the Nation Outcome Scales), StartAV (Short-term assessment of risk and treatability) and CGAS (Children's global assessment scale).

Staff used technology to support children and young people.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers compiled a range of weekly and monthly audits on topics included care plans; observations and engagement; rapid tranquillisation; seclusion and segregation; dealing with medical emergencies; Section 17 leave; physical health; long term segregation; food and fluid; infection control and review of CCTV. Managers used the results from audits to make improvements.

Skilled staff to deliver care

Child and adolescent mental health wards

The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers made sure they had staff with the range of skills needed to provide high 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 access to a full range of specialists to meet the needs of the children and young people on the wards, this included doctors, qualified nurses, psychologists, family therapists, social workers and psychotherapists and occupational therapists. Young people also had access to paediatricians, educational psychologists, art therapists, and speech and language therapists.

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. The service had developed a suite of competencies. Managers told us over 800 competencies had been completed with permanent, bank and agency staff since January 2023. Young people were included in the development of some of these competencies.

Managers gave each new member of staff a full induction to the service before they started work. We reviewed the service's induction schedule which included essential training and information for new staff such as, observations, basic life support, security and conflict resolution. We saw there was an induction schedule for agency staff. Staff we spoke with told us the induction programme met their needs.

Managers had ensured that all staff regular, constructive appraisals of their work. Overall, 33 of 36 eligible staff, 92% had received an annual appraisal.

Staff received support in the form of regular, constructive supervision of their work, appraisal and induction training. At the time of inspection 100% of staff on both Jasper and Opal wards had received supervision. Staff we spoke with confirmed they had received regular supervision.

Managers made sure staff attended regular team meetings. Minutes were circulated to those who could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

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

Managers made sure staff received any specialist training for their role. The service provided both permanent and regular agency staff with specialist mandatory CAMHS training including, for example, Legal Framework for Working with Young People; Development of the Teenage Brain and Managing Self-Injury and Harm amongst others.

Eligible staff also completed an introduction to CAHMS course (commissioning for Quality and Innovation, CQUIN). This course included the following topics, understanding personality and identity development; understanding psychosis; impact of trauma on adolescents and understanding family systems and working with families.

At the time of inspection 81% of eligible staff had received the mandatory Oliver McGowan training on learning disability and autism.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers we spoke with gave examples.

Child and adolescent mental health wards

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

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Staff handovers took place at every shift change. Handover discussions included essential information regarding the previous shift and any changes in patients' individual needs or risks. We saw essential patient information were recorded on a board on the wards so all staff could quickly see information about each patient. However, during the night visit patients had wiped the information from the board. Staff told us this would be written back up.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of inspection, 85% of eligible staff had received training.

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

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

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

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. The Independent Mental Health Advocate (IMHA) was from HertsHelp, an independent information and advice service. There were posters with contact details on display.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. Both wards had recently received a Care Quality Commission Mental Health Act Compliance monitoring visit during July 2023. At these visits reviewers found that young people knew under which section of the MHA they were detained and young people confirmed they knew their rights.

Child and adolescent mental health wards

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Section 17 leave was authorised by the consultant psychiatrist who was the responsible clinician for all the young people. A standardised form was in use which recorded the type and duration of leave granted, plus any conditions identified. Staff appropriately recorded the outcome of Section 17 leave.

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

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The service undertook audits such as Section 17 leave, long-term segregation and seclusion compliance with Mental Health Act code of practices.

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 trust 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 but did not always record consent and capacity or competence clearly for 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 5 principles. At the time of inspection, 85% of eligible staff had received training.

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

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

Staff gave 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.

Staff assessed and recorded capacity to consent clearly each time young person needed to make an important decision. Both wards had recently received a Care Quality Commission Mental Health Act Compliance monitoring visit during July 2023. At these visits reviewers found gaps in completing assessments of capacity to consent to treatment to accompany certificates of consent (T2 forms) and certificates authorising treatment not being available on the medication charts.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the young person and considered their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

Child and adolescent mental health wards

The service monitored how well it followed the Mental Capacity Act and made 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.

Is the service caring?

Good 

Our rating of caring stayed the same. 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 on both wards treated the young people with compassion and kindness. They respected young peoples' privacy and dignity. They understood the individual needs of the young people and supported the young people to understand and manage their care, treatment or condition. Staff were discreet, respectful, and responsive when caring for the young people. We observed staff being attentive and engaging in activities with the young people. We also saw staff spoke respectfully to and about young people.

There were thirteen young people at the hospital at the time of our inspection. Five young people wanted to speak with us whilst we were on-site. The young people said staff treated them well and were mostly kind and supportive. Staff we spoke with understood and respected the individual needs of each young person. They clearly knew the young people well and were familiar with triggers that might upset them. However, 3 young people felt that agency night staff were quick to apply restrictive practices such as restraint, rather than using other interventions first. Managers were made aware of these concerns prior to our inspection following these being shared with the CQC and had taken action to address this. Managers met with young people and staff for feedback, visited the wards at nighttime and randomly reviewed CCTV footage, including all incidents to monitor the practice. This led to changes to the staffing at nighttime, staff reflection on the interventions they were using and a change in approach and practice when caring for certain young people with specific needs. Managers have informed us that they have already seen a reduction in incidents following these changes and are continuing to monitor this. One young person told us that night-time staff sometimes spoke in their own language. We saw in staff meeting minutes that managers had acted on this feedback and staff were encouraged to avoid talking in any language other than English unless during staff breaks. Managers were continually monitoring this.

Staff gave young people help, emotional support and guidance when they needed it. For example, staff told us that during the day of the night inspection, staff and young people had all come together to have lunch. Staff had supported a young person with an eating disorder to attend. Another young person was supported to achieve their wish to undertake a car valeting "business", they had been granted section 17 leave to wash the hospital car.

Staff supported children and young people to understand and manage their own care treatment or condition. We saw in records that young people were involved in their care plans.

Child and adolescent mental health wards

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

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. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the wards and the services as part of their admission.

Staff involved children and young people and gave them access to their care planning and risk assessments. We saw evidence of this within the electronic patient records and young people we spoke with told us they felt involved in their care and listened to.

Staff involved children and young people in decisions about the service, when appropriate.

Young people could give feedback on the service and their treatment and staff supported them to do this. Staff held weekly community meetings on the wards. Staff followed up requests and fed back to the young people. The young people could give feedback on the service and their treatment and staff supported them to do this. We reviewed minutes from the previous 3 weeks. We saw examples of suggestions raised by young people and what actions had been taken. For example, young people had suggested social events such as a Pride event and a Prom. Other topics raised by young people included food choices, activities and use of phones and laptops. We saw that actions had been taken because of feedback for example, a blender had been purchased for Jasper ward; takeaway budget had been increased and a request for a ward pet, staff suggested exploring sponsoring a pet (WWF, London Zoo etc) as an alternative.

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

Staff made sure children and young people could access advocacy services. We saw an example of a quarterly advocacy report on topics that advocates have helped young people with.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers.

We saw from records that care plans included a section “keeping connected” where staff encouraged young people to maintain family relationships.

We saw examples of CPA reviews, where family could attend, should they choose to.

Child and adolescent mental health wards

Carers told us they were invited to ward rounds and mostly felt involved in care.

We viewed minutes of the last 3 carers forum meetings where carers had the opportunity to feedback on services, make suggestions and raise questions. Examples of issues discussed included activities, education and staffing updates.

However, 1 carer told us they felt that communication with staff could be improved as they sometimes got differing responses.

Two carers told us that the service should offer more staff training on autism.

Staff helped families to give feedback on the service.

The provider had launched a co-production event in June 2023 where families and carers were invited to attend to share ideas to help improve services for young people.

Is the service responsive?

Good 

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

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Managers made sure bed occupancy did not go above 85%. The average bed occupancy rate was 65%.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. The average length of stay for all young people was 8.1 months. At the time of inspection there was 1 delayed discharge. This was due to delays in finding an appropriate placement in the community.

The service routinely accepted young people from across the UK and so some young people were far from home. At the time of inspection, the service had 8 out-of-area placements.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned.

Children and young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest.

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

Child and adolescent mental health wards

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed and took action to reduce them, where possible.

Children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. We saw clear and individualised discharge plans in young people's records. Staff involved commissioners and community teams in discharge planning.

Staff supported children and young people when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom 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 young person had their own bedroom, which they could personalise. Bedrooms were en-suite.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had a laundry, dining area, quiet room and communal living space.

The service had quiet areas and a room where children and young people could meet with visitors in private. Visits could also take place in the outdoor courtyard/ gardens.

The young people could make phone calls in private using the wards mobile phone.

The service had an outside space that children and young people could access easily. However, the outside courtyard space was small and uninviting. Managers told us there were plans in place to improve this and we saw plans to redesign outdoor space was an action on the risk register.

Children and young people could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Young people were able to make choices and suggestions about food.

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 wards.

Child and adolescent mental health wards

Staff made sure children and young people had access to opportunities for education and work, and supported them.

Staff supported the young people with activities outside the service and made sure young people had access to education throughout their time on the wards. There was a school on site and teachers also attended the wards to provide 1-to-1 education. Young people took part in GCSE qualifications or a functional skills qualification.

The service had job descriptions in place for young people to have job roles. This included, for example café assistant; magazine assistant; therapy orderly and ward cleaner.

Staff helped children and young people to stay in contact with families and carers. We saw from records that care plans included a section “keeping connected” where staff encouraged young people to maintain family relationships. There was evidence that young people had regular contact with families and carers. Family therapy was offered and there was a support group for carers.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain.

Managers made sure staff, children and young people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people.

Young people had access to spiritual, religious and cultural support. Young people could access and attend the local church and staff could facilitate leave and attendance to other local places of worship.

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.

Managers investigated complaints and identified themes. They categorised, analysed, reviewed and acted upon complaints. They maintained a complaints log. We reviewed the log and found that between July 2022 and July 2023 the service had received 3 formal complaints. All 3 complaints related to clinical care. Of the 3 complaints, 1 was not upheld and the other 2 were partially upheld. Actions taken were clearly recorded.

Child and adolescent mental health wards

We saw from meeting minutes that both formal and informal complaints and actions taken as a result were discussed at monthly clinical governance meetings.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

The young people and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and young people and their families received feedback from staff after raising a complaint or giving feedback.

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. For July 2023 Jasper ward had received 14 compliments and Opal ward had received 16. Managers reviewed themes and used feedback to inform improvements and service delivery.

Is the service well-led?

Good 

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

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 young people, families and staff.

Leaders had the skills, knowledge and experience to perform their roles. They understood the issues, priorities and challenges the service faced and managed them.

Staff said leaders and senior managers were approachable, helpful and supported them in their day-to-day work. Managers were visible in the service and knew the needs of the service and the young people using the service in their care.

Staff told us that managers supported them to develop and there were good opportunities for career progression. The provider gave staff the opportunity to develop their leadership skills through a leadership pathway programme.

Staff told us that managers were visible and approachable. Senior managers took turns to visit the wards out of hours. The hospital director held monthly lunchtime meetings with staff and shared a monthly newsletter with staff. We observed young people engaging with managers during our on-site visit.

Vision and strategy

Child and adolescent mental health wards

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

The service had a set of 3 values. These were Best Care, Best People, Best Place.

The provider has set out their strategic aims and nursing strategy for 2023 to 2028.

Staff had the opportunity to contribute to discussions about the development and strategy of the service.

Culture

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

Staff we spoke with told us they felt, respected, supported and valued. They said it was a great atmosphere to work in and that there was good teamworking amongst colleagues.

We viewed a hospital wide culture and whistleblower report for June 2023. Staff had been interviewed and they described the wards as a “good and happy place to work” and staff described themselves as feeling “empowered”. Managers had identified themes, trends and actions on a range of feedback, that was mostly positive.

Staff were supported by a well-being service. The service had recently held a wellbeing event for staff that included games and prizes.

Some staff we spoke with told us that they accepted that being injured whilst at work was “part of the job”. We saw that managers reviewed and analysed data about aggression towards staff. Data from June 2022 to July 2023 showed that the number of incidents of aggression towards staff had varied from month to month but overall, the average was approximately 4 or 5 incidents per month. In the past 12 months there had been 1 serious incident of aggression and violence against staff that was reported to the police. Managers took action to learn lessons; we saw an example of where a staff member had been injured preventing a young person from self-harming on Jasper ward. Managers immediately held a de-brief and offered support to staff. We saw in staff meeting minutes that well-being checks were routinely discussed, and managers encouraged staff to report all incidents of violence and aggression against them. All staff we spoke with told us they felt very well supported by management following incidents.

There was a dedicated Diversity Equality and Inclusion team within the hospital. Staff undertook equality and diversity training, and this was promoted in their day-to-day work. At the time of inspection 98% of staff had received Diversity, Equity and Inclusion training.

Staff and young people had recently celebrated PRIDE month in June 2023 with themed events and activities. This included a drag show which was co-produced with young people, “paint a brick” a pride colour of choice (this activity cost £1 and the money was donated to charity) and the entrance rails at the hospital site were painted with PRIDE colours.

We viewed an email to staff promoting the use of gender inclusive language and a bulletin on “The importance of using gender affirming language when delivering trauma informed care”.

Child and adolescent mental health wards

Staff told us that they felt comfortable to raise concerns without fear and were encouraged to do so. Staff were aware of the Freedom To Speak Up (FTSU) policy. There were posters in the wards and on staff laptops to signpost staff to contact details.

Staff told us they had not experienced any bullying or discrimination at work.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Systems were effective in ensuring that wards were clean and safe. There were always enough adequately skilled staff on shift who were regularly supervised and supported in their roles. The service had a structure in place to support the overarching governance framework. This included staff meetings, monthly clinical governance meetings and monthly organisational governance meetings. The monthly clinical and organisational governance meetings recorded a rolling list of actions, that described the issue, risk and detailed mitigations or action to be taken. We viewed minutes of meetings and found that key information such as, health and safety, audits, complaints, incidents and staffing matters were regular agenda items for discussion. Minutes also noted action to be taken as a result. Any issues needed to be escalated were raised to the regional clinical governance group.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff participated in clinical audits and acted on the results.

Management of risk, issues and performance

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

Managers had ensured that systems and processes were in place on the wards to keep young people safe. This included environmental checks, patient searches, clinical risks assessments and risk management plans.

Managers recorded, monitored, and managed risks and issues within a hospital wide local risk register. Risks had been rated according to their severity. Mitigations had been put in place across all identified risks.

We saw the service's annual audit schedule. This included essential topics such as safeguarding, complaints, ligatures, reducing restrictive practices and dealing with a medical emergency.

Information management

Managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and people's care.

Patients' confidential personal information was stored securely.

Staff had the technology required to carry out their role.

Child and adolescent mental health wards

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 from the service participated actively in the work of the local transforming care partnership.

The service engaged well with young people, staff and external partner organisations. Staff, young people and carers could access information about the work of the provider through the intranet, bulletins and newsletters. The young people and their carers had the opportunity to give feedback on the service. Managers reviewed all feedback. Staff could make suggestions via “you said, we did”.

The service conducted annual service user and carers experience surveys.

Learning, continuous improvement and innovation

In March 2023 the service underwent an external closed culture audit. “Developing and maintaining a culturally open service”. The inspection assessed performance on the following 6 sections:

- Poor Experience of Care
- Use of Restrictions and Restraint
- Physical Environment
- Poor and Weak Management
- Lack of External Oversight

The inspection found that the service was “low risk” and had performed better across all sections compared with the previous year.