South London and Maudsley NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

Trust Headquarters
1st Floor Admin Building
London
SE5 8AZ
Tel: 02032286000
www.slam.nhs.uk

Date of inspection visit: 28 September 2023
Date of publication: 22/12/2023

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Child and adolescent mental health wards

Inspected but not rated

This was an unannounced focused inspection of the child and adolescent mental health services' (CAMHS) psychiatric intensive care unit (PICU) ward at the Bethlem Royal Hospital. The CAMHS PICU inpatient service offers assessment, management and treatment for children and young people aged 12 up to their 18th birthday. The ward can accommodate up to 7 male and female young people. At the time of the inspection, the ward had reduced their admissions and was only admitting up to 3 young people.

We carried out this inspection to see if improvements had been made following a serious incident which occurred on the ward in June 2023.

During this inspection we looked at the safe, effective and well led domains. We did not rate the service at this inspection as we only inspected one ward - the CAMHS PICU. We did not inspect the other child and adolescent mental health wards provided by the trust.

We found:

- The clinic room was not well maintained. Staff did not always ensure medicines were stored properly or in date. Assurance processes including medicines management audits had not identified the need for improvements.
- Simulation training to support staff to know how to respond in a clinical emergency did not appear to help individual staff understand clearly how they needed to improve to perform this role competently. This did not provide assurance that staff felt confident and would be able to respond to a medical emergency.
- Learning from incidents was not routinely discussed at team meetings to ensure learning was shared although staff had access to reflective practice sessions.
- The service needed to improve some areas of the ward environment. For example, an up-to-date ligature risk assessment was not kept in an accessible area for all staff to use. The ward did not have a designated female lounge to comply with mixed sex accommodation guidance.

However, we found several areas of good practice:

- The ward had enough nursing and medical staff to keep the current number of young people admitted safe. Recruitment of nursing staff was ongoing. Staff had received most of the basic training to keep people safe from avoidable harm.
- Young people and family members told us staff treated them with compassion and kindness. Staff understood the individual needs of young people and supported them to understand and manage their care and treatment.
- Staff used the positive behavioural support (PBS) model to understand young peoples' behaviours which challenge.
- Staff reported that morale had improved on the ward. Staff felt able to raise concerns with the wider team and senior managers.

Our findings

Is the service safe?

Inspected but not rated

Safe and clean care environments

The ward was safe, well furnished, well equipped and fit for purpose. However, staff needed to ensure that the ward was kept clean and well maintained.

Safety of the ward layout

The layout of the ward did not allow for staff to have clear lines of sight of children and young people in every area. Staff managed the risk of blind spots through regular safety checks, convex mirrors, observations, and engagement with patients. There was closed circuit television (CCTV) monitoring in communal areas. However, the ward did not display a sign to inform young people and visitors that CCTV was in operation.

Staff completed and regularly updated thorough risk assessments for the ward and removed or reduced any risks identified. The most recent risk assessment audit was completed in February 2023 and all ligature points were identified and scored appropriately. However, a copy of this ligature risk assessment was not stored in the nurse's station and staff did not know where to access it.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The trust had taken steps to reduce the number of ligature points on the ward, by fitting bedrooms and bathrooms with anti-ligature fittings such as collapsible curtain rails and anti-ligature door handles. Staff were aware of the ligature cutters and where to access them.

The ward had an up-to-date fire risk assessment. Young people had a personal emergency evacuation plan if they needed assistance to leave the premises in a fire.

The ward provided mixed sex accommodation but did not completely comply with guidance. All bedrooms were ensuite and staff could separate bedroom corridors into male and female. However, the ward did not have a female only designated communal space.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness, and infection control

Most ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. The ward manager carried out monthly audits of the environment to minimise the risks of infection.

Seclusion room

Our findings

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. A second seclusion room was in the process of being built, this included a de-escalation suite and access to outside space. The works were due to complete in October 2023.

The seclusion room was not in use during the inspection.

Clinic room and equipment

Staff did not always check and maintain the clinic room equipment and medicines. For example, the surfaces were dusty, and medical equipment did not have 'I am clean' stickers displayed to ensure that staff had cleaned them. The pharmaceutical waste bin had not been signed or dated when it was started. This meant there was a risk of expired medicines being diverted.

The clinic room was spacious and included handwashing facilities. The clinic room had emergency equipment including oxygen masks and tubing. This was contained in an emergency response bag, which staff kept sealed to prevent interference between checks. Staff regularly checked the resuscitation equipment and emergency drugs.

Safe staffing

The ward had enough nursing and medical staff to keep the current number of young people admitted safe. However, the trust needed to recruit more qualified nurses before they increased admissions.

Staff received basic mandatory training but the simulation training to support staff to know how to respond in a clinical emergency did not clearly identify where individual staff needed to improve.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. Since July, the trust had reviewed their safer staffing numbers on the ward. The trust had an on-going recruitment programme to fill their vacant positions for registered and non-registered nurses.

The service had reduced their vacancy rates. The ward had calculated their establishment levels according to when they were at full capacity. The ward had an establishment of 29 whole time equivalent healthcare support workers and 11 nurses working. There was only one vacancy for a healthcare support worker, with a further 2 recently being recruited. For the nurses, there was one vacancy for a band 5 nurse and 2 vacancies for band 6 nurses. The trust had just received funding for 2 full time band 7 nurses to work on the ward, the advert for these posts was due to go out imminently.

The ward manager could adjust staffing levels according to the needs of the children and young people. The manager used the trust's 'safer staffing' tool to calculate the number of staff needed for each shift. At the time of the inspection the day and night staffing levels were 2 nurses and 4 healthcare support workers. To prepare for increasing the admissions on the ward, the trust was adjusting the number of registered nurses on the day shift to 3. Additional staff were provided for young people who required a higher level of observation.

The service still relied on bank and agency nurses. We reviewed the safer staffing data for the ward between July – September 2023. For the months of July and August, the ward reported a bank staff fill rate of 32% and for September a

Our findings

fill rate of 30%. The ward reported a small usage of agency staff at 1% and up to 2% in September. Bank staff were being used regularly to cover the vacancies and the 3 band 5 nurses who were not working at the time of the inspection. Nursing staff reported that staffing had improved in the last 6 months, but there was still always a bank staff member allocated on most shifts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The trust created an induction for new starters. Staff read and completed the induction booklet which contained trust policies and important information about the ward.

Levels of sickness were lower. Managers supported staff who needed time off for ill health.

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, even when the service was short staffed. Young people and their families reported that they received their leave. The service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had a full-time consultant psychiatrist and 2 junior doctors working during the daytime. For out of hours cover, the consultant and junior doctors worked on a rota basis. In addition, the junior doctors provided out of hours medical cover in an emergency covering CAMHS specifically.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Overall nursing staff had completed 96% of their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included basic life support (88%), immediate life support (86%), infection control (100%) and fire safety awareness training (97%).

Staff attended weekly emergency simulation training to ensure they knew how to respond in a medical emergency. These sessions had started to be recorded. We reviewed the recordings of these sessions. However, the recordings did not provide evidence of what went well and what areas staff needed to improve on. This did not provide assurances that staff would feel confident and be able to respond to a medical emergency.

The trust provided Seni Lewis training to all permanent, bank and agency staff. This training provides staff with the knowledge and skills in the prevention and least restrictive management of behaviours that challenge in a mental health care inpatient setting.

Assessing and managing risk to children and young people and staff

Our findings

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.

However, staff needed to improve the monitoring of young people's physical health observations.

Assessment of patient risk

We reviewed 2 young people's risk assessments. Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included a patient's physical, mental, and social risk history.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, children and young people. The multidisciplinary team reviewed the risks daily in handover meetings. More detailed risks assessments were discussed in the weekly ward rounds with the multidisciplinary team, taking into account the young person's views on their current risks and behaviours. Staff formulated risk management plans with young people to help reduce their level of risk. Due to the nature of the self-harming incidents on the ward staff developed positive behavioural support plans with the young people to include their early warning signs, triggers and what staff should do if the situation escalated.

However, staff needed to improve the monitoring of young people's physical health. We looked at 2 young people's physical health records. Staff checked patients' vital signs to ensure there was prompt identification of potential physical health problems. The results of the checks were recorded on early warning score charts. Staff used a specific modified early warning score system and undertook these checks daily in the first 72 hours of admission and then weekly (minimum) or more regularly depending on the patient's care plan. For one patient, the observation chart had raised scores on five different dates, and it was not clear what escalation staff had taken. This meant there was a lack of assurance that young people had received the right response to their physical health presentation or condition. We raised this with the trust after the inspection, who told us that this scoring was normal for this individual and did not need to be escalated. However, it was not identified in the young person's care plan.

Staff followed procedures to minimise risks where they could not easily observe children and young people. The multidisciplinary team assessed the level of observation patients required. At the time of the inspection, all the young people were subject to one-to-one observations as they had a high level of risk. This was to reduce the risk of harm to themselves or to others.

Staff followed the provider's policy and procedures when carrying out observations. As part of the ward's improvement plan, all staff had recently undergone competency training for carrying out enhanced observations and engagement with young people. Part of the competency assessment involved demonstrating effective listening and risk assessment skills and the ability to give written and verbal feedback.

Staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Young people were searched when they returned to the ward from leave. Young people had care plans which identified what individual restrictions they had placed upon them, for example, a ban on razors or lighters.

Our findings

Use of restrictive interventions

Staff worked hard to reduce the levels of restrictive interventions placed on young people. Staff participated in the provider's restrictive interventions reduction programme which was overseen by the trust's reducing restrictive practices committee. The ward had a reducing restrictive practice lead and a senior manager within the CAMHS directorate who focused on reducing restrictive interventions. Ward staff attended the monthly reducing restrictive practices CAMHS meeting.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Staff used an approach called 'safer wards' to support young people to regulate their emotions and behaviour. For example, staff used ice packs or weighted blankets to support young people when they were feeling overwhelmed.

Staff received accredited training in carrying out physical interventions. Although this training was not specifically designed for young people. The trust said that the training was directorate focused, which meant the trainer taught specific approaches and techniques relevant to children and young people.

Since May 2023 there had been 18 incidents involving physical restraint. These restraints were low-level holds and mostly attributed to 2 young people. Staff had not restrained young people in the supine or prone position. Staff used safety pods to support with de-escalation.

There had been no use of rapid tranquilisation in the last 3 months.

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 nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff had completed level 1 training in how to recognise abuse in children. However, only 74% of staff had completed level 3 safeguarding children training. The trust said that those staff who had not completed this training were in the process of booking onto the course. Staff also received training in how to recognise abuse in vulnerable adults.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The social worker attended handovers to offer guidance and support on safeguarding incidents.

Staff gave examples of where they had identified a patient at risk of suffering avoidable harm. Records showed staff had reported an incident of abuse where a patient had suffered harm.

Staff followed safe procedures for children and adults visiting the wards.

Staff access to essential information

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

Our findings

Information was available to all relevant staff when they needed it. Staff used a combination of electronic and paper files to store and record patient care and treatment records. These were stored securely on each ward.

Medicines management

Although the service had systems and processes to prescribe, administer, record and store medicines, these were not always effective. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff did not store and manage all medicines safely. For example, we found expired syringes stored with syringes that were in date, some expiration dates were 2020. We found liquid medicine bottles, such as creams and paracetamol opened with no date of opening on them.

We checked the fridge temperature for the months of August and September 2023 and found 2 gaps on 6 August and 4 September, in staff recording of the fridge temperatures. This meant that staff did not ensure that medicines were stored at a safe temperature.

Nursing staff carried out audits of the clinic room. However, these audits did not pick up on the areas of concern we found in the clinic room. Since the inspection, the trust said they will be reviewing the audits to determine their effectiveness.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people, and carers about their medicines. Staff explained to young people and their families when the dosages changed. Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Track record on safety

There had been one serious incident reported by the ward in 2023. In June 2023, the trust reported the death of young person whilst under the care of the ward. The investigation had not concluded yet. However, the trust had completed a fact-finding investigation with actions and learning for staff. Actions included staff correctly observing and engaging with young people in line with their policy.

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 knew what incidents to report and how to report them. Incidents included self-harm, physical restraint and violence and aggression.

Staff were able to tell us about recent incidents and the learning from them. There was evidence that changes had been made because of feedback. After a serious incident in June, senior nursing staff completed a Service Quality Review on the ward to identify areas of improvement. Actions included staff undertaking competency training for carrying out enhanced observations on patients and for staff to use the correct enhanced observation forms as per trust policy. At the time of the inspection, staff had completed the competencies training and the bespoke self-harm awareness training.

Our findings

Managers debriefed and supported staff after any serious incident. Staff said they had opportunities to debrief after incidents and felt supported by management after they had reported an incident.

However, managers did not always ensure that they met with staff to discuss the feedback and look at improvements to patient care. For example, the staff team meeting minutes for July – September 2023 did not show managers discussing with staff the feedback from the serious incidents and the improvements to patient care that had been made.

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. Two parents we spoke to said that staff kept them informed if their loved one had been involved in an incident as soon as practicable.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Is the service effective?

Inspected but not rated

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.

We reviewed 2 young people's care plans. 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 ward.

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

Staff used the positive behavioural support (PBS) model to understand young people behaviours which challenge. The multidisciplinary team and young people contributed to their PBS plans. For example, PBS plans included the young persons' early warning signs and what staff can do if the situation escalates.

Care plans were personalised, holistic and recovery orientated.

Skilled staff to deliver care

The ward team included the full range of specialists required to meet the needs of children and young people. 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.

Our findings

The service had a full range of specialists to meet the needs of the children and young people on the ward. As well as nurses and doctors, there were occupational therapists, a social worker, clinical psychologists and a family therapist.

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. It was recognised that new staff may not previously have worked in mental health services for children and young people. Staff, including temporary staff, had received an updated comprehensive induction to the service, which covered key aspects of caring for children and young people. However, the induction only ran twice a year, which meant staff might have to wait up to 5 months if they had started after the induction date. The trust said they were looking into increasing the number of inductions they facilitated throughout the year.

In addition, there was a welcome pack available to staff joining the team, to prepare them for working in the service. This pack had not been updated in line with the site improvement plan. Since the inspection, the trust had submitted additional information that this welcome pack had now been updated.

Managers supported staff through regular, clinical supervision of their work. At the time of the inspection, 86% of staff had received supervision. Staff said they received supervision monthly and found that it was supportive and helpful.

Staff attended regular reflective practice sessions facilitated by the clinical psychologist. This gave staff a space to reflect on incidents that had happened on the ward.

The ward manager provided agency staff with supervision if they were undertaking regular shifts. For example, where an agency member of staff worked over 10 shifts a month.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings occurred once a month and the ward manager disseminated the minutes for those staff that could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The trust had a framework for testing staff competencies in certain subjects. As part of the site improvement plan, the priority was to ensure that all staff had their competencies in carrying out observations and engagement on young people tested. All staff had received their competency training in this.

Managers made sure staff received any specialist training for their role. After a recruitment drive to cover the vacancies on the ward, new staff were not experienced in children and adolescent services. This included training sessions in the importance of boundaries, working with young people and self-harm and trauma informed care. After a serious incident, senior managers had rolled out a bespoke self-harm training to improve staff awareness of dealing with children and young people self-harm incidents.

Managers recognised poor performance, could identify the reasons and addressed any performance issues.

Is the service well-led?

Inspected but not rated

Leadership

Our findings

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

Since the last inspection in 2016 there had been changes to the children and adolescent mental health service (CAMHS) inpatient service at the Bethlem Royal Hospital. The CAMHS PICU ward had a protocol in place to accept admissions to the ward approved at execuive level. At the time of the inspection there was only 3 young people admitted to the ward, with one young person discharged home that day.

The ward management team had the skills, knowledge, and experience to perform their roles. The service had access to a clinical service lead and matron, who supported the ward manager to carry out frontline tasks such as staff supervision and training. The consultant psychiatrist worked full time on the ward and had extensive experience working in CAMHS inpatient services. The head of nursing and quality had worked for the trust for a number of years.

Staff reported that senior managers were visible on the ward and were approachable. Senior managers such as the head of nursing and quality for the directorate and the matron had oversight of the ward after a serious incident had occurred on the ward. Two extra band 7 nurses were in the process of being recruited to support the ward manager and the band 6 nurses.

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 reported that morale had improved amongst the team on the ward. Staff said they worked well together as a team. The nursing staff felt aligned to the clinical multidisciplinary team and empowered to input into decisions in young peoples' care and treatment.

Since a death on the ward of a young person in June, staff were referred to counselling and debrief meetings were increased to support them. The trust provided bespoke training to staff on self-harming. Staff felt this helped them to better support the cohort of young people on the ward.

The ward had recently attended a team away day to support with team building. Staff valued this and said it was the first time in a long time they had organised a team away day.

Staff felt able to raise concerns. The senior management team were visible on the ward and staff felt able to approach them with any concerns they had. Staff said they received regular supervision and could also speak to senior managers informally about young people's care.

Staff knew about the trust wide Freedom to Speak up Guardian, and the ward had nominated 2 champions for the directorate.

Staff reported that the service promoted equality and diversity in the workplace and provided opportunities for career progression. Development opportunities were available for staff. Staff who were healthcare assistants had been supported into roles such as assistant occupational therapists and registered nurses.

Our findings

Managers dealt with poor performance when needed. The ward manager gave examples of when they had followed the trust's disciplinary processes.

Governance

Our findings demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Overall, the governance of this service needed strengthening and further embedding to ensure the quality and safety of the service. The systems and processes to safely store medicines were not effective. The ward carried out medicines management audits, but these did not pick up on the areas of concern we identified during the inspection. Additionally, a pharmacist attended the ward each week and carried out audits of medicines management. However, it was not clear where these audits were discussed and fed back to the nursing staff for areas of improvement.

The service had a clear framework for what must be discussed at senior management and ward level, but this did not always reflect what was happening on the ward. We reviewed the staff and clinical governance meetings minutes for July – September 2023. Whilst these meetings had a standard agenda to follow, the minutes did not clearly show pertinent issues were discussed. For example, the ward's audits and areas of improvement were not discussed in these minutes. These meetings needed to be more robust to ensure staff were aware of governance processes and could improve.

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.

At the time of the inspection, the service had a site improvement plan in relation to identified areas for improvement. The plans included improving senior management and multidisciplinary team stability, the environment and increasing bed capacity. However, staff had yet to complete some of the actions from this site improvement plan, including sufficient registered nursing staff recruitment.

The service had a local risk register, to which the managers could add risks. Risks included staffing of registered nurses and observations of young people. This reflected the ward's site improvement plan.

Information management

Staff collected and analysed data about outcomes and performance.

The service collected reliable information and analysed it to understand performance. The ward manager collected data on incidents, physical restraints, the environment and safeguarding to identify themes and trends.

The managers could easily access information about the overall training and supervision for staff. The data was readily available on the dashboard showing training for each of the staff team. Managers also used a supervision tracker to see the supervision rates for the service.

Our findings

The information systems were integrated and secure. Information governance systems included confidentiality of patient records. Young peoples' records were kept electronically in a password-controlled database that only staff could access.

Our findings

Areas for improvement

Action the trust MUST take to improve:

- The trust must ensure the simulation training delivered to staff on how to respond to a medical emergency is robust and enables staff to act appropriately when needed. **Regulation 18 (1)**
- The trust must ensure assurance processes identify shortfalls in medicines management to enable staff to make improvements where needed. **Regulation 17 (1) (2)**

Action the trust SHOULD take to improve:

- The trust should ensure that staff complete patients' physical health care in line with trust policy. Staff should ensure that where a young person has an elevated early warning score due to a managed physical health condition, that these are recorded in the young person's care plan.
- The trust should ensure that an up-to-date copy of the ligature assessment is accessible for all nursing staff.
- The trust should ensure that the ward complies with mixed sex accommodation guidance.
- The trust should ensure that staff inform young people and visitors that CCTV is used in communal areas.
- The trust should ensure that the CAMHS specific induction is rolled out regularly to new staff.
- The trust should ensure that learning from all incidents is routinely discussed with the staff team and minutes for the staff team meeting and clinical governance meetings are recorded clearly.

Our inspection team

The team that inspected the service comprised of three CQC (Care Quality Commission) inspectors and a specialist advisor who had experience working in children and adolescent services.

This was an unannounced, focused inspection of the CAMHS PICU ward, part of the child and adolescent mental health wards core service.

During this inspection we looked at the following key questions:

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

Before the inspection visit, we reviewed information that we held about the service.

During this inspection, the inspection team:

• visited the ward, observing the environment and how staff were caring for patients

• spoke with 14 members of staff including the unit matron, consultant psychiatrist (clinical lead) and the head of quality and nursing

• spoke with 1 young person and 2 family members

• reviewed 2 young peoples' care and treatment records

• observed a weekly clinical multidisciplinary meeting and a daily handover meeting

• reviewed other documents concerning the operation 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.

What people who use the service say

We spoke with 3 young people and their families. We received positive feedback from young people and their families about the quality of care they received. Young people said staff treated them well and behaved kindly. One family member specifically praised the family therapist and said they were 'extremely good.'

We attended a ward round and observed that staff spoke compassionately about young people and their loved ones. Young people did not attend their ward rounds but had the opportunity to give written feedback on their care and treatment through the 'have your say' forms. Staff listened to their responses.

Families reported that staff were good at keeping them updated on their child's care and communicated with them regularly. We heard how education staff motivated a young person to complete education courses and attend the school facilities onsite. Now they attended college.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance