Cygnet Hospital Woking

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

We rated Cygnet Hospital Woking as **Inadequate** because:

- Young people had repeatedly self-harmed when on enhanced observation levels and staff had been slow to respond to incidents of self-harm.
- There were a high number of incidents reported in CAMHS and a high use of restraint, of which 10% of restraints were carried out in the prone position.
- Staff in the CAMHS did not possess the experience, skills and competencies to safely manage the complex behaviours of young people in their care.
- Physical health care conditions, including significant weight gain, were not managed effectively on the CAMHS ward.
- Risk assessments in the CAMHS ward did not contain the latest risk factors and the care plan progress was not measured.
- Safeguarding alerts were not always made to the locality authority or CQC when young people were assaulted by other patients.
- Staff on the CAMHS ward did not always log, report or review adverse events. Staff did not manage complaints and issues of concern according to hospital policy. Staff therefore did not always take opportunities to learn from the investigation of incidents and complaints.
- Collectively, the young people felt frustrated, said they were not listened to and felt that staff did not read or follow care plans.
- Lengths of stay on the CAMHS psychiatric intensive care unit ward were not in line with NHS England service specification guidance (no longer than eight weeks). Two young people had been resident for eight months due to delays in transfer to adult services once they had reached eighteen.
- Staff reported that calls for assistance were not always responded to.

However:

- Staff working within the low secure service rarely used physical restraint.
- Staff on the low secure wards, used nationally recognised tools to support their assessment of patients and were actively involved in clinical audit.
- There had been only one delayed discharge in the low secure service in the six months period prior to the inspection.

We found a number of concerns during our visit to CAMHS on Park View First ward. However, the provider was responsive to the issues we raised and took immediate action to address them. The provider has continued to engage with the Care Quality Commission and NHS England to resolve issues and ensure that in the future

Summary of findings

patients will receive care that is in line with the standards expected. The provider closed the ward in question and has undertaken a significant review of staffing and workforce.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good 	
Child and adolescent mental health wards	Inadequate 	

Summary of findings

Contents

Inadequate

Cygnet hospital Woking

Services we looked at

Forensic inpatient/secure wards;

Child and adolescent mental health wards;

Summary of this inspection

Background to Cygnet Hospital Woking

Cygnet Hospital Woking is registered to provide the following regulated activities; treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures.

Cygnet Hospital Woking had a registered manager in place.

Cygnet Hospital Woking provides low secure services for men and women and psychiatric intensive care for young people aged 12-18.

At the time of inspection, there were three wards in use.

Greenacres 17 beds for men, low secure admission, assessment and treatment

Oaktree 11 beds for women, low secure admission, assessment and treatment

Park View First 11 beds, mixed gender, psychiatric intensive care unit for adolescents (PICU)

Park View First ward had, until two months prior to the inspection, provided a step-down facility for young people transferring from two other mixed gender, admission PICU wards on site, which were now closed.

All patients were detained under the Mental Health Act 1983

We have inspected Cygnet Hospital Woking 11 times since registration with the Care Quality Commission (CQC) in November 2010. The last inspection took place in October 2015. At that inspection, we identified some breaches of regulations. The seclusion facilities on the low secure wards were not of a suitable design and layout to keep people safe and the use of seclusion on the CAMHS wards did not conform to the Mental Health Act Code of Practice. We reviewed these breaches of regulation during our inspection. The seclusion facilities on the low secure wards had been decommissioned. Seclusion facilities for young people were available on one of the recently closed ground floor CAMHS wards. Where seclusion had been used, it complied with the MHA Code of Practice.

Our inspection team

Our inspection team was led by Russell Hackett, Inspector, Care Quality Commission.

The team that inspected the forensic inpatient/secure wards comprised four people: two inspectors, one mental health nurse and one expert by experience (someone who has developed expertise in health services by using them or through contact with those using them – for example as a carer).

The team that inspected the CAMHS PICU ward comprised five people: two inspectors, one mental health nurse, one psychiatrist, and one expert by experience (someone who has developed expertise in health services by using them or through contact with those using them – for example as a carer).

A pharmacy inspector and a Mental Health Act reviewer also took part in the inspection and inspected both services.

Why we carried out this inspection

We inspected these services as part of our ongoing comprehensive mental health inspection programme.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

This was an announced inspection.

Before the inspection visit, we reviewed information that we held about the location and met with commissioners of the services.

During the inspection visit, the inspection teams:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service and collected feedback from 16 patients using comment cards
- spoke with four parents of young people from the CAMHS PICU ward
- spoke with the registered manager and managers, or acting managers, for each of the wards
- spoke with 37 other staff members; including doctors, nurses, occupational therapists psychologists and a social worker
- received feedback about the service from an NHS England commissioner
- spoke with an independent advocate
- held two patient focus groups facilitated by Healthwatch , the independent health and social care consumer champion
- held two staff focus groups attended by 22 staff including nurses and support workers
- attended and observed three hand-over meetings and two multi-disciplinary meetings
- visited the wards and spoke with staff and patients during the night shift
- looked at 17 care and treatment records of patients
- carried out a specific check of the medication management on three wards and reviewed 23 medicine charts
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients spoke positively about the permanent staff employed to provide their care. However, they spoke less positively about agency staff who did not always introduced themselves or engaged with patients. Parents of young people reported that staff were generally caring. However, they did not feel that if they raised issues of concern that these were investigated properly and that sometimes ward staff were rude and unhelpful.

Some staff felt that the hospital was a good place to work. Most staff stated that the managers were supportive of them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **Inadequate** because:

- In the past 12 months there had been 24 serious incidents recorded on the CAMHS ward. These included alleged sexual assault, significant self-harm, absconsion, serious medication administration error and failure to return from official leave. The service had not introduced sufficient safety improvements or learning from incidents to prevent repetition of these serious incidents although the Hospital had recently started holding monthly risk management meetings to look at learning and actions from incidents.
- Staff on the CAMHS wards did not protect young people from harm. Young people were occasionally able to breach security and gain access to the ward office which contained confidential information and items that could be used to self-harm. The procedures followed to clean the ward meant that young people had access to potentially harmful equipment and objects. Staff on the CAMHS ward did not follow the provider's engagement and observation policy nor were managers supervising its application. As a result, young people who were on enhanced observation levels had harmed themselves and there had been allegations that patients had been sexually assaulted by other patients whilst on enhanced observation levels. Staff on the CAMHS ward did not review and update risk assessments frequently enough to ensure that they took account of the most recent risk information for each patient.
- We identified incidents on the CAMHS ward that were not reported as safeguarding alerts to the local authority when they should have been. Some incidents which had been raised as safeguarding alerts on datix (an incident reporting system) were dealt with internally when they should have been reported to both the local authority and the Care Quality Commission.
- Restraint was frequently used within CAMHS.
- Staff from all wards reported that they had raised calls for urgent assistance and there had not been a response from staff from other wards.
- In a three month period prior to the inspection, the hospital had covered 464 shifts with bank or agency staff and 110 shifts were unable to be filled by bank or agency staff and therefore the wards were understaffed. This meant that some new staff

Summary of this inspection

were not familiar with the risks and care needs of patients and that on occasions, the wards did not have the numbers of staff that the ward staffing assessment tool had indicated were required.

- On the CAMHS ward, some permanent staff members reported that there were not enough staff working on the ward. Staff told us the ward was unpredictable and that there were only sufficient staff numbers to undertake the basic duties. In addition, staff reported that incidents were higher when staffing numbers were low.
- Staff on the CAMHS ward did not report all incidents that should have been reported. This meant that the service lost the opportunity to investigate and learn lessons from all incidents.

However:

- The low secure wards had enough staff on duty to ensure that patients' needs were met. Patients from the low secure wards said that there were always enough staff available to support them to attend to the local community for their prescribed leave.
- In contrast to the CAMHS ward, the use of physical restraint was very low within the low secure service. The psychology team carried out reflective practice sessions where the multidisciplinary team discussed and formulated responses to support the management of some of the more challenging patients and their behaviours.

Are services effective?

Inadequate

We rated effective as **Inadequate** because:

- Care plans for patients in the CAMHS were brief, lacked substance and did not include measurable outcomes. Although goals were identified there was no progress towards achievement of these goals recorded on the care plans. The care plans were not recovery oriented or focused upon return to a less restrictive environment.
- Care plans for young people did not include whether therapeutic input, either individual or group based, was being provided to the young person to assist with reducing problematic behaviours, such as self-harming. No young person reported having a copy of their care plan.
- Although there was some evidence of monitoring of ongoing physical health problems within the CAMHS, strategies were not in place to manage physical health problems effectively. One

young person had a long-term physical health condition. Whilst this was being monitored by an external specialist team, the day to day management of the condition by ward staff was poor.

- Psychological interventions were offered in isolation on the CAMHS PICU ward and did not guide the daily management and treatment of young people on the ward, for example in the management of self-harm and/or relapse prevention.
- The CAMHS PICU did not ensure staff had specific training to work with young people with complex needs. No nursing staff held specific qualifications for working with young people although the hospital had provided service specific training for all staff as part of their CAMHS PICU induction.

However:

- Within the low secure service, all the patients' notes reviewed had a comprehensive assessment on file completed prior to admission by at least two members of the multidisciplinary team.
- The hospital had implemented the "my shared pathway" tool across all adult wards. This recovery based tool was used well in the forensic services and focused on patients' strengths as well as their risks. All 11 sets care plans on the low secure wards consistently followed this care planning structure.
- Within the low secure service, assessments took place using nationally recognised tools and staff were actively involved in clinical audit.

Are services caring?

Requires improvement

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

- Some young people that we talked with on the CAMHS PICU were unhappy about the attitude and behaviour of staff. Some young people reported being intimidated by some staff. Two young people told us that staff had been unsympathetic and vindictive towards them. We received nine comment cards completed by the young people in the CAMHS service. Five comment cards stated that some staff did not care or respond to young people when they were in distress or when they self-harmed
- The young people from the CAMHS ward that attended the focus group felt frustrated as they were not listened to and felt that staff did not read or follow care plans. Young people also told us that staff did not approach them after an incident to discuss how incidents of self-harm could be better managed in the future.

Summary of this inspection

- Young people from the CAMHS ward told us at interview that they were not made to feel welcome on arrival and had not been given copies of their care plans.
- Parents of young people on the CAMHS ward told us at interview that it was difficult to access information from the ward, or to raise issues of concern. Parents told us they felt ignored by ward staff, some of whom they described as rude and unhelpful.

However:

- On the two low secure wards we observed positive and caring interactions between the staff and the patients. Staff expressed a caring approach when they were talking about the patient group. It was clear that ward staff understood the patients' individual presenting issues and how best to support them on a daily basis.
- All of the patients we spoke to on the low secure wards were very positive about the support and care they received from the staff team at the hospital. Patients felt there were always enough staff available and they felt their needs were being met.
- The eight CQC comment cards from the low secure wards stated that patients felt safe and that it was peaceful on the unit. There were repeated comments that patients felt that the staff were doing a good job in supporting their needs.

Are services responsive?

Requires improvement

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

- In the six month period to March 2017, there had been 37 delayed transfers of care across both services. The main reason for delay was the lack of suitable available beds in specialist services.
- In accordance with the NHS England CAMHS PICU specification, lengths of stay in these restrictive environments should be no longer than eight weeks. Some young people had been on the CAMHS PICU ward for eight months due to the delayed transfers to specialist hospitals and adult services when the young person turned eighteen.
- Young people reported that there were no structured activities at the weekend and some young people told us they were bored.
- Young people were aware of how to complain but they told us they often felt they were not listened to or taken seriously.

Summary of this inspection

- Staff did not handle complaints by parents of young people in the CAMHS in line with the hospital's complaints policy. Some parents told us they now raised complaints directly with NHS England due to the poor response from the hospital.
- Complaints were under-reported and therefore the service lost the opportunity to investigate and learn lessons from all complaints.

However:

- There had been only one delayed discharge in the six month period prior to inspection on the low secure wards. This patient's discharge was delayed due to a lack of availability of appropriate local authority housing provision for the patient's particular needs.
- The wards had small enclosed garden areas. On the low secure wards, patients were encouraged to become involved in maintaining their garden space. We observed patients working with enthusiastic staff members to maintain the ward gardens.
- There was information on how to complain displayed on notice boards and in the patients' welcome packs. The welcome pack explained that detained patients had the right to raise complaints about the Mental Health Act directly with the Care Quality Commission. It also explained how to make complaints and the support available from the advocacy service.

Are services well-led?

Inadequate

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

- Non-permanent staff (agency, bank and locum) made up a large proportion of the work force on the CAMHS ward. These staff did not have regular supervision meetings or appraisals. One permanent senior staff member had not received supervision in the past six months.
- The service did not have systems in place to ensure that there were sufficiently experienced staff in the CAMHS wards at all times to keep young people safe.
- Not all CAMHS staff routinely took part in clinical records audit, environmental audit or infection control audit or report all incidents on the electronic Datix system. Not all agency staff had access to electronic systems for recording purposes.
- The hospital did not have effective processes in place to ensure that all complaints and incidents relating to the CAMHS ward were recorded or investigated.

Summary of this inspection

- The hospital did not ensure that safeguarding procedures were followed by staff on the CAMHS ward. Some incidents of harm to young people recorded on the datix system were not routinely raised as safeguarding alerts and had not been reported to the Care Quality Commission.
- Management and leadership training was not available for CAMHS staff in positions of senior responsibility.
- Staff did not meet their duty of candour obligations as issues of concern were not always raised, recorded or investigated. Staff were not always transparent or gave explanations to young people when things had gone wrong.

However:

- Staff working in the low secure service felt that the operational objectives for the service were positive. These staff had also been involved with recent organisational developments.
- Staff were aware of the local senior management structure and knew who to contact if there was a particular issue with safeguarding, facilities or human resource (HR) issues. The ward managers had a visible presence across the hospital and staff told us they felt that the hospital had a stable management structure.
- All managers collected data in relation to key performance indicators. Managers completed a daily return regarding staffing to the HR department.
- The hospital supported the service user involvement programme by recently completing a comprehensive service user feedback report. A Cygnet People's Council had been introduced. This forum captured patients' views of the service and shared them at senior management meetings.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (MHA) 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

- Ninety per cent of staff had received training on the MHA within the past year. All staff we spoke with were knowledgeable about the MHA, understood their holding powers under the Act and the restrictions imposed on people both on and off of the ward.
- Hospital staff completed a form recording the capacity and consent to treatment interview for detained patients under the age of 16. Consent to treatment forms were attached to medicine cards for all young people.
- All patients were detained under the MHA. Each patient had their rights explained to them on admission and then monthly thereafter. This was documented in case notes.
- The hospital employed a MHA lead who was available Monday to Friday for advice and guidance.
- Legal documentation regarding detention under the MHA was available for scrutiny and appeared correct. An outline approved mental health professional report was available in four of the six files scrutinised. There was evidence that the MHA administration team repeatedly requested copies of these reports.
- The MHA office staff audited all legal documents contained in case notes and the authority to prescribe medication, quarterly. Learning from incidents relating to the MHA audit was cascaded to the ward by means of staff meetings and emails.
- A consent to treatment form was attached to every of medication card for patents on the low secure service.
- Patients had access to generic advocacy, independent mental health advocates and independent mental capacity advocates. Patients spoke positively about the service. Records showed that staff informed patients of their rights of appeal against their detention under the MHA.
- There was information available on the notice boards in the wards regarding detention under section 2, section 3 and section 37 of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff members who worked on the CAMHS ward were aware that the Mental Capacity Act (MCA) did not apply to young people under the age of 16. The decision-making ability for young people under the age of 16 is governed by Gillick competence. This recognises that some young people have sufficient maturity to make some decisions for themselves.
- Staff we spoke with on all wards were generally knowledgeable of the MCA and the wards held a copy of the hospital policy. However, only 43% of staff had completed training in the MCA. The MCA training had been included in mandatory staff training earlier in the year and additional training opportunities were being made available to ensure that staff completed the training.
- Capacity to consent to treatment was discussed in clinical reviews on the low secure wards and recorded throughout care and treatment records. Staff were aware when mental capacity assessments had taken place and where to locate these.
- Clinical staff assessed the young people's capacity (or Gillick competency) to consent to treatment for mental disorder but did not do so for other decisions such as consent to treatment for physical health issues.
- The MHA office staff regularly completed audits of the consent to treatment records.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Good	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

- The layout enabled staff to observe most parts of the low secure wards. There were convex mirrors covering blind spots which enabled staff carrying out observations to see areas of the ward with restricted lines of sight. In areas of restricted line of sight the staff carried out regular zonal observations to ensure that all areas of the ward were regularly reviewed. There was closed circuit television (CCTV) in both wards which could be viewed from the staff office. We were told the CCTV was reviewed after an incident to support the staff to ensure that lessons were learned from the incident.
- There were multiple ligature points on the wards. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff had identified all ligature points using the organisation's screening tool. Staff completed environmental ligature assessments annually. We reviewed a sample of these and saw that identified risks were either rectified or managed using individual patient risk assessments. Staff were aware of the ligature audits and told us they felt able to manage individual patient risks. We saw evidence of safe management of ligature cutters in readily accessible locations. They were stored safely and staff were able to tell us where they were kept if needed. Areas where there were high levels of identified risk were kept locked when not in use to maintain patients' safety.
- Both low secure wards complied with the Department of Health guidance on same sex accommodation as men and women were accommodated on separate wards.
- Clinical staff and senior managers had undertaken a comprehensive review of the environments and the usage of the seclusion rooms on both wards. As a result of this review, seclusion rooms had been decommissioned and were no longer used for this purpose. Staff members felt confident that their new training in the prevention and management of violence and aggression meant they intervened and supported patients before there was a need for physical restraint and therefore seclusion was no longer necessary.
- All areas of the wards were clean and well maintained. We looked at routine cleaning schedules on both wards and spoke with cleaning staff. Cleaning schedules were up to date and were signed off by ward managers. There were regular audits of infection control and nominated staff responsible for infection control to ensure this was kept to a good standard. We saw signs in place on the bathrooms reminding people to ensure they washed their hands regularly and we observed good hand hygiene during medication rounds.
- Ward managers carried out and kept records of regular walk arounds to ensure that equipment and furniture were clean and well maintained. An external company checked clinical equipment to ensure that it was safe to use.
- There were alarms in place throughout the wards and every member of staff had an alarm and a set of keys issued to them from the reception area when they started their shift. The reception and site security staff checked alarms regularly to ensure they were working

and safe to use. Both wards had identified first and second responders on each shift. These staff carried a pager to ensure that in the event of an incident they were able to go straight to the incident.

- Resuscitation and emergency equipment was available on the ward and staff checked this regularly. Emergency medication and maintenance schedules were in date. Clinic rooms were clean and well stocked. Stock items were in date and facilities were available for safe disposal of sharps and waste.
- Both wards had a medication dispensing room. Patients did not access these rooms as they were used solely for the dispensing of medication.

Safe staffing

- The wards had reduced their dependency on agency staff and were now only carrying one vacancy for qualified nurses on each ward. The staffing levels had been assisted by the closure of the two CAMHS wards which had meant more staff were available to work on the low secure wards. Between January 2017 and March 2017, 321 shifts had been worked by bank or agency staff to cover vacancies, sickness or absence. There were 99 shifts during that period where staff vacancies were not covered by bank or agency staff.
- The wards had enough staff on duty to ensure that patients had their needs met and the patients fed back that there were enough staff available most of the time to escort them to the local community for their authorised leave. The staff rotas for the three weeks prior to our inspection showed that minimum staffing numbers had regularly been met across both wards.
- The ward used the organisation's bank of staff which consisted of qualified nursing staff and health care assistants who worked across the organisation and were available to work extra shifts. This meant that the ward was able to call on consistent workers who were already known to the patients and staff to cover staff absence.
- There were enough members of staff trained in the use of prevention and management of violence and aggression (PMVA) to ensure that in the event of an incident suitably trained staff were able to attend to ensure safety was maintained. Ninety-three per cent of staff on Oaktree and 88% of staff on Greenacre were up to date with their PMVA training.
- Ward managers felt confident that they could increase staffing levels when required without having to consult senior staff members to ensure that patients' leave was always facilitated.
- Patients told us they were able to have one to one meetings with their primary nurse regularly and this was reflected in the nursing notes.
- There was appropriate medical cover from the doctors on a rotational basis to ensure that there was medical cover for the wards over the 24 hour period. There were clearly defined on-call arrangements for managers and medical cover across both wards. All staff we spoke to felt this was suitable to meet the needs of the patients.
- Staff were receiving mandatory training and the average training figures for both wards was 85% on Oaktree and 79% on Greenacre, with training lowest in the Mental Capacity Act across both wards.

Assessing and managing risk to patients and staff

- We reviewed 11 sets of care records and risk assessments and found that the formulation of risk for the patients was clearly defined and regularly reviewed. All patients had an HCR-20 (historical clinical risk assessment tool) in place to assess issues relating to historic violent risk. This supported the clinical teams to ensure they were identifying and managing historic risks leading up to the admission. We also saw the use of a tool which supported the protective factors of each patients care called the structured assessment of protective factors. This meant that the clinical teams were not only looking at historic risks but were identifying positive factors shown by the patients to support treatment progress.
- Each patient also had a completed document within their care record known as the Salford tool for assessment of risk. This was a clinically recognised tool that identified the risk triggers for each patient and enabled the staff to support the patient and identify what actions to take to reduce their level of risk.
- Each patient had care plans in place which specifically referenced the patient's individual risks which meant that risk was being regularly identified and reviewed as part of the care planning process.
- There were blanket restrictions in place but these were clinically appropriate for the secure services environment. Restrictions included access to the outside garden space and use of china mugs

Good

Forensic inpatient/secure wards

- On both wards we saw there was a recording system in place to ensure that the observation of the patients was clearly allocated and staff knew who should be supporting which patient at all times throughout the day. There was a clear policy covering personal and room searches and all occasions when searches had been carried out we could see this was documented in patients' notes and on an incident report. Patients and staff were aware of which items were allowed on to the ward and which were considered contraband. There was a clear list available to ensure there was no confusion.
- Safeguarding structures were embedded across both wards with identified safeguarding leads for the wards and an identified safeguarding lead overall for the hospital. Staff had received mandatory training in safeguarding and were aware of the hospital's policy and who to contact. Staff were confident in identifying and reporting abuse and felt that the senior management team would be supportive if they had to raise an allegation.
- Medicine was being safely stored and managed across both wards. Fridge temperatures and room temperatures were being regularly recorded and reviewed by the ward managers. The hospital used an external pharmacist who visited weekly and also carried out regular reviews and audits of the medicine cards and the storage of the medicines.
- The use of physical restraint across the low secure wards was low. All staff had recently been trained in a new style of management of violence and aggression which was based on verbal de-escalation rather than physical management. In the three months between March and June there was a total of 11 recorded uses of physical management of restraint across the low secure wards.

Track record on safety

- There were no serious incidents reported by the hospital in the three months prior to the inspection.

Reporting incidents and learning from when things go wrong

- The organisation used an electronic recording system for recording when an incident happened. This system was called datix and was used to report incidents and near misses, complaints and concerns.
- Staff were aware of how the datix system worked and were able to access the system with their own personal log-in details. Therefore staff were able to effectively report incidents. These reports were reviewed by the senior team and discussed in daily handover meetings and monthly clinical governance review meetings.
- Staff also reviewed datix data in the staff team meetings on a monthly basis. Senior manager attended to discuss incidents and identify lessons learned. The lessons learned report was circulated to all staff and recorded in a specific file held on the ward so all staff were able to read and review the teams comments. Themes in incidents were identified and there was evidence that practice was being adapted to minimise repeated incidents. For example, we saw medication error issues identified and reduced as a result of the introduction of additional medication management training for staff members.
- The psychology team carried out reflective practice sessions on both wards where the multidisciplinary team discussed and formulated responses to support in the management of some of the more challenging patients.
- All ward managers described how debrief was available to staff post-incident, this was confirmed by staff who felt supported by their local and senior managers post-incident.
- Staff reported that they were open and transparent with patients when things had gone wrong. We were told that a patient had missed a hospital appointment because staff were unable to arrange enough cover to facilitate the leave. The patient advised us that they had been given a verbal apology.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Individual needs had been assessed and care and treatment plans were in place to cover the assessed need in all of the 11 sets of care and treatment records that we reviewed.

Good

Forensic inpatient/secure wards

- Multidisciplinary team members had completed provisional assessments of need prior to admission.
- The hospital had implemented the "my shared pathway" tool. This was a recovery tool which was used in forensic services and focused on patients' strengths as well as their risks. All 11 sets of care plans consistently followed this care planning structure.
- All 11 patients had a physical health care assessment in place. Physical health care plans were in place for all patients assessed by staff to have additional physical health concerns. These had been developed by the medical team working alongside the ward staff and the practice nurse. Every patient was registered with a local GP who carried out a clinic on site using the treatment room on each of the wards. The GP ensured that patients were referred to opticians, dentists and the most appropriate local NHS service for their needs. For example patients had been referred to the local diabetic team or epilepsy specialist nursing team.
- Daily care records were held electronically but all other documentation was paper based. The paper based records were easily accessed and kept in good order. All staff knew where paper documentation was kept in the office and were able to access this when required.
- Staff were following National Institute For Health and Care Excellence guidelines in relation to prescribing medication. Where possible medical teams reduced or adapted medication regimes to ensure patients experienced minimal side effects.
- The wards had white boards in the offices which identified the dates that patients' care plans needed to be reviewed so all staff could easily see when they needed to arrange one to one sessions to involve the patients in progressing their care plans.

Best practice in treatment and care

- Staff were using the "my shared pathway" care planning system in place for all patients. "My shared pathway" is a collaborative approach to supporting and developing care which keeps the patient's perspective as the focus of the care.
- Full- time psychologists were allocated to both wards. The psychology sessions offered were focused on cognitive behavioural therapy and dialectical behavioural therapy guidelines.
- Clinical assessments took place using nationally recognised tools including the health of the nation outcome score and HCR-20 which were regularly updated at clinical review and CPA meetings. Occupational therapy staff used the model of human occupation tool. This is an occupation based model that looks at why and how people are motivated to carry out an activity.
- Staff were actively involved in clinical audit on the ward. This included hand hygiene monitoring, seclusion auditing, missed medication monitoring, mattress and pillow assessment audits and national suicide prevention audits.

Skilled staff to deliver care

- The hospital employed a team that consisted of nursing staff, psychiatrists, psychologists, occupational therapists and assistants, with Mental Health Act administration and pharmacy input available on a regular basis. In addition, there were housekeeping staff and administration support based at the hospital. Full time psychologists were allocated to both wards and occupational therapists were available across both wards with support from occupational therapy assistants allocated to the wards. This ensured there was a comprehensive overall timetable of available sessions and activities.
- The staff felt that their training needs were being met both with the statutory training but also with any additional training requirements. Staff had for their own personal and professional development, for example training in the use of the HCR-20 risk assessment tool. The patients told us that they felt that the staff had the necessary training requirements to meet their needs.
- Both wards had regular team meetings and staff felt supported by the local ward management structure in place.

Multidisciplinary and inter-agency team work

- The multidisciplinary team carried out a weekly ward round. Patients were seen by the multidisciplinary team every two weeks and the team had the flexibility to see people more frequently if their level of risk escalated.
- New staff had both an organisational and local induction programme prior to working on the ward. The induction programme included all mandatory training and physical management training.
- The organisation had been through significant change in the six months prior to the inspection and staff felt morale was at a high due to the positive changes introduced.

Good

Forensic inpatient/secure wards

- Staff told us that they felt performance issues were dealt with promptly via the line management structure. The managers felt supported by the human resources (HR) and administration teams because information was made available to them when they needed it and there were organisational policies to guide them.

Adherence to the MHA and the MHA Code of Practice

- The staff we spoke with demonstrated a good knowledge and understanding of the Mental Health Act (MHA) and they told us they had accessed training through the organisation. The hospital's training records showed that 87% of staff on Oaktree ward and 81% of staff on Greenacre ward had completed training in Mental Health Act awareness.
- We saw all of the sets of medication cards had copies of consent to treatment forms appropriately attached.
- There was a full and thorough system for checking that section 132 rights under the MHA were regularly discussed with patients.
- Patients had access to generic advocacy, independent mental health advocates (IMHA) and independent mental capacity advocates (IMCA). Records showed that patients were informed of their right of appeal against their detention under the MHA.
- There was information available on the notice boards in the wards regarding detention under section two, section three and section 37 of the Mental Health Act.

Good practice in applying the MCA

- The staff we spoke with demonstrated a good awareness of the Mental Capacity Act (MCA) and the guiding principles. They were aware of how the MCA impacted on the client group and described how the MCA could help when supporting a patient to manage their finances. However, when we reviewed training figures for the wards we could see that only 53% of staff on Oaktree ward and 38% of staff on Greenacre ward had completed training in the Mental Capacity Act. This training had recently been added to the mandatory training list and additional training sessions were being provided to ensure the local mandatory training target of 75% uptake would be achieved.
- Staff knew how to access the MCA policy and additional information about the Act on the provider's intranet.
- We saw that capacity to consent to treatment was discussed in clinical reviews and recorded throughout care and treatment records. Staff were aware when capacity assessments had taken place and where to locate them.
- All patients within the service were detained under the Mental Health Act and there were no deprivation of liberty safeguard (DoLS) applications required.
- Patients had access to generic advocacy and independent mental capacity advocates (IMCA).

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed positive and caring interactions between the staff and the patients. Staff were courteous and responsive to patients' requests. Staff in the patient areas actively engaged with the patients. Staff expressed a caring approach when they were talking about the patient group and it was clear there was an understanding of the patients' individual presenting issues and how best to support them on a daily basis.
- All of the patients we spoke to were very positive about the support and care they received from the staff team at the hospital. Patients felt there were always enough staff available and they felt their needs were being met.
- The eight CQC comment cards returned stated that patients felt safe and it was peaceful on the unit. There were repeated comments that patients felt that the staff were doing a good job supporting their needs.

The involvement of people in the care they receive

- On admission patients received a welcome pack which covered all the information necessary to support someone new to the hospital environment. The pack identified the key members of the team and the treatments available for patients while they were resident at the hospital.
- When we discussed care plans with the patients, we found they were all aware of their treatment goals and they had discussed their goals with their consultant and key worker. Individual needs were well documented and care plans were orientated towards recovery.

Good

Forensic inpatient/secure wards

- The hospital held community meetings with the patients to gather their views about what was happening on the ward. We saw minutes of these meetings displayed around the service and patients told us they were able to read the minutes if they wished.
- Patients had access to an independent mental health advocacy service and independent mental capacity advocacy. Both services were local to the hospital. There was information available both on the notice boards and in the introduction pack on how to access these organisations.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy for the service in a six-month period prior to inspection was 90%. The service was a regional service and admitted patients from the South of England, although there were some patients from the local area.
- Beds were kept available for patients returning from weekend or transitional leave and patients were moved on to other services based on their assessed clinical needs.
- Patients were discharged to the community or transferred to an alternative hospital placement by arrangement during the working week and at an appropriate time of day.
- There had been one delayed discharge in the six month period prior to our inspection. This patient's discharge was delayed due to a lack of availability of appropriate local authority housing provision suitable for the patient's individual needs.

The facilities promote recovery, comfort, dignity and confidentiality

- There were well appointed kitchens for the patients to access hot and cold drinks and snack items. These areas were well stocked and accessible to the patients 24 hours a day.
- Internet access was available for patients, subject to individual risk assessment, in the occupational therapy-managed internet café.
- The hospital had multiple occupational therapy spaces which were well used by the patient group. These included a crafts/art room, a skills kitchen and a small gym. Many of the patients preferred to attend the local external gym and staff supported these trips.
- The wards had small, enclosed garden areas. Patients were encouraged to become involved in maintaining their garden space. We observed areas of the grounds that were being cultivated by the wards and put to good use by patients growing flowers with support from enthusiastic staff members.

Meeting the needs of all people who use the service

- Patients spoke positively about their regular contact with the chaplaincy service who visited the hospital on a weekly basis or more frequently if required. Patients gave examples of their cultural needs being met such as access to culturally appropriate food and visits to local faith buildings or visits from faith leaders. Contact details for representatives from different faiths were available on the wards.
- Staff received training in equality and diversity and training records showed that an average of 98% of staff across both wards had completed the training.
- Information was available in other languages if needed. Interpreters were used if necessary and the staff were aware of the process for arranging this service. This was not regularly used due to the current ethnic mix of the local population.

Listening to and learning from concerns and complaints

- There was information on how to complain displayed on notice boards and in the patients' welcome packs. The welcome pack explained that detained patients had the right to raise complaints about the Mental Health Act directly with the Care Quality Commission. It also explained how to make complaints and the support available from the advocacy service. Patients said they would complain either directly to staff, or at the daily morning meeting. Staff knew the complaints procedure and felt able to manage informal and formal complaints.

Good

Forensic inpatient/secure wards

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- The wards did not have the organisational vision and values clearly displayed for patients and staff to see. However, staff felt that the operational objectives were positive. They told us they felt connected to the objectives and were involved with the recent developments of the organisation.
- The staff were aware of the local senior management structure and knew who to contact if there was a particular issue with safeguarding, facilities or HR issues. The ward managers had a visible presence across the hospital and the staff told us they felt that the hospital had a stable management structure.

Good governance

- Managers were collecting regular data in relation to key performance indicators using a system called Ecensus. Managers completed a daily return regarding staffing details to the human resources department.
- Ward systems were effective in ensuring that staff received appropriate mandatory and statutory training. There was local guidance to enable staff to undertake their roles effectively. Staff received regular group supervision, had annual appraisals and carried out clinical audits. There were audits available on the ward and easily accessed by the manager who had good oversight of the audits.
- There was a system in place to ensure that mandatory training was regularly reviewed and that staff members were up to date with their training.

Leadership, morale and staff engagement

- Staff felt able to raise any concerns they had with the hospital management as they were approachable and had an open door policy to staff concerns.
- Ward managers felt supported within their line management structure to affect change within their clinical environment. They had sufficient authority to perform their roles effectively including the requirement for authorisation of additional staff and/or expenditure.
- Staff were supportive of each other and reported a positive working environment within the multidisciplinary team. Staff recognised the importance of each other's roles and responsibilities.

Commitment to quality improvement and innovation

- The hospital was committed to reducing the impact of restrictive practices. Restrictive practice recording files were available on the wards. Restrictions were considered at the level of individual care and staff tried to follow least restrictive principles.
- The low secure services were part of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services. The hospital supported the service user involvement programme. The hospital management team had recently completed a comprehensive service user feedback report and had introduced a Cygnet People's Council which captured patients' views and shared these with senior managers.

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- Park View First ward was located on the first floor of a purpose built hospital. When the mixed admission and PICU wards closed due to staff shortages, patients and staff were consolidated within this one ward.
- There was no extra care area or seclusion facility on the ward. A seclusion room was available on one of the closed wards on the ground floor. When seclusion was required, the appropriate level of supervision was provided.
- The ward had poor signage generally, some locked cupboard rooms were not labelled and some staff working on the ward were not aware of the contents of each cupboard.
- The ward was L-shaped with the locked nurses' office at the centre of the ward. There were convex mirrors above the nurses' office to assist staff to see along each corridor. However, the nurses' office had many posters fixed to the inside of the glass which blocked sight lines both into and out of the office. Bedrooms were located along each corridor. Each bedroom had a viewing panel to assist with observation. The ward communal areas were covered by CCTV.
- During the week, the young people attended the on-site school subject to their clinical presentation. The school area was adjacent to the ward area and was supervised by both ward and teaching staff.
- Young people were able to access an outside, secure garden space with escorts.
- A comprehensive ligature point audit had been completed and was reviewed on a three-monthly basis. A ligature point is a fixed or static object that a ligature could be secured to and used for self-harming purposes. The audit highlighted areas where ligature risks remained. Each risk had been rated and a management plan was in place for each separate risk item. For example, the plan stated that doors to non-patient areas including the ward office and ward cupboard doors should remain locked at all times.
- The ward treated both male and female patients. Each bedroom had an en-suite bathroom with a shower, sink and toilet. A separate, locked bathroom with a bath was located near the centre of the ward and was available for use on request. Each corridor was designated as primarily male or primarily female. There was only one young male patient in the service during our inspection. He was accommodated on Park View Ground ward with two nurses in attendance at all times. The ward was therefore, by default, female only during our inspection. There were no separately designated male or female areas.
- The clinic room for Park View First ward was centrally located. It was small but clean and tidy. There was insufficient room in the clinic room for it to be used for clinical examinations. Therefore clinical examinations were conducted off the ward in a larger clinic room. There were regular equipment checks and fridge temperature checks were recorded. Emergency equipment was clearly labelled. All emergency drugs were appropriately stocked and in date and were regularly checked by the ward staff and the pharmacist.

The clinic room fridge key had broken off in the lock. Staff stated this had been reported to the maintenance team and the fridge was replaced during our inspection. The weighing scales had no calibration date recorded and staff were unaware of when the scales were last calibrated. Uncalibrated weighing scales could give an inaccurate reading when monitoring a young person's weight.

- The emergency resuscitation bag and ligature cutters were kept in the nurses' office in the centre of the ward. The office security measures had been breached on multiple occasions. Young people had gained access to potentially harmful items and confidential information in the office because staff had not ensured the office door was closed behind them as they left or entered the room. There were four breaches of office security recorded on the incident reporting and recording system (datix). Two inspectors witnessed a patient gaining access to the office as a member of staff vacated the office.
- Ward areas were mostly clean. However, the locked bathroom contained a bath full of very dirty water. There was no plug in place, the water had not drained away and contained what appeared to be contents from the drain. This was brought to the ward manager's attention in the morning and the problem had been rectified by the afternoon. The furnishings were colourful, of good quality and in good condition.
- Staff were observed adhering to basic principles of infection control. Staff washed their hands frequently. There were no hand gel dispensers on the ward to remove the risk they could be misused by young people. Staff maintained good levels of hand hygiene during the dispensing of medication. An infection control lead had been appointed for the hospital site who was in the process of undertaking a review of infection control procedures and a hospital wide audit although this had not been completed.
- Ward-based equipment appeared to be well maintained and clean. Not all equipment had visible, clean, stickers recording the date of the last maintenance check. The cleaning rotas and records showed that all areas for cleaning were listed and ticked as being cleaned each day. There did not appear to be any supervisory checks in place. Young people reported that their rooms were cleaned regularly but two young people reported that a roll of plastic bin bags had been left in their rooms. One young person reported that their stoma button (a small plastic plug used for keeping a temporary bowel opening on the surface of the stomach open) had been thrown away by the cleaner and a replacement took six weeks to source.
- Prior to the inspection, we had received written concerns from two parents that young people were placed at unnecessary risk due to the cleaning regime on the ward. Parents reported that the ward cleaner swept the clinic area first, then swept the rest of the ward areas before leaving the sweepings unattended to fetch the vacuum cleaner to suck up the sweepings. Young people picked through the sweepings to identify any items that could be used to self-harm. On the first day of the inspection, inspectors observed that the ward cleaner cleaned the ward as described to us by parents and left the sweepings unattended. We reported the concern to the catering manager who supervised the cleaning staff and were assured that this process would be amended immediately to ensure the continued safety of young people.
- Ward staff recorded that they undertook daily environmental risk assessments. This included a tour of the ward and facilities to ensure that there were no breaches of security and that facilities and equipment were in good working order. In addition, on each shift, a member of staff was designated to have lead responsibility for environmental security. Despite these measures, young people had on numerous occasions gained access to ligatures for tying, sharp items for cutting and items to swallow for example, batteries and a tube of glue.
- Staff carried two-way radios to speak with other staff, wards and departments. Staff also carried keys and personal call alarms issued by reception at the start of each shift. There were call button alarms located in each of the rooms on the ward and in school areas. In addition to the ward's own staff who responded to alarms, staff on each ward were designated to be first or second responders to alarms on other wards. It had been reported to us through the whistleblowing process that there were occasions when no staff from other wards attended to alarms raised on the CAMHS ward. We held two staff focus group meetings during our inspection which were attended by 22 staff members. We asked all staff if they had raised alarms and staff from other wards had not attended. Eighteen staff

reported they had experienced this issue. There were also two datix incidents recorded that staff from other wards failed to attend when alarms were activated. The hospital were aware of the incidents and as a result had conducted alarm response tests to monitor the situation.

Safe staffing

- The daily ward staffing levels were established by identifying the individual needs of the young people. The establishment levels for the ward were six qualified nurses and 12 support workers. There were four qualified nurse vacancies and no support worker vacancies at the time of our inspection. The ward operated a minimum staffing number of two qualified nurses and three support workers for the day shift and two qualified nurses and two support workers during the night. Staff worked 12-hour shifts. Due to the levels of observation required on the ward, agency staff were used to add to the minimum staffing numbers.
- From January 2017 to March 2017 143 shifts were covered by bank or agency staff to cover vacancies, sickness or absence. There were 11 shifts during that period where staff vacancies were not covered by bank or agency staff.
- The hospital reported difficulties in recruitment to vacant posts, particularly for qualified nurses. The hospital reported that it managed this shortfall through offering long-term contracts with agency staff who were expected to undertake the same induction and mandatory training as the permanent staff. However, agency staff members we spoke with told us that agency staff no longer held long-term contracts and were given ad-hoc hours of work. This meant that the hospital was no longer required to supply supervision or mandatory training to the staff as this responsibility sat with the agency itself. We reviewed the staffing rotas for the previous three months which identified continuous use of some of the same agency staff.
- The staff gender mix was not always appropriate to ensure that there were sufficient female staff to undertake engagement and enhanced observation of young females. This had led to eight recorded datix incidents where male staff failed to intervene when young females were self-harming as they would not enter the young person's bedroom to remove a ligature or a sharp item until a female nurse was available to witness the intervention.
- The staffing rotas for the three-month period prior to inspection showed that on average, nine staff members worked each shift of which over half were agency staff. More agency staff were used to cover the night shift. Both the ward manager and clinical team lead had the ability to flex staffing levels in accordance with need.
- Some permanent staff members reported that there were not enough staff working on the ward to manage the care needs of the young people. Staff told us the ward was unpredictable and that there were only sufficient staff numbers to undertake the basic duties. In addition, staff reported that incidents were higher when staffing numbers were low and it was difficult to facilitate dedicated one to one time with young people under their care. There was not always a qualified nurse present in communal areas of the ward although senior support workers were generally present. Both staff and young people reported that activities were rarely cancelled. Activity co-ordinators who worked with the occupational therapist planned and facilitated most activities.
- There were not always sufficient staff available to carry out physical interventions if required and assistance was requested from other wards but not always responded to. Hospital staff were in the process of transitioning from the therapeutic management of violence and aggression model to the prevention and management of violence and aggression model (PMVA). The hospital had a transitional plan for the effective completion of the training. The aim of the change in training was to reduce the need for physical interventions. During this transition period there were staff trained in different methodologies of restraint which could lead to patient or staff injury.
- Medical staff were present in the hospital Monday to Friday during office hours and each evening. In addition a doctor was resident and on call for night cover. At weekends there was a doctor on call to respond to emergencies.
- CAMHS staff had received and were up to date with all mandatory training except for Mental Capacity Act

training (which had recently become mandatory) which was below 25%. The hospital reported that the learning and development team investigated the cause for low compliance rates with mandatory training and implemented a remedial plan with the department managers. There was a remedial plan for Mental Capacity Act training and additional training opportunities were being provided.

Assessing and managing risk to patients and staff

- From September 2016 to March 2017 seclusion had been used to confine young people 168 times. Seclusion is the supervised confinement of a patient in a room or area that may be locked to protect others from harm. The highest occurrence of episodes of seclusion was found on Park View Ground ward. This ward had closed two months prior to the inspection. We reviewed care records for young people that had been secluded. The seclusion episodes were recorded and appropriately managed. Seclusion had been assessed as being necessary to maintain the safety of the young person or others.
- During the same period, long-term segregation had been had been used 11 times. Long-term segregation is a practice used to reduce the sustained risk of harm to others by not allowing patients to mix freely with others on a ward. One young person was segregated from others at the time of the inspection and received their care on an alternative empty ward with two nurses in attendance at all times. The care records for this patient were reviewed and confirmed segregation episodes were recorded and appropriately managed. Segregation had been assessed as being necessary to maintain the safety of other young people.
- During this same six-month period, staff had used physical restraint on 839 separate occasions. These restraint episodes had involved 69 different service users across all three wards that were open during this time period. There were 88 incidents of restraint in the prone (face down) position, the majority of which (59 incidents) occurred on Park View Ground admission ward prior to closure. The frequency of the use of restraint had reduced in the three months prior to the inspection. This may have been due to changes in practice or a reduction from three wards to a single ward. However, during this period, the use of seclusion had increased.
- Restraint was regularly used. Ward staff were transitioning to a new model of physical restraint which had an emphasis on de-escalation. Not all staff were trained in this new methodology which could lead to restraints being poorly managed and staff or young people sustaining injuries. There was a plan in place to ensure all staff were trained in the new methodology within the next two months and the hospital had undertaken a risk assessment regarding the transition of training and put a plan in place to mitigate against transition. Prone restraint was taught as part of the new syllabus, we were advised this would only be used as a last resort and for the shortest time possible. There had been 46 (out of a total of 88) occasions when rapid tranquilisation had been an outcome of prone restraint. We reviewed the rapid tranquilisation protocol in conjunction with care notes which recorded that appropriate physical health care checks had been undertaken and recorded.
- The risk of harm patients presented to others was managed through the application of enhanced or constant observation or by removing the young person to one of the previously closed wards, where seclusion and extra care areas were available.
- A CAMHS PICU environment is intended primarily for short stay patients (up to eight weeks). At the time of inspection there were seven young people receiving care and treatment at the hospital. We examined six of the care records. Two young people had been receiving care and treatment at this hospital for eight months, two for five months and two for three months. The service had made referrals to transfer young people but they were delayed especially two young people who had turned eighteen and were awaiting transfer to adult services.
- Each young person had an assessment of risk completed using the Salford tool for assessment of risk (STAR). However, the assessments were not updated following incidents. Staff discussed risks in the weekly multidisciplinary meeting and recorded them on a different form. These forms were not stored in the risk management section of the care plan and there were no risk management plans to accompany this form which rated risk as high, moderate or low. Any new risks identified at this meeting were not incorporated into the formal risk assessments which were updated monthly.

Therefore new or agency staff working on the ward may not be fully aware of the latest risks posed by, or to, young people in their care if relying on the risk assessment Information.

- Due to the nature of the environment, blanket restrictions were imposed, for example, young people did not have access to their own mobile phones but were given a hospital mobile so the young person could stay in contact with family and friends. However, there was an identified least restrictive champion on the ward and a process in place to review blanket restrictions.
- A comprehensive engagement and observation policy was used on the ward. The policy was explicit about the therapeutic benefit of talking with young people at the same time as ensuring young people were kept save through constant observation. However this was not applied correctly or supervised appropriately. There had been four incidents reported of alleged sexual assault and multiple incidents of young people self-harming whilst on constant observation. Young people reported that when some staff members were carrying out constant observations at night, they did not introduce themselves, did not engage with the young people and spoke about them in a foreign language which made them feel unsafe.
- Staff searched young people on return to the ward if they had been on unescorted leave or home leave. Searches were conducted in accordance with the policy. Young people were made aware of the search procedure and there was a list of contraband items of risk displayed on the ward. Young people were able to use items of risk, for example scissors, under supervision. When not in use these items were locked away.
- Staff had received and were up to date with training in safeguarding of young people. However, through the review of reported incidents, we identified seven occasions when incidents should have been raised to the local authority as safeguarding alerts. For example, there had been incidents of patient on patient assault. Safeguarding concerns were reviewed internally before a decision was made to raise an alert with the local authority. There were incidents within the internal safeguarding log where alerts should have been made to the local authority but were dealt with internally. The Care Quality Commission was not informed of safeguarding incidents that were not reported to the local authority.
- Medicines were dispensed from the clinic room. We observed a medication round. The qualified nurse identified the young person and informed them what medication they were receiving. The expiry dates of the medications were checked and the qualified nurse checked that the young person had taken their medication. The medication charts were appropriately signed and the qualified nurse was able to describe the medication error procedure. However, there had recently been a serious incident whereby a member of staff had dispensed a dose significantly above the maximum daily dosage. The young person required hospitalisation, constant monitoring and withdrawal of all medication. Drug administering competency assessments had been introduced by the hospital to improve practice in response to this incident.
- At inspection, medication was stored appropriately. Ward nurses ordered stock medicines and named patients' medicines via an online ordering portal. In addition, a pharmacist visited weekly to check the clinic room on the ward and to screen and audit medication charts as well as checking completion of monitoring forms. Any issues identified were communicated with the prescriber using the electronic system (Liveview) which maintained a log of issues raised. This system could be used to print off reports.

Track record on safety

- There were 24 serious incidents recorded in the past 12 months, these included alleged sexual assault, significant self-harm including swallowing of batteries, cutting and ligature tying, absconsion, a serious medication administration error and failure to return from official leave.
- The provider had introduced medication management competency assessments in response to the medication error. There were no other discernible safety improvements or learning outcomes seen following the other incidents. There had been repetition of serious self-ham incidents and alleged sexual assault whilst young people were under constant observation.

Inadequate

Child and adolescent mental health wards

Reporting incidents and learning from when things go wrong

- We reviewed all datix incidents associated with the young people on the ward from the time of their admission until the time of inspection. In all 732 incidents were reviewed. Staff reported that they knew what to report and how to report. However, agency staff did not always have access to the datix system and therefore were unable to record incidents. In addition, we found incidents recorded in the contemporaneous care notes that had not been recorded on the datix system. The incident concerning the cleaner who disposed of the young person's stoma button was recorded in the care notes but not logged as an incident. The parents we spoke with told us that on many occasions they had reported incidents to staff and requested feedback as to how these incidents would be better managed in the future, but this had not been forthcoming.
- There was a process in place for staff to receive feedback following the investigation of incidents which included a monthly ward-based forum to review incidents and lessons learned. However, as there was an under reporting of incidents, opportunities for lessons learned were compromised. Staff reported that improvements arising out of incident reviews consisted of changes to care plans and increased vigilance and awareness. There was however, no discernible evidence of positive procedural changes arising from feedback as incidents continued to be repeated. One permanent staff member reported that post-incident debriefing had declined to the point of being non-existent.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We reviewed six care records. All care records demonstrated that following admission to the hospital, nursing staff had completed care plans in conjunction with the young person. The care plans were modularised with generic domains, for example, my mental health and staying safe. Overall, the care plans were brief, lacked substance and did not include measurable outcomes. Although goals were identified, for example 'I want to get out of hospital' there was an absence of information with regard to how the young person would be helped to achieve these goals and no progress towards achievement recorded on the care plans. The care plans were not recovery oriented or focused upon return to a less restrictive environment.
- Care plans did not include whether therapeutic input, either individual or group based, was being provided to the young person to assist with reducing problematic behaviours for example, self-harming. Not all young people had positive behavioural support plans in place and we were not able to see if young people had been given a copy of their care plans. Some young people interviewed reported that they had been involved in care planning, others not. No young person reported having a copy of their care plan.
- Medical staff had completed a physical examination of patients at or shortly after admission to the ward. Whilst there was evidence of some monitoring of ongoing physical health problems, strategies were not in place to manage physical health problems effectively. Young people reported significant weight gain that had not being managed. Young people with excessive weight gain had not been referred to or been seen by a dietitian although the practice nurse was available to provide dietary advice through the physical health promotion programme. Parents reported that ward staff offered no advice or guidance to young people who had gained weight and allowed the purchase and consumption of high sugar content foods and drinks. One parent described how their daughter whilst on enhanced observations, routinely put five heaped tea-spoons of sugar in her hot drinks without comment by the observing staff member.
- Care plans were completed on one paper document, risk assessments on another, multidisciplinary meeting outcomes on a further paper document whilst the care notes were recorded electronically. Therefore, it was difficult to find the latest information in the care plans. Some staff reported that they were reliant upon the information given at handover to manage the young person's care and would not access care plans during the shift.

Inadequate

Child and adolescent mental health wards

Best practice in treatment and care

- We reviewed five medicine charts. All prescriptions were signed and dated and PRN (occasional use medications) indications were specified. All administration boxes were completed. No young people were prescribed more than one antipsychotic medicine. The number of regular medication prescriptions ranged from three to eight per service user.
- All medicine charts had the start date of the medication specified as the start date of the new prescription chart. This was inaccurate and made it difficult for staff to keep track of the length of the prescription as the actual start date of the prescription was not recorded. This practice meant that the clinical staff could not easily monitor the possible long-term use of some medication. In addition, medications used to assist with sleep are only licensed for young people's use for up to four weeks. There was no record of the rationale for off-license use of medicines. For one young person, variable indications were specified for the use of anti-psychotic medication on different dates, for example mood disorder, auditory and visual hallucinations, agitation. It was not clear what the rationale for use of this medication was, and what symptoms the multidisciplinary team were trying to target. This lack of clarity made it difficult for the multidisciplinary team to identify outcomes from some medicines and may have given mixed messages to the young person concerned.
- One young person had a documented serious adverse effect from one medicine. However, this was still being prescribed and administered. This was brought to the attention of the medical team during the inspection but remained unresolved.
- Young people had access to a range of psychological therapies. These were provided on an individual or group basis. Psychological interventions were offered in isolation and did not guide the daily management and treatment of young people on the ward, for example in the management of self-harm and/or relapse prevention.
- The hospital employed a qualified practice nurse to oversee the physical health care needs of the young people. A GP from a nearby surgery visited the ward weekly. Appointments with the GP were made by the practice nurse. There was regular screening for physical health conditions and in addition the GP referred young people to specialist services as required. Ward staff routinely completed modified early warning scores (MEWS) each week for the young people. This consisted of checks of temperature, pulse and blood pressure; however weight was not recorded routinely for all young people.
- One young person had a long-term physical health condition. Although this was being monitored by an external specialist team, the day to day management of the condition which was the responsibility of the ward staff was poor. A brief invasive clinical procedure was required to be completed every two days to manage the condition effectively. Failure to complete this procedure regularly could lead to life-changing surgery. The young person had been trained to perform the procedure themselves. In addition, two ward staff had also been trained to complete the procedure if the young person was not managing the condition effectively. On examination of the treatment record, this procedure had only been completed four times in the past nine weeks. This was brought to the attention of the ward doctor, the ward manager and the practice nurse who amended the physical health care plan immediately. On a separate occasion, a medication intended for cleaning an area of the body had been dispensed incorrectly.
- Staff had completed the health of the nation outcome scales for each young person. This assessment had not been repeated in the care notes that we reviewed and did not inform care planning. It was difficult to identify what outcome measures if any were being used to measure the severity of symptoms and progress towards achieving care plan goals.
- Infection control audits had been carried out on a quarterly basis by internal infection control leads. The use of seclusion, segregation and restraint were also audited on a monthly basis. The monthly management of medication audit was completed by the external pharmacy contractor.

Skilled staff to deliver care

- An interim medical director had recently been appointed. The ward had one consultant psychiatrist and a ward doctor. There was a locum occupational therapist who worked Monday to Friday and an activity co-ordinator who worked weekends. In addition, there was a locum social worker, two part time psychologists

and one psychology assistant who worked full time. The provider employed a practice nurse who covered all wards in the hospital. Staff had experience of working with young people. However, few staff had previous experience of working in a young person's PICU environment.

- No nursing staff held specific qualifications for working with young people but had attended a service specific induction for working on CAMHS PICU.
- Some staff had completed a 14-day induction programme, four days of which was self-directed learning including e-learning. The training was focused around components of mandatory training, policies and procedures. New support worker employees were given 13 weeks to complete the care certificate training. Staff reported that they were not able to complete the training during work time, had no access to the training materials at home and were threatened with disciplinary action for failure to complete the training.
- Training did not address the development of skills-based competencies required to work effectively and therapeutically with young people with complex presentations. There was not an ongoing programme of training other than mandatory training.
- Permanent staff were in receipt of regular supervision. Supervision was not routinely available for agency staff. Sixty per cent of permanent nursing staff on the ward had completed an appraisal within the past 12 months. There were regular team meetings held at ward level.
- At the staff focus group, it was reported that poor performance was managed with suspension and dismissal. Staff stated that fear of allegations being made against them was the main underlying factor for poor responses to alarms from staff on other wards called to attend the CAMHS ward.

Multidisciplinary and inter-agency team work

- We observed a multidisciplinary review of young people's care. This was well led by the consultant who encouraged the rest of the multidisciplinary team to contribute. Care plans and risk assessments were reviewed and each young person was invited to attend. It was noted that the nurse attending did not give any feedback as to the young people's current presentations on the ward and did not contribute to the discussion.
- Each morning, there was a handover to the senior management team which included a brief review of each young person, a report on incidents that had occurred, a review of staffing numbers and a plan for the day. The meeting enabled senior staff to have an awareness and oversight of how the ward was being managed. All staff appeared to have a good knowledge of each young person. However, some staff spoke in quite dismissive and negative ways regarding some of the young people.
- Monthly integrated governance meetings were held, chaired by the hospital manager, and included representatives from the wards, other multidisciplinary team members and the clinical services manager. This meeting reviewed complaints and compliments, safeguarding, serious incidents, use of restraint and seclusion, infection control and a report from each service.
- We observed a shift to shift handover; this included a brief review of the young people, recent incidents, a review of risk and allocation of staff to roles.
- External staff, including care co-ordinators, were invited to attend formal reviews of care. It was reported that attendance was inconsistent which may have been due to the geographical distance staff were required to travel to attend. The CAMHS social worker was responsible for liaising with local authorities and attended monthly safeguarding meetings. The social worker was also responsible for liaising with parents.
- A GP service was available weekly on the ward and at other times at the nearby surgery. GP appointments were managed by the practice nurse.

Adherence to the MHA and the MHA Code of Practice

- Staff received training in the Mental Health Act (MHA) which was provided by the MHA lead for the hospital. Ninety-five per cent of staff had received training on the MHA within the past year. All staff we spoke with were knowledgeable of the MHA, their holding powers under the Act and the restrictions imposed on young people both on and off of the ward.
- Consent to treatment forms were attached to medicine cards for all young people.
- All young people were detained under the MHA, each young person had their rights explained to them on

admission and then monthly thereafter. This was documented in case notes. However, there was no evidence that patients had their rights explained to them at others times as required by the Code of Practice, for example, following renewal of detention.

- The hospital employed a MHA lead who was available Monday to Friday for advice and guidance.
- Legal documentation regarding detention under the MHA was available for scrutiny and appeared correct. An outline approved mental health professional report was available in the two of the three files scrutinised. There was evidence that the MHA administration team requested copies of these reports.
- The MHA office staff audited all legal documents contained in the young person's case notes and their medicine cards quarterly. Learning from incidents relating to the MHA audit was cascaded to the ward by means of staff meetings and emails.
- Young people had access to an independent mental health advocacy service, the advocate visited the ward weekly, and some young people spoke positively about using the service. Staff also knew how to contact the service.

Good practice in applying the MCA

- Not all staff members who worked on the CAMHS ward were aware that the Mental Capacity Act (MCA) did not apply to young people under the age of 16. For this group of young people, the decision making ability is governed by Gillick competence, this concept recognises that some young people have sufficient maturity to make some decisions for themselves.
- Staff we spoke with were generally knowledgeable of the MCA and the ward held a copy of the hospital policy. Mandatory staff training had been introduced earlier in the year and additional training opportunities were being made available to ensure that staff had completed the training.
- Issues of capacity or Gillick competency were taken into account in relation to consent to psychiatric treatment, but not in relation to other decisions, for example those decisions relating to treatment for physical health issues.
- The MHA office staff regularly completed audits of the records for consent to treatment. Some young people reported that staff were supportive in assisting them to understand elements of their treatment to enable them to make better informed decisions.

Are child and adolescent mental health wards caring?

Requires improvement

Kindness, dignity, respect and support

- We held a patient focus group facilitated by Healthwatch and four young people chose to attend. In addition we spoke with four young people on an individual basis and conducted telephone interviews with four parents.
- We observed staff interactions with young people on the ward, off the ward and during education and activities. Education staff encouraged the young people and gave positive feedback for effort made however small. Most staff engaged appropriately with the young people when required. It was noted that certain staff were targeted by young people who made numerous requests of them. Other staff were often ignored or did not actively engage with young people. We saw practical support being offered but we did not witness emotional support being given even after incidents.
- We spoke to five young people and asked if they felt that the staff were caring. Whilst there was agreement that most staff were caring, young people wanted to also share their negative experiences of some staff. Young people told us they were intimidated by some staff and alleged that they had been told, for example, 'your parents have left you', 'you are a badly behaved little girl', you will do things our way' and 'you will leave when I tell you'. One young person reported that a male agency staff member stated 'your health does not concern me, if I broke your arm it doesn't matter'. Another young person reported that agency staff were awful and that staff bore grudges against them. They described an incident where they were being assaulted

by another young person and told not to scream or they would be killed. The young person was later chastised by the staff member for not screaming for help and stated it was their own fault.

- Another young person who reported hearing voices at the time had hit a staff member. When more settled, the young person tried to apologise for their behaviour and was told not to apologise as they had done this before, and their apology would not be accepted. Another young person who was self-harming through banging her head against the wall reported that she was told she was selfish as this behaviour triggered similar behaviour in others.
- We reviewed the comment cards completed by the young people on the ward. One young person stated they were not treated well by the staff member when on enhanced levels of observation, as 'he did not come into my room to help me when I was tying a ligature round my neck'. A further completed comment card read that male staff 'never care and don't prevent incidents and they don't communicate with us when we are struggling'. However, another comment card read that the activity co-ordinators always listen and are very caring.
- The young people at the focus group said they felt frustrated as they were not listened to and felt that staff did not read or follow care plans.
- Permanent staff had a good knowledge of each young person's care plan and risk assessments. Education staff were included in morning handovers and were supported by ward staff in the classroom. Agency staff were less familiar with the individual needs of the young people and the application of strategies to prevent them from serious self-harming episodes. Young people reported that staff did not approach them after incidents to discuss how incidents of self-harming could be better managed in the future.

The involvement of people in the care they receive

- Two young people reported that they were not made aware of where they were going to prior to arriving at the hospital. Young people reported that they were not made to feel welcome on arrival. One young person described being shown around the ward and shown their bedroom. No young people recalled being given an admission pack containing relevant ward information on arrival.
- Two young people reported being involved in their planning of care and assessment of risk whilst others stated they had not been involved in care planning and were not aware of care plans. No young people reported being given a copy of their care plans. Young people were aware of the weekly multidisciplinary team care reviews and were encouraged to attend.
- Advocacy was provided by an external agency. The advocate visited the ward weekly and engaged well with young people and staff. The advocate planned their weekly visit to coincide with the ward community meeting.
- We spoke with four parents during our inspection about their children's care. All parents reported that they were not as involved in the care of their child as they would wish to be. This was partly due to the distance from home. All parents said they had difficulty in accessing information from the ward and in raising issues of concern. Parents told us they felt ignored by ward staff, some of whom were described as rude and unhelpful. Parents felt they were told of changes to care planning rather than being involved in the process.
- We observed a community meeting which was chaired by a young person and attended by the ward advocate, the hospital manager, the acting medical director, the occupational therapist and nursing staff. Three young people attended. All participants were respectful of each other and all were asked to contribute to a discussion concerning what it felt like on the ward at the moment. Young people concluded that they were more supportive of each other, and focused on attendance at groups.
- Feedback from the service user and parent satisfaction survey completed following formal care programme approach reviews showed a decrease in satisfaction in communication from the CAMHS. The provider concluded that this may have been due to key staff being on leave.

Inadequate

Child and adolescent mental health wards

- Young people interviewed had not been involved in future decisions about their service. Staff reported that ward closures and consolidation to a single ward were not discussed with them and that the whole process was handled badly.

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

Requires improvement

Access and discharge

- Average bed occupancy across all three CAMHS PICU wards had been as high as 87% prior to the closure of Park View Ground ward and Acorn ward in April 2017 and May 2017 respectively. As this hospital provided a regional CAMHS PICU, most young people resident here were not from the immediate local area but from the South East of England which was the designated catchment area.
- The hospital was closed to new admissions at the time of inspection. This decision had been taken in conjunction with the commissioning body, NHS England (NHSE) in April 2017. This decision had been taken due to staff shortages and the reporting of serious incidents of concern
- Young people were not routinely moved from one ward to another unless on clinical grounds. However, the recent closure of wards at the hospital and consolidation of services to the single ward meant that young people had moved across wards as they were closed down. Movements between wards occurred during day time hours when there were sufficient staff present to facilitate them. Discharge or transfers to alternative hospitals were completed during the week at a time pre-arranged with the receiving hospital.
- In a six month period to March 2017, there had been 37 delayed transfers of care (discharge). The main reasons for delay were the lack of available beds in hospitals of both lesser and greater security, lack of specialist placements for people with learning disabilities, eating disorders and autistic spectrum disorder. In addition, local care teams had found it difficult to put together bespoke care packages for people who self-harm. All of these issues had been raised regularly by the hospital manager with the commissioning body.

The facilities promote recovery, comfort, dignity and confidentiality

- Park View First ward had a lounge and a quiet room as well as a kitchen for the young people to use. There was a small clinic room which did not contain a couch for examination. A quiet room could be used to meet visitors. A small room containing a payphone was also available for use. A range of activity rooms and classrooms and a multi faith room were located adjacent to the ward and were well used.
- Young people were not allowed their own mobile phones but were able to use the ward mobile phone in privacy upon request. There were two secure garden areas on the ground floor area available for young people to use. These could only be accessed with an escort and upon request.
- Young people described the food as being of good quality with a choice of either a meat or a vegetarian main meal option. Menu suggestion forms were available on the ward for young people to give the kitchen ideas for choices. There was no access to a nutritionist. The chef researched menu plans and balanced meals through information available on the internet. In addition, young people had access to the kitchen under supervision to make hot drinks and snacks although this was closed at 10pm.
- Young people said they felt safe in their bedrooms and they were able to personalise them. Each bedroom contained an en-suite bathroom. There were lockable cupboards in the bedrooms to secure personal belongings. These were not accessible to the young people.
- Education classes ran between 9.45am and 3.30pm Monday to Friday with a break for lunch. Subjects covered were English, maths, science and art. The classes were not mandatory but the young people were encouraged with incentives, for example, attendance awards, behaviour rewards and access to activities on a Friday afternoon. The hospital provided £100 a week for the activity and the young people planned what they would do or where they would go. Activity co-ordinators

planned additional recreational sessions following education. However, there were no structured activities at the weekend and some young people described being bored.

Meeting the needs of all people who use the service

- Park View First ward was accessible only by staircase, there was a lift on the ward but this was not used as a passenger lift, it conveyed supplies and meals. The ward was not designed to accommodate people with significant physical disabilities.
- All of the young people present on the ward used English as their first language. All information, leaflets and posters were written in English. Some information was available in easy read format. Notice boards contained information on how to make a complaint, rights under the MHA, access to advocacy services, access to psychology and physical health services. In addition, a white board listed the initials of each young person and the member of staff allocated to oversee their care for the shift. Staff reported that there was access to interpreters if required and described how one had been utilised in the past.
- On admission, each young person was provided with a dietary form so that they could note any dietary, cultural, religious requirements or any allergies which were then kept on file in the kitchen. One young person told us they had not been given a form or been asked whether they were a vegetarian or not. A multi-faith room was available to assist with meeting spiritual needs although this was not equipped.

Listening to and learning from concerns and complaints

- In the 12 month period up to March 2017, there had been 72 complaints recorded of which 30 had been upheld or partially upheld. No complaints had been referred to the complaints ombudsman. In the six month period up to June 2017 there had been 12 complaints logged, of these five remained unresolved, seven were upheld or partially upheld and one complaint was not upheld. Two of the unresolved complaints were three months old at the time of the inspection.
- Young people were aware of how to complain. However, they often felt they were not listened to or taken seriously.
- All four parents we spoke to had raised issues of concern on numerous occasions. In line with the hospital policy, these should have been logged, investigated and reported on. This had not happened. Many individual complaints had not been responded to. For example, one parent informed us that they had been waiting 10 weeks for a reply to her complaint about how her child sustained an injury. One parent described how they had raised issues of concern and the hospital failed to respond to them. They said they had waited a week to follow up the concerns raised and nothing happened. Another parent stated they had not received a substantial response to the concerns they raised and that the staff were rude and unhelpful. Some parents said they had stopped sharing their complaints with the hospital as there had been such a poor response and they now raised their complaints directly with NHS England.
- One parent told us they contacted the ward after their child had self-harmed. The parent had wanted assurances that safety issues were being addressed to ensure her child's safety. The parent was asked to put their concerns in writing and they would be responded to within 21 days.
- There was a forum established for reviewing outcomes of incidents and complaints and a process to enable action to be taken with regard to complaints findings. However, as many complaints were not captured in the first instance the opportunities for lessons learned from complaints was severely compromised.

Are child and adolescent mental health wards well-led?

Inadequate

Vision and values

- Senior staff were aware of the values of the organisation and were able to articulate the values and how they were incorporated into their individual working practices. Staff were not aware of team objectives that were based upon these values. Staff generally were

unclear of the future direction of the service and described feeling vulnerable due to the uncertainties surrounding ward closure and closure to further admissions.

- Senior managers attended the ward frequently; the hospital manager attended the weekly ward community meeting. Staff described senior managers as being approachable and supportive.

Good governance

- Governance systems did not ensure that young people were kept safe. Incidents were not always responded to by staff from other wards; this had been reported to senior managers and logged on the datix system but continued to happen. Oversight of staffing rotas did not ensure that there were sufficient female staff to undertake engagement and observation duties of young female patients. There was a high use of restraint including prone restraint. The provider had introduced a new training regime for the management of aggressive incidents which included the continued use of prone restraint.
- Clinical governance processes in the form of multidisciplinary meetings reviewed risk factors for each young person but there was not a process in place to ensure that risk assessments were updated in response to these reviews.
- There was repeated poor application of the engagement and observation policy. Many young people self-harmed, sometimes when they were meant to be on constant observations. This was most prevalent when a male staff member was conducting the observation on a young female patient as there was a reluctance to intervene without a female staff member being present. These incidents were logged on the Datix system and any lessons learned were not put in to practice as incidents continued to occur.
- Senior staff with lead responsibility for safeguarding did not ensure that safeguarding processes and procedures were adhered to in all instances. Harm to young people was not always reported under safeguarding or shared with the appropriate authorities.
- There was not an effective process in place to ensure that all incidents were routinely logged and reviewed, opportunities for lessons learned was compromised.
- Governance systems did not ensure that treatment was effective. Management of ongoing physical health conditions was poor. Concern had been raised by parents to senior managers about young people experiencing excessive weight gain. There had been an inadequate response to these concerns, no young people were referred to a dietitian and regular weight monitoring did not occur but the young people had access to dietary advice through the physical health promotion programme, led by the practice nurse.
- Systems used for care planning did not incorporate a process for recording progress against identified goals. Senior managers did not ensure that all agency staff had access to systems used for care planning and incident reporting. There was no system embedded in practice to ensure staff took part in clinical audit.
- There was not a system in place to ensure that all permanent and agency staff had appropriate competencies to effectively provide care and treatment to young people in a CAMHS PICU environment.
- The governance processes and systems for monitoring the uptake of mandatory training were effective. The uptake and completion of this training was good. Systems had been put in place to raise and improve completion rates for those modules with lower attendance through increased training availability.
- Non-permanent staff (agency, bank and locum) which made up a large proportion of the workforce were not in receipt of regular supervision or appraisal. Systems were effective in ensuring that permanent nursing staff regularly received supervision on a monthly basis. The supervision was recorded as having taken place but the supervision content was not recorded by the supervisor.
- The complaints policy was poorly applied. Complaints and issues of concern were not being routinely captured despite there being a process in place for this. Therefore, there were lost opportunities for lessons learned.
- Governance arrangements were in place for reporting, registering and managing ongoing organisational risks. Although those procedures were in place staff were not always following them. The hospital risk register drew risks from core services and was reviewed monthly. Staff were able to submit items to the risk register which rated the level of risk, controls were identified and actions were allocated to staff down to ward manager level. Despite control measures and action plans being put into place the likelihood of recurrence remained high on key indicators. The register included identified

risks for example, lack of understanding of the safeguarding process for agency staff, high levels of self-harm, high use of agency staff and the continued use of some restrictive practices on the ward.

Leadership, morale and staff engagement

- The staff survey conducted in the preceding 12 months prior to ward closures highlighted the top three strengths as staff support and team working, compassion and dedication and friendly and approachable staff team. The top three weaknesses were identified as poor historical reputation, high use of agency staff and the working environment for staff and service users. The hospital had formulated an action plan to address the weaknesses, for example, good news social media stories, recruitment planning and a programme of site maintenance.
- Sickness and absence rates for permanent staff were low at 1%.
- Staff were aware of the whistle-blowing process. We had been contacted by four staff members using this process to voice their concerns about staffing difficulties and patient safety. One senior staff member had expressed their concerns with regard to the safety of young people and the undermining of clinical responsibility. This issue had been discussed with hospital and organisational senior managers but was not resolved.
- Staff reported that job satisfaction had been higher prior to the closure of the two wards, which they felt had a detrimental impact on staff. Morale had also fallen due to the closure of the wards and being closed to new admissions. Some staff believed it was their collective fault that that these measures had been taken.
- Management and leadership training was not available for staff in positions of senior responsibility although it was reported that this was currently being investigated. Staff described good working relationships generally amongst staff members, however, recruitment incentives and enhanced pay for new staff had caused disharmony amongst longer serving staff who felt undervalued. They reported that new support workers were being paid at the same rate as senior support workers with up to six years' experience.
- Opportunities for staff being transparent and open and explaining to young people when something had gone wrong were compromised because not all incidents or issues of concern were raised, recorded and investigated.
- Staff reported that they were able to give feedback on service provision and development, however, staff felt that they were not consulted on the recent ward closures and were not listened to when offering advice as to which ward environment and ward team could provide the most appropriate environment for keeping young people safe.

Commitment to quality improvement and innovation

- A quality improvement plan was contained within the overarching local action plan for the hospital. This incorporated the issues on the risk register and commitments to improving quality by for example, reducing restrictive practices. The service was not part of the Quality Network for Inpatient CAMHS (QNIC) and was not involved in research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ward safety procedures do not allow young people to gain access to non-patient areas or have avoidable access to materials that may be used to self-harm.
- The provider must ensure that staff respond to all calls for assistance in a timely manner.
- The provider must ensure that there are sufficient permanent staff with the appropriate experience, skills and competencies to safely manage young people with complex and challenging behaviours at all times.
- The provider must ensure that staff are competent to dispense medication correctly.
- The provider must ensure that physical restraint is used as a last resort and that prone restraint should be avoided.
- The provider must ensure that risk assessments contain the latest risk information.
- The provider must ensure that enhanced observations are conducted according to hospital policy and all staff intervene as early as possible when it becomes clear that a young person is self-harming.
- The provider must ensure that staff adhere to the hospital safeguarding policy at all times and report safeguarding incidents to the relevant local authorities and the CQC.
- The provider must ensure that all incidents are captured, reviewed, reported upon and shared with external agencies when required to do so.
- The provider must ensure that care plans for young people are recovery-oriented, measurable and focused upon reducing harmful behaviours and the need for restrictive environments.
- The provider must ensure that strategies are in place to monitor and manage physical healthcare problems safely and effectively.
- All complaints and issues of concern must be logged, investigated and reported back to the complainant in accordance with hospital policy. Lessons learned from complaints must be cascaded to all staff.
- The provider must ensure that all staff working in the hospital including bank and regular agency staff, receive regular supervision and appraisal.
- The provider must ensure that staff are being transparent and open and explain to young people when something has gone wrong.

Action the provider SHOULD take to improve

- The provider should ensure that care plans incorporate the views of all disciplines including the patient and are followed. Patients should be offered a copy of their care plan and this should be documented.
- The provider should ensure that psychological interventions are offered to guide the daily management and treatment of young people.
- The provider should ensure that medication management checks are conducted and acted upon to prevent the reoccurrence of adverse side-effects to prescribed medication, once this is known and documented.
- The provider should ensure that staff are non-judgemental and are open and receptive to receiving apologies from patients.
- The provider should ensure that staff approach young people after incidents to discuss how incidents of aggression and self-harming could be better managed in the future.
- The provider should ensure that the admission policy prevents inappropriate admissions occurring. Admission decisions made should be based upon a full multidisciplinary review of the known information in the absence of a multidisciplinary face-to face assessment.
- The provider should ensure that there are a range of therapeutic activities available at weekends.
- The provider should ensure that clinical audits are carried out and recorded in order to enable staff to learn from the results and make improvements to the service.
- The provider should review the requirements for providing management and leadership training to staff in positions of responsibility to enable them to carry out their role more effectively.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the Regulation was not being met: Staff did not respond appropriately to calls for assistance on the CAMHS ward in good time to safely manage people's changing needs. This was a breach of Regulation 12 (2) (a) The provider did not do all that is reasonably practicable to mitigate the risk of harm to young people of assault by other patients in the CAMHS ward. This was a breach of Regulation 12 (2) (b) The provider did not do all that is reasonably practicable to ensure that patients' ongoing physical health conditions including weight gain were managed safely on the CAMHS ward. This was a breach of Regulation 12 (2) (b) The provider did not ensure that staff on the CAMHS ward had the necessary competencies, skills and experience to apply the engagement and enhanced observation policy, thereby placing young people at increased risk of harm. This was a breach of Regulation 12 (2) (c) The provider did not ensure that all staff on the CAMHS ward were compliant with the proper and safe management of medicines. This was a breach of Regulation 12 (2) (g)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the Regulation was not being met: Safeguarding systems and processes were not operated effectively within the hospital to prevent abuse of young people occurring or to enable the immediate investigation of any allegation or evidence of abuse. This is a breach of Regulation 13 (2) (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the Regulation was not being met: The provider did not establish and operate effectively an accessible system within the CAMHS service for identifying, receiving, recording, handling and responding to complaints by service users and other persons This was a breach of Regulation 16 (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the Regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider had not established effective systems or processes to introduce measures to reduce or remove risks associated with self-harm whilst under enhanced observation on the CAMHS ward.

This was a breach of Regulation 17 (2) (b)

The provider did not have a system in place to ensure that contemporaneous assessment of risk factors were recorded in the risk assessment document.

This was a breach of Regulation 17 (2) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the Regulation was not being met: The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons on the CAMHS wards to ensure patients were safely observed and protected from harm. This was a breach of Regulation 18 (1) The provider did not ensure that all staff received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to effectively carry out the duties they were employed to perform. This was a breach of Regulation 18 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the Regulation was not being met:

This section is primarily information for the provider

Requirement notices

The registered person did not notify the Commission without delay of incidents of abuse or allegations of abuse in relation to the safeguarding of young people on seven occasions in the CAMHS service.

This was a breach of Regulation 18 (2) (e)