Active Young People Limited

Taplow Manor

Inspection report

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

Ratings

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

Summary of findings

Overall summary

The ratings for this service were suspended in March 2022 following a focused inspection. The hospital was previously rated requires improvement in July 2021.

Our rating of this service stayed the same. We rated it as requires improvement overall however the safe domain has been rated inadequate. We rated safe inadequate as the provider had failed the meet the conditions of a warning notice that had been issued at the previous inspection. The warning notice was issued under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulations 12 (1)(2) (c), Safe care and treatment and with Regulation 17 (2) (a)(b) Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst improvements had been made in some areas, we found the same concerns at this inspection.

We rated the service as requires improvement overall, with the safe domain rated inadequate, because:

- Staff did not always manage risks posed to young people. There had been a significant number of incidents reported where staff had demonstrated poor practice when completing observations of young people. Incidents included staff falling asleep, leaving young people unattended to complete other tasks and not following young people when they left the member of staff's direct vision. Young people across all wards told us that staff would not always follow them when they left the room, including those who needed to be directly observed at all times. Young people also told us that at times they would have to point out that their peer had left the room, and no one had followed them.
- Not all staff were fully trained and competent to keep young people safe. At the time of the inspection, not all staff had completed supportive engagement and observation training or passed the competency assessment. We found that some of these staff had been assigned to complete observation duties prior to being signed off as competent.
- Not all the child and adolescent mental health wards were environmentally fit for purpose and not all wards were clean. Tamar ward had narrow corridors and the ward was split across different levels. Kennet ward was difficult to navigate. The ward was spread-out and involved going up and down small sets of stairs to reach different areas. Thames ward was not thoroughly clean. We noted that the nursing office's windows were dirty, smudged and partially obstructed by paper. Some young people and parents commented that Thames and Kennet wards were not always clean, including the bathrooms.
- The hospital did not have enough specialists required to meet the needs of the young people across all wards. There were gaps in the psychology, occupational therapy, and dietitian teams. There were also not enough youth engagement practitioners or activity co-ordinator teams to ensure that young people always received meaningful activities. Young people told us they did not always receive therapy and were often bored due to the lack of activities. Young people also commented that activities weren't meaningful for their recovery and often only involved crafts or watching TV. Parents commented that they didn't know what therapy their loved ones were receiving or due to receive.
- Young people and parents were not involved in their care and treatment planning and care plans were not always personalised and did not include clear goals. Young people told us they were not involved in developing their care plans and weren't aware of the content of their care plans. Parents told us that they weren't involved in their loved one's care and were often not informed about changes to their care. Parents did not know what their loved one's treatment plan was and were concerned about the lack of clear goals and structure to care.
- The hospital's governance processes did not work effectively at ward level and risks were not managed well. Those who completed the rota were not aware of which staff had completed their observation training and assessment and there was no clear process in place to ensure that only competent staff were assigned this role. When incidents of poor practice occurred, there was no clear plan for managers to follow in terms of performance management. The policy related to observation lacked details of what should happen if staff members fail their observation

Summary of findings

competency assessment or when staff do not follow the observation protocols correctly. We found that when incidents had occurred with regards to poor practice, actions taken were inconsistent and there was no clear audit trail to show what actions had been taken. We also found that audits, such as the observation audit and infection and prevention control audit, did not clearly identify what actions had been taken when concerns were identified.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff minimised the use of restrictive practices.
- Staff managed medicines safely.
- The service followed good practice with respect to safeguarding.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to Taplow Manor

Taplow Manor, previous known as Huntercombe Hospital Maidenhead, is a specialist child and adolescent mental health inpatient service (CAMHS).

It provides specialist mental health services for adolescents and young people from 12 to 18 years of age. The hospital delivers specialised clinical care for young people requiring inpatient CAMHS, including psychiatric intensive care (PICU) and eating disorders. The hospital and its surrounding grounds are within a rural setting and are situated near a town with easy access to transport links and shops. Young people are supported in their education via the hospital school which is rated good by Ofsted. Where appropriate the young people have access to the hospital grounds and local community facilities.

The hospital was going through a refurbishment at the time of the inspection. When all wards are fully open, the hospital has 59 beds. The PICU wards have a cap on admissions and are only able to admit a maximum of 22 young people due to conditions imposed on its registration by CQC at a previous inspection in July 2021. At the time of this inspection, the cap was still in place.

The hospital consists of four wards:

- Kennet ward provides eating disorder services and has 20 beds
- Tamar ward provides tier four CAMHS general adolescent services and has 10 beds
- Thames ward has 14 beds and provides psychiatric intensive care services (PICU).
- Juniper ward provides psychiatric intensive care services (PICU). At the time of inspection this area was under refurbishment. The ward previously known as Severn had been split, with seven beds renamed as Juniper. The remaining part of the ward was under construction but when open will have eight beds and be named Holly Ward.

There was a registered manager in post at the time of the inspection.

The hospital is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures

At the previous inspection in February and March 2022, we suspended the ratings and served a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulations 12 (1)(2) (c), Safe care and treatment and with Regulation 17 (2) (a)(b) Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in June 2022, we found that the provider had not met the conditions of the warning notice and there were still significant concerns to young people safety regarding managing risk through observations. There were also significant improvements needed to the oversight of staff competency to complete observations correctly and ensuring only competent staff were assigned observation duties.

At the previous inspection in February and March 2022, the provider was also issued with requirement notices. We told the provider to make the following improvements:

Summary of this inspection

- The service must ensure that the hospital environment is safe and fit for purpose. Regulation 15: Premises and equipment, (1)(c) and (e).
- The service must ensure that they continue to review incidents on CCTV that are not covered by the external provider, to ensure staff follow care plans and policies and document any action taken to address concerns identified. Regulation 17: Good Governance, (1)(a) and (b).
- The service must ensure that that all staff working with young people in the hospital are appropriately trained, assessed as competent to carry out all aspects of their role and understand how to follow the hospitals observation policy. Regulation 12 (1) and (2)(c)
- The service must ensure that all identified concerns from audits have a documented action plan that clearly identifies actions needed to make improvements and that those actions are taken. Regulation 17 (2)(a) and (b).
- The service must ensure that there are always enough suitable qualified and competent staff on duty at all times. In addition, if must ensure that staff are always clear what staff are on duty on each shift and which shifts are unfilled (so these can be filled appropriately). The service must ensure that staff follow the agreed processes if they want to change their shifts. Regulation 18 (1).

We found at this inspection that some improvements had been made. We found that not all ward environments were fit for purpose but there was an estates plan in place to replace Tamar ward with a purpose-built ward and a refurbishment was underway for the psychiatric intensive care wards. We found that the service had continued to review incidents on CCTV, that staff understood the provider's observation policy and that there were enough suitably qualified staff on duty at all times and that staff followed agreed processes for changing shifts.

At the time of the inspection, the service had not ensured that staff were appropriately trained and assessed as competent to carry out all aspects of their role. Immediately following the inspection, the provider took action to ensure all staff were trained and signed off as competent to complete observations and provided an action plan that clearly identified actions needs to make improvements.

Following this inspection, we issued a letter of intent to the provider under section 31 of the Health and Social Care Act 2008 identifying our serious concerns about the safety of young people. We requested the provider submit information to explain how it would make immediate improvement. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. A letter of intent sets out our intention to take urgent action if the provider does not assure us that it will make the required improvements urgently.

We were assured by the actions the provider told us they were taking to immediately improve the safety of the hospital. We chose not to take further action at this time. The provider is working with the commissioners for the service and we will continue to monitor the hospital closely.

What people who use the service say

We received mixed feedback from young people across the hospital.

Young people from Juniper and Thames wards told us that staffing had improved since the last inspection. Staff were more regular, there was less use of agency staff and they were more familiar with the staff on shift. Young people from Juniper, Thames and Kennet ward said staff overall were supportive and approachable and that there were typically enough staff on duty. However, young people on Tamar ward stated that some staff were rude, disrespectful and made jokes about them and young people on Juniper ward said some staff treat them like they are misbehaving.

Summary of this inspection

Young people across Juniper, Thames and Kennet said that activities on the wards were very limited and there were very few therapy staff such as occupational therapists, activity co-ordinators and dietitians. Young people on Tamar commented the support workers often took on the therapy role. Young people commented that there were no activities during the day whilst school was on but not all young people attended school, so this left them bored and left alone. Others commented that activities were in place, but these weren't therapeutic or meaningful for example, consisted of arts and crafts, puzzles and watching TV.

Most young people said that they weren't involved in care planning and hadn't seen copies of their care plans.

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?

The team that inspected this service comprised of two CQC mental health inspectors, one CQC inspection manager, one specialist advisor, and one expert by experience. The expert by experience has lived experience of mental health services. The specialist advisor has professional experience of working in child and adolescent mental health services.

Before the inspection visit, we reviewed information that we held about the service and met with stakeholder organisations

During the inspection visit, the inspection team:

- Undertook a tour of the hospital and all four wards
- Spoke with 29 children and young people who were using the service
- Spoke with 11 relatives/carers of children and young people who were using the service
- Spoke with the hospital director who is the registered manager for the service
- Spoke with 28 staff members including ward managers, health care assistants, nurses, consultant psychiatrists, assistant psychologists, dietitians, a therapy liaison worker, the head teacher for the school, social worker and the head of therapy
- Looked at eight care and treatment records
- Reviewed 16 medication charts
- Attended and observed one site operations meeting and
- Reviewed a range of policies, procedures and other documents relating to the running of the hospital.

Summary of this inspection

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

- The service must ensure that all relevant staff are appropriately trained and assessed as competent to carry out observation checks of young people. (Regulation 12)
- The service must ensure that all ward environments are fit for purpose. (Regulation 15: Premises and equipment, (1)(c) and (e))
- The service must ensure that staff receive a debrief and/or reflective practice session following serious incident, including after incidents that involve restraints. (Regulation 12)
- The service must ensure that staff have completed managing medications and immediate life support training. (Regulation 12)
- The service must ensure that young people and the relevant family/carers are involved in care and treatment planning. (Regulation 9)
- The service must ensure that young people have access to the recommended psychological therapy as outlined in best practice guidance and that young people have access to meaningful activities seven days a week. (Regulation 9)
- The service must ensure that there are effective and robust governance procedures in place to ensure that young people always receive safe care and treatment. (Regulation 17)
- The service must ensure that they complete the actions of the action plan following the issue of the letter of intent and embed the improvements to the service. (Regulation 17)

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

Action the service SHOULD take to improve:

- The service should review the shared bedroom arrangements in Kennett ward.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Inadequate

The ratings for this service were suspended in March 2022. Safe was previously rated requires improvement in July 2021.

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all ward environments were suitable to meet the needs of young people and one ward was not clean. However, the wards were well equipped, well furnished, and there was a refurbishment under way for the psychiatric intensive care wards.

Safety of the ward layout

Tamar ward was not fit for purpose. At the previous inspection we were told planning permission was being sought to replace the current ward with a purpose-built general adolescent ward. The application had still not been submitted as the provider was working with architects to develop plans.

Tamar ward had narrow corridors and the ward was split across different levels. This meant that staff could not observe all parts of the wards and staff and young people were constantly going up and down stairs to move across the ward. There were convex mirrors in place to see around corners, but the narrow corridors made it difficult for people to pass one another.

Kennet ward was difficult to navigate. The ward was spread-out and involved going up and down small sets of stairs to reach different areas. The dining room, for example, was up a small flight of stairs and then down another small flight, increasing the risk of trips and falls. There were also blind spots due to the layout of the ward. Kennet is a specialist eating disorder ward and the need to access areas by going up multiple stairs with lots of turns could pose a challenge for those whose physical health is poor. There had been incidents where young people who were required to be observed by staff at all times had been able to move out of their direct vision due to the layout of the ward. To mitigate the risks posed by the layout on both Kennet and Tamar ward the provider had installed a system of CCTV monitored continuously by external clinicians that covered all communal areas.

Requires Improvement

Child and adolescent mental health wards

At the time of the inspection, the refurbishment of the psychiatric intensive care wards (PICU) was underway. Half of Severn ward had been renamed Juniper, which had seven beds. The other half of the ward was still undergoing refurbishment and was closed to admissions. When open, this ward would be named Holly and have eight beds.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Each shift had a member of staff allocated to complete daily security checklist by completing walk throughs of the wards to check for risks.

Tamar, Thames and Juniper wards accepted young people of any gender. Kennet ward only accepted females. The wards that accepted young people of different genders complied with guidance on mixed sex accommodation.

There were potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and completed ligature audits on all wards. The risks across all wards were mitigated with staffing, observation and use of CCTV. However, staff were not always competent to mitigate risks through observation of young people. Some staff had assigned to complete observation duties who had not passed their observation competency. There were incidents of staff falling asleep, leaving young people unattended or not following young people when they left their direct vision. Some incidents involved young people being able to self-harm while unattended. At the time of inspection, the hospital had CCTV in most wards, with the remaining areas due to be installed. The CCTV was monitored by an external company who would contact the ward if they saw poor practice with observation, such as if a young person was left unattended but it takes time to contact the ward and for someone to attend the scene. Some incidents showed that staff took over a minute and half to respond.

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

Maintenance, cleanliness and infection control

Young people on Thames ward commented that the ward was not always clean, including communal areas and bedrooms. We noted it was difficult to see into the nursing office as the windows were dirty, smudged and partially obstructed by paper.

Staff followed infection control policy, including handwashing. There were hand sanitising stations throughout the hospital. An infection control and COVID-19 audit had been completed in April 2022 and a hand-washing audit had been completed in May 2022. The audits showed the services to be mostly compliant however when there were gaps, there were no actions detailed. For example, audit stated “did not happen in all units” but did not detail which wards were not complying and what actions would be taken.

Seclusion room

Juniper ward had the hospital’s only seclusion room. The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment. Staff completed weekly clinic room audits and an external pharmacist completed a monthly audit.

Requires Improvement

Child and adolescent mental health wards

Safe staffing

Whilst the service had enough staff, who knew the children and young people, there was a high use of agency staff which meant it was difficult to provide consistent care. Not all staff had completed basic training to keep young people safe such as managing medicines, immediate life support and observation training.

Nursing staff

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

The service had reducing vacancy rates.

Managers had reduced their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had an induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health.

Levels of sickness were reducing. There had been a reduction in staff sickness by 5%. Sickness rates in January 2022 were 16% but in May 2022 this had reduced to 11%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the children and young people. For example, when there were multiple young people who required high levels of observation.

Children and young people rarely had their escorted leave cancelled even when the service was short staffed. However, young people told us that there were not enough activities or access to therapy, and this was due to having too few therapy staff and youth engagement practitioners.

The service had enough staff on each shift to carry out any physical interventions safely. Extra staff were on shift where there was a need for regular physical interventions, such as to support nasogastric tube feeding under restraint on Kennet ward.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was an out of hours on call rota so a doctor was always available for support.

Mandatory training

Staff had completed and kept up-to-date with the majority of mandatory training. However, managing medications and immediate life support training compliance were 48% and 69% respectively.

At the time of the inspection, not all staff had completed supportive observation and engagement training and not all staff had completed and passed the supportive observation and engagement competency assessment. At the time of the inspection, 31 agency staff had not completed the training and competency assessment and 32 permanent staff had not completed and passed the competency assessment. Despite not having completed the training and/or competency assessment, staff were being allocated observation duty whilst on shift. We reviewed the shift allocations and observation record forms between 1 June 2022 and 7 June 2022 and found that six agency staff and three permanent staff had completed observations of young people. During a night visit of the hospital, we checked that every member of

staff had passed their observation competency. We were told that staff who had not completed their competency assessment were made to do so before starting their shift that evening. However, there was no contingency plan if those staff failed the competency assessment and this procedure had been implemented that evening, not prior to the inspection.

The mandatory training programme was comprehensive. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

Staff assessed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. However, staff did not always manage risks young people posed to themselves and did not always act to prevent or reduce risks for example, managing the risk of self-harm when young people were on observations.

Assessment of patient risk

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

Management of patient risk

Staff knew about any risks to each child and young person but did not always act to prevent or reduce risks. Staff did not always manage risks young people posed to themselves. Young people across the hospital were on varying levels of observations and staff on each ward were assigned to complete observation checks whilst there were on shift. Observation checks vary in frequency between checking a young person once every 60 minutes to ensuring they are always only an arm's length away. Between 14 March 2022 and 14 June 2022 there had been 22 incidents involving poor practice with observing young people. The incidents ranged from staff falling asleep, not following young people when they left the room and completing other tasks whilst they were meant to be observing someone. Young people told us that they were able to walk away from staff who were assigned to observe them, and they would not always be followed. Young people also told us that sometimes they had to alert staff when their peer had left the room because staff had not noticed.

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

Staff followed procedures to minimise risks where they could not easily observe children and young people. For example, the service had CCTV across the hospital. There were cameras that were monitored in the nursing stations as well as an external company monitoring cameras who would contact the wards if they observed an incident or increasing risk.

Staff followed hospital policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and when necessary to keep them or others safe. Staff we spoke with were able to give examples of strategies that they would use to try and de-escalate situations. The service did not routinely seclude young people and there had been no incidents of seclusion since April 2021.

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

Staff followed national guidance when using rapid tranquilisation.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training and received monthly safeguarding supervision and reflective practice sessions from the designated safeguarding lead.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Senior leads attended a daily site meeting, which included tracking actions from safeguarding incidents and concerns. A social worker was present at these meetings. The service also had regular meetings with the local authority, commissioners, and other stakeholders to discuss open safeguarding cases and share learning, best practice and discussed themes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain clinical records.

Young peoples notes were comprehensive and all staff could access them easily.

Records were stored securely. The hospital used an electronic records system as the main record of care and treatment.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

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

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

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

Requires Improvement

Child and adolescent mental health wards

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

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

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

Track record on safety

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well and staff were not always debriefed following an incident.

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with policy. The service had no never events on any wards.

The service did not always manage patient safety incidents well. We reviewed 22 incidents of poor observation practice and found that the management of these incidents was inconsistent. Outcomes for incidents ranged from no action taken to raising a safeguarding concern. Some staff were given supervision and some were referred to the social worker.

Staff did not always receive a debrief after incident. There was a high number of restraints on Kennet ward due to the number of young people requiring nasogastric tube feeding. Staff told us they were not debriefed after these incidents, which often involved restraining a young person for a significant length of time and left staff exhausted. The psychology team was only available during the day and therefore staff on night shifts were not able to receive a formal debrief after incidents.

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

Staff received feedback from investigation of incidents, both internal and external to the service.

Are Child and adolescent mental health wards effective?

Requires Improvement

The ratings for this service were suspended in March 2022. Effective was previously rated requires improvement in July 2021.

Our rating of effective stayed the same. We rated it as requires improvement.

Requires Improvement

Child and adolescent mental health wards

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, care plans were not always personalised, holistic and recovery-oriented.

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

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

Staff developed care plans for each child or young person that met their mental and physical health needs. Care plans were reviewed and updated when children and young people's needs changed. However, care plans were not always personalised and lacked clear goals. Young people were not involved in care planning.

Best practice in treatment and care

Staff did not provide a range of treatment and care for children and young people based on national guidance and best practice.

They ensured that children and young people had good access to physical healthcare. Staff used recognised rating scales to assess and record severity and outcomes.

Staff did not provide a range of care and treatment suitable for the children and young people in the service and did not always deliver care in line with best practice and national guidance. There was a shortage of therapy staff, including activity co-ordinators and youth engagement practitioners. Young people and parents told us they did not have access to regular therapy sessions with a psychologist and staff confirmed it was difficult to hold regular individual session due to staff shortages. The occupational therapist was only able to do initial assessments and the assistant psychologists had to run groups typically run by assistant occupational therapists, such as kitchen skills. Young people told us there were not enough activities on the wards and that the activities in place weren't meaningful. Young people also told us that if they didn't attend school, there was nothing to do during the day. The provider told us that this was to encourage young people to engage with education. However, some young people told us they struggled to concentrate in school and would rather engage in activities that benefitted their mental health. Parents told us they were worried about the upcoming school summer holidays as previous school holidays had no structure or additional activities, leaving young people feeling bored and isolated.

Staff identified children and young people's physical health needs and recorded them in their care plans. Staff made sure children and young people had access to physical health care, including specialists as required. A GP attended the hospital every Wednesday. The physical health nurse lead ensured that all newly admitted young people had blood tests and echocardiographs (ECGs) and developed the care plans for physical health care. They also ensured that new staff received physical health training as part of their induction.

Staff met children and young people's dietary needs, and assessed those needing specialist care for nutrition and hydration. However, there was only one dietitian and one assistant dietitian for all four wards.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes.

Requires Improvement

Child and adolescent mental health wards

Skilled staff to deliver care

The ward teams did not have enough specialists required to meet the needs of children and young people on the wards. Managers did not make sure they had staff with the range of skills needed to provide high quality care.

The service did not have enough specialists to meet the needs of the children and young people on the ward. There was a shortage of therapy staff, including input from psychology and occupational therapy. There was a shortage of dietitians. There was also a shortage of activity staff, including activity co-ordinators and youth engagement practitioners. Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. For example, assistant psychologists were conducting a kitchen skills group which would typically be run by an occupational therapist as there was a shortage of occupational therapists and assistants at the time of the inspection. Young people told us there were not enough dietitians to meet with them. Managers were recruiting additional staff with some already recruited and going through employment checks.

Managers did not make sure nursing staff and health care assistants received specialist training for their role. Staff had not received training in learning disability. We were told that many of the agency staff had never worked in a CAMHS unit before. Staff told us it was difficult to access additional or specialist training.

Managers gave each new member of staff an induction to the service before they started work.

Managers supported staff through regular, constructive supervision and appraisals of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. The ward teams had effective working relationships with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Requires Improvement

Child and adolescent mental health wards

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had an interim Mental Health Act administrator at the time of inspection and additional Mental Health Act support staff to ensure the relevant audits were being completed and tribunals were arranged as required.

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

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. The advocate came to the hospital at set days and times. The advocate saw all newly admitted young people within their first 10 days at the service.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

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

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

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

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

Requires Improvement

Child and adolescent mental health wards

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

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Are Child and adolescent mental health wards caring?

Requires Improvement

The ratings for this service were suspended in March 2022. Caring was previously rated good in July 2021.

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

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

Staff gave children and young people help, emotional support and advice when they needed it.

Children and young people said staff treated them well and behaved kindly.

Parents said the staff were kind, caring, approachable,

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

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

Staff followed policy to keep patient information confidential.

Involvement in care

Staff did not always involve children, young people and their families in care planning and risk assessment.

Involvement of children and young people

Staff did not always involve children and young people or give them access to their care plans and risk assessments. Young people we spoke to were not aware of their care plans or positive behavioural support plans. Young people told us they were not involved in their care.

Children and young people could give feedback on the service and staff supported them to do this. Each ward held weekly community meetings with young people. The provider responded to feedback from young people, which was displayed in “you said, we did” posters.

Requires Improvement

Child and adolescent mental health wards

Staff made sure children and young people could access advocacy services. The advocate attended the hospital four days a week to visit each ward. There were drop-in sessions across the wards. We were told that whilst the advocate was flexible with visiting times, they sometimes weren't able to see a young person if they weren't available at the time they visited.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform or involve families. Parents told us that they were not routinely informed about their loved one's care or informed of changes such as medication changes. Parents told us they weren't clear on their loves one's care and treatment plan including what therapy they will receive. Parents told us that they weren't given information about the service, such as a leaflet and that communication from the hospital lacked clarity. Parents said that the review meetings, known as care programme approach (CPA) were unhelpful and did not provide clear information on care and treatment, discharge plans or their loved one's progress with goals.

Parents were sent a monthly newsletter about the service.

Are Child and adolescent mental health wards responsive?

Good

The ratings for this service were suspended in March 2022. Responsive was previously rated requires improvement in July 2021.

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

Access and discharge

Staff managed beds well. A bed was available when needed and children and young people were not moved between wards unless this was for their benefit. However, the service had several young people with excessive lengths of stay and delayed transfers of care due to a lack of suitable placements or difficulties arranging social care packages in the community. The hospital was liaising with services that would provide aftercare and worked with relevant organisations to find suitable placements for young people due to move on from the hospital.

The hospital was at maximum capacity at the time of the inspection with bed holds in place where required. When children and young people went on leave there was always a bed available when they returned.

Managers regularly reviewed length of stay for children and young people and worked with relevant organisations when young people had long lengths of stay.

The service had out-of-area placements due to the specialist nature of the hospital and because there is a national shortage of beds for children and young people with mental health conditions. The hospital is the only one with psychiatric intensive care beds in the wider area. The hospital works closely with the local provider collaborative, who fund some of the beds, as well as the young person's local provider collaborative.

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

Requires Improvement

Child and adolescent mental health wards

Children and young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest. Staff did not move or discharge children and young people at night or very early in the morning.

Discharge and transfers of care

The service had a number of delayed discharges in the past year. Managers monitored the number of delayed discharges. The reason for the delayed discharge were due to not being able to find a suitable placement or difficulties accessing social care packages to support discharge to the community.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well.

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

Facilities that promote comfort, dignity and privacy

The furnishings of the wards supported children and young people's treatment, privacy and dignity. Except for Kennet ward, which had shared bedrooms, each child and young person had their own bedroom. Not all bedrooms were en-suite. There were lockers on the wards to keep their personal belongings safe. There were quiet areas for privacy.

On Juniper, Thames and Tamar ward each young person had their own room which they could personalise. This included blackboard walls to create artwork and write key messages to staff about their likes and dislikes.

On Kennet ward six of the rooms were shared bedrooms, meaning at any one time up to 12 young people shared a bedroom.

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

Staff used a full range of rooms and equipment to support treatment and care. As part of the refurbishment, a sensory room had been added on Juniper ward.

The service had quiet areas and a room where children and young people could meet with visitors in private.

The service had an outside space that children and young people could access easily. This included access to a picnic area and basketball nets off the PICU ward and a large outside door space with gazebos and benches.

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

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

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

Requires Improvement

Child and adolescent mental health wards

Staff made sure children and young people had access to opportunities for education. The hospital had a school on site and young people were encouraged to attend. At the time of the inspection, several young people were taking their exams.

Staff helped children and young people to stay in contact with families and carers.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for those with communication needs or other specific needs. However, the hospital was not suitable for anyone with a mobility issue.

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

The service had information leaflets available in languages spoken by children, young people and the local community.

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

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

Children and young people had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Children, young people, relatives and carers knew how to complain or raise concerns. However, some parents told us that it was difficult to get complaints heard and followed-up.

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

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

Managers investigated complaints and identified themes.

Managers shared feedback from complaints with staff.

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

Are Child and adolescent mental health wards well-led?

Requires Improvement

Child and adolescent mental health wards

Requires Improvement

The ratings for this service were suspended in March 2022. Well-led was previously rated requires improvement in July 2021.

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

Leadership

Following the inspection, the leaders of the hospital provided an action plan to address concerns raised in the letter of intent. The leaders showed a commitment and understanding of what needed to be done to make improvements.

Leaders had the skills, knowledge and experience to perform their roles. Each ward had a ward manager and the hospital had a complete senior leadership team. They had a good understanding of the service they managed and were visible in the service and approachable for children, young people, families and staff. Staff and young people told us that the hospital director was particularly approachable, friendly and visible in the service.

Vision and strategy

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

Culture

Staff felt respected, supported and valued by most of their peers and managers. The ward teams described working closely with one another.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that risk were not managed well. We found that audits with identified issues did not have clear actions, timeframes to complete actions or assigned responsible individuals. For example, the hand hygiene and infection prevention and control audit stated "not all units doing this" but not did specify which wards, what the specific concern was or what actions would be taken to improve. The supportive observation and engagement audits stated "staff to be reminded of…" but there was no clear audit trail to show where action had been taken to address concerns with staff observation competency. The audit for observations was also infrequent. The audit took place monthly and only reviewed an hour a day and an hour at night from each ward. Due to the high number of incidents where staff had demonstrated poor practice when completing observation duty, we would expect the frequency of the audit to have increased so that poor practice could be identified promptly.

The supportive observation and engagement policy did not have a clear protocol to follow if staff were found to have poor practice when completing observations of young people. Following the inspection, the provider updated this policy.

Management of risk, issues and performance

Teams did not had access to the information they needed to provide safe and effective care. Managers completing the rotas for the wards were not aware of which staff were not competent to complete observation checks before adding them to the rota.

Requires Improvement

Child and adolescent mental health wards

The provider had not met the conditions of the warning notice previously issued by the Care Quality Commission in the agreed timeframe and the issues identified at the previous inspection had not improved.

Information management

Staff engaged actively in local and national quality improvement activities. The service had implemented 'Safewards' across Tamar and Juniper ward. This was supported by a working group that included a consultant psychiatrist, nursing, social work and support staff. Safewards is a way of working designed to improve the safety of everyone in inpatient wards by reducing conflict (physical, verbal aggression, absconding) and containment (forced medication, seclusion, and restraint) events.

The service had also commissioned a sensory environment survey across the site led by a team of experts by experience to make recommendations on making the hospital more suited to autistic people.

There was also a quality improvement project led by the group medical director to reduce the number and improve the quality of care plans.

Engagement

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

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 The service did not ensure that staff had completed managing medications and immediate life support training.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The service had not ensured that all ward environments were fit for purpose.

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 9 HSCA (RA) Regulations 2014 Person-centred care The service had not ensured that young people and their relevant family/carers were involved in care and treatment planning.

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 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Requirement notices

	The service had not ensured that young people had access to the recommended psychological therapy as outlined in best practice guidance and that young people had access to meaningful activities seven days a week.

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 The service had not ensured that there were effective and robust governance procedures in place to ensure that young people always received safe care and treatment.

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 The service must ensure that they complete the actions of the action plan following the issue of the letter of intent and embed the improvements to the service.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that all relevant staff are appropriately trained and assessed as competent to carry out observation checks of young people.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	The service did not ensure that staff received a debrief and/or reflective practice session following serious incidents, including after incidents that involve restraints

This section is primarily information for the provider

Enforcement actions

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.