Hertfordshire Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Ratings

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

Our findings

Child and adolescent mental health wards

Requires Improvement 

We carried out this unannounced focused inspection of Forest House because at our last inspection it was rated as inadequate overall. The purpose of this inspection was to review compliance with previous enforcement actions, against the trust action plan, which was required to meet legal requirements following the last inspection. During this inspection, we were pleased to confirm that legal requirements from the previous inspection had been met, with progress observed in areas where we had previously identified concern'.

We examined all five key questions with a view to re-rate the service to reflect progress. We visited the service on 6 – 8th July 2022, and on 24 July 2022.

Hertfordshire Partnership University NHS Foundation Trust provides child and adolescent services throughout the county. There are approximately 250,000 children and adolescents (under 18 years) in Hertfordshire. For the core service child and adolescent mental health wards, Hertfordshire Partnership University NHS Foundation Trust has one location. Forest House is a 16-bed unit that provides specialist inpatient care and treatment for young people living in or outside Hertfordshire, aged 13 to 18 years, requiring admission as a Tier 4 provision. The unit is based at Radlett in Hertfordshire and the beds available are for female, male and non-binary gender young people.

Our rating of services improved. We rated them as requires improvement because:

- The ward had no call bell system for children and young people. If help was needed, they would rely upon staff to use their personal alarms. We were concerned that this could cause a delay in the event of an emergency.
- When secluding patients in their bedrooms, staff on one identified occasion attempted to clear a patient's bedroom but, due to the risk of assault, were not able to clear the room of items which may have been used by the patient to cause harm.
- The ward depended upon bank and agency nursing staff to meet the needs of children and young people, although we observed that bank and agency use had improved since the last inspection.
- Not all staff had reported incidents in line with trust policy. The trust addressed this when it was bought to their attention. The system for reviewing of incidents had improved over recent months.
- There were vacancies within the therapy team, although this had improved since the last inspection. Recruitment was ongoing.
- Feedback from young people and carers / relatives was mixed. Some concerns had been raised around inconsistent care, due to the levels of bank and agency staff used, particularly in the evenings and over weekends.
- There had been occasions when children and young people had not had access to outside space due to the ongoing refurbishment of the unit.

Our findings

However,

- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills, in line with trust policy.
- Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. This was evident in clinical records.
- Staff used systems and processes to safely prescribe, administer, record and store medicines. Systems and audits were in place to monitor this.
- Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe.
- Staff 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.

How we carried out the inspection

During this inspection we:

- Reviewed information we currently hold about the service
- spoke with 23 different staff members including the head of nursing; the service manager; consultants; modern matron; nurses; health care support workers; social workers; occupational therapist; occupational therapy assistant; therapy team lead; as well as some bank and agency care staff
- spoke with three young people who were using the service
- received some written feedback from one young person who was using the service
- spoke with five carers / relatives
- received feedback from one external professional
- undertook a tour of the environment
- observed a handover meeting
- observed a community meeting
- reviewed all six care records
- reviewed medicines management to include rapid tranquillisation and physical health
- undertook a sample review of observation records
- undertook a sample review of reported incidents
- reviewed a range of policies and procedures, data and documentation relating to the running of the service.

What people who use the service say

We received feedback from four young people who were using the service, and five carers / relatives.

Our findings

Feedback from young people and carers around the kindness of staff was mixed. Three young people we spoke with told us that staff were kind and caring and were usually around when they needed them for emotional support and advice. Two carers spoke very positively about the staff, stating that they worked very hard, they were very pleased with care and treatment being offered, and praised them for doing such a good job under challenging circumstances.

Two other carers spoke with us about some unacceptable staff behaviours. One related to staff members making inappropriate comments around appearance, which had caused distress. The carer did raise this with staff who apologised.

Another example given by another carer was a poor and uncaring response a staff member made when a young person was engaging in deliberate self-harm. This incident was escalated to senior staff, who took appropriate actions with the staff member involved.

Three out of five carers and one young person of the three we spoke with, talked about the ward using a lot of bank and agency staff. Two carers talked about there being inconsistencies in care on a day to day basis due to the different staff. One young person told us they would prefer staff who worked with them regularly so that they could get to know them better.

Two carers were disappointed that despite some young people being on enhanced safe and supportive observations, they had still managed to engage in deliberate self-harm. One carer described the staff as “complacent” in respect of they are so used to such behaviours they almost become “desensitised”.

Two carers spoke to us about the ongoing refurbishment of the ward and commented on the noise and disruption this had caused. Concerns raised specifically were around limited space for young people to utilise if they needed to be alone, and lack of access to fresh air.

Young people said they were able to keep in regular contact with parents / carers and friends through telephone call, video calls or through visits.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were visibly clean, adequately equipped, furnished and well maintained. Refurbishment was ongoing at the time of inspection. Staff had continued to manage this safely.

Safety of the ward layout

Staff did regular risk assessments of the care environment. Staff knew about potential ligature anchor points and mitigated the risks to keep children and young people safe. Staff completed and regularly updated the ligature and environmental safety audits for the unit and removed or reduced identified risks. The audits included photographs of different areas of the unit and detailed actions in place to manage identified risks.

Our findings

Ward layout did not allow staff to observe all parts of ward. The ward had some blind spots where staff would find observation of children and young people difficult or obstructed. Staff were aware of these and managers had reflected these in the audits. Mitigations of blind spots included supervised access; locked areas; anti-ligature fittings and mirrors to aid sight.

Closed circuit television (CCTV) was present in main corridors of the ward. CCTV did not cover all communal areas including the recreational room, dining room and quiet room. Staff informed us they would be present in these areas when in use by children and young people.

The ward complied with guidance on eliminating mixed-sex accommodation. The ward offered mixed gender accommodation which met national guidance. Each bedroom included an en-suite bathroom.

Staff had access to alarms and could summon help when required. Regular staff had their own issued alarms. Staff provided the inspection team with personal alarms. We noted that there did not appear to be any signing in or out process on any of the three days visited. It was unclear how staff managed this to ensure non-permanent staff were issued with alarms. The trust informed us the ward had 14 additional alarms for bank and agency staff and confirmed that further alarms had been ordered. Children and young people did not have access to a nurse call system. They relied upon staff to raise the alarm if urgent help was needed. We were concerned that children and young people may not be able to seek assistance at all times when needed. Staff assured us that they managed patient risk by using individualised care plans. The trust accepted that this could present risk to young people and that practice may be unsafe. As a result of this inspection the trust provided assurance that a nurse call system would be installed and operational by the end of October 2022.

Maintenance, cleanliness and infection control

The unit was undergoing major refurbishments during our visit. Different works had been ongoing since April 2021. The refurbishment included remodeling of the assessment suite to create a two bedroomed high dependency unit. The refurbishment works also included further extensions to enable a larger staff room and further offices to the first floor.

Ward areas were generally clean, well maintained and adequately furnished. Housekeeping staff maintained up to date cleaning records and worked seven days a week. External contractors undertook deep cleans as and when required.

The most recent young person-led assessment of the care environment (PLACE) was completed in July 2021 with two young people. The audit identified the service as “confident” to deliver a good level of patient care and experience within the unit.

Staff adhered to the trust’s infection control policy, including regular handwashing. Staff followed national guidance around Covid-19 and updated local protocols accordingly. At the time of inspection, all staff wore face masks. We did observe on several occasions that not all staff wore masks correctly due to them slipping down below their noses. These staff members did readjust the masks to ensure appropriate face coverage at these times.

Seclusion

The ward did not have a designated seclusion room. The trust’s seclusion and longer-term segregation policy permitted staff to use a non-identified seclusion room if a designated seclusion room was not available.

There had been 19 occasions when children and young people had required care in seclusion between January and July 2022. These related to six different children and young people.

Our findings

The trust had a health-based place of safety (known as a Section 136 suite) attached to Forest House for children and young people. This is a designated safe space where the police can detain children and young people when they present as a risk to themselves or others and require a mental health assessment. Staff had used this space for the seclusion of children and young people at Forest House on 12 occasions between January and July 2022. These episodes of care related to four different children and young people. Using this space for seclusion was dependent upon the availability of the suite as well as the assessed risks of staff escorting the child or young person to this area. During the period of seclusion, the patients remained under the care of the Child and Adolescent Mental Health Services (CAMHS) staff.

Seven of the 19 seclusions had occurred in the young person's bedroom. On two of these occasions, the young person had been transferred to a designated seclusion room attached, which the multi-disciplinary team assessed as the safest option. On these occasions, to ensure continuity of care for the young person, the care and treatment continued to be provided by Forest House CAMHS staff.

Several staff told us that they utilised whichever room was close to the incident which required the child or young person to be cared for in seclusion. We were concerned that bedrooms may not be a safe place to use for seclusion, due to different available items within the room and limited visibility of children and young people through the bedroom door. When secluding patients in their bedrooms, staff on one identified occasion attempted to clear a patient's bedroom but, due to the risk of assault were not able to do so to ensure that the environment was safe. Communication with the child and young person was maintained by staff through the closed door.

Staff used seclusion for the shortest time possible in line with guidance. A sample of records viewed showed that staff recorded episodes of seclusion correctly and undertook regular nursing and multi-disciplinary reviews as expected.

On eight occasions, staff had cared for children and young people under the long-term segregation (LTS) framework. This refers to caring for young people in a separate area away from others. Staff knew the difference between long term segregation and seclusion. Staff conducted regular nursing and mulit-disciplinary reviews for children and young people being cared for in long term segregation. Staff implemented relevant care plans which stipulated what the child / young person had access too, and how they could re-enter the main ward areas and mix with others.

As part of the refurbishment, the trust had built a new two bedroomed high dependency area. Staff felt this would enable them to manage young people who were very unwell, in a private and appropriate environment without impacting on other young people on the ward. Staff also felt this would decrease the number of seclusions used in bedrooms and in the Section 136 place of safety suite, as it had been designed to be able to safely care for children and young people who may require seclusion or segregation.

Clinic room and equipment

We undertook a clinic room check. The clinic room was fully equipped, with accessible resuscitation equipment and emergency medicines that staff checked regularly. Nursing staff had cleaned equipment between use. Staff checked medical equipment, such as blood sugar monitoring devices regularly to ensure they were fit for purpose.

Staff monitored expiry dates on medicines and re-stocked when needed to ensure all medicines needed were stocked, in date and safe to use.

Safe staffing

The service did not have enough permanent nursing staff, who knew the children and young people well. All staff received basic training to keep people safe from avoidable harm.

Our findings

Nursing staff

Managers had reduced the ward occupancy in December 2021 from 16 to ten beds, due to the ongoing building works and staffing. Occupancy since January 2022 has remained under ten patients. At the start of the inspection, the occupancy was six.

Managers had continued to work on recruitment. Of the registered nurse roles, of varying seniority, there was a total of 16 budgeted nurses for Forest House. Of these posts, 5.36 were vacant. Managers had recently recruited four nurses. Recruitment checks were ongoing prior to any confirmed offers and proposed start dates. The service had been reliant upon bank and agency staff to meet safe staffing requirements.

Managers had calculated the number and grade of nurses and healthcare assistants required. Day to day staffing levels were dependent upon the individual needs of the children and young people on the ward. When children and young people required enhanced safe and supportive observations, the number of staff increased to facilitate this.

Some children and young people at Forest House had required a transfer to a specialist service, such as a low secure unit or a psychiatric intensive care ward. This had been a challenge for the staff team due to external pressures of limited bed availability. To keep the children and young people safe until a more appropriate setting was located, enhanced safe and supportive observations had been prescribed. There had been two occasions when the numbers of staff on shift could not meet the prescribed levels of safe and supportive observations. Staff had reduced these temporarily. On both of these occasions the young people had been nursed under the long-term segregation framework. Staff had continued to provide safe and supportive observations, but at a lower level than prescribed. The service had a fluctuating use of bank and agency staff between January and July 2022.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels.

The number of registered nurse shifts covered by bank and agency staff ranged month on month, with 87 being the lowest in June 2022, and 154 as the highest back in January 2022. These numbers had been reducing since March 2022.

The number of shifts covered by bank and agency health care support workers ranged between 417 in May (lowest) and 742 being the highest in March 2022.

Managers used regular bank and agency staff who were familiar with the service when possible. Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. Ward staff completed a new staff orientation checklist for any staff member who was new to the ward. This document was very comprehensive. A healthcare support worker told us that this would typically take two to three hours to complete. Additionally, nursing staff printed off individual patient care plans which were available for bank and agency staff to view in the ward office.

The trust reported there had been a total of 827 unfilled shifts of nurses and healthcare support workers between January and July 2022. The number of unfilled shifts for healthcare support workers was variable, with a noted decrease in numbers since March 2022. Similarly, for registered nurses, there had been a decrease in unfilled shifts since April 2022. The unfilled shift rates included staff required to facilitate staff training or away days, as well as being able to chaperone building contractors during ongoing building works.

Our findings

The Trust measures safe staffing levels through SafeCare. SafeCare is used three times a day to check staffing across inpatient areas, and reviews staffing numbers, skill mix and acuity at ward level. Using this model, the trust reported that between January and July 2022, there had been 11 shifts whereby the actual staffing was below expectations, On these occasions, managers ensured that different members of the multi-disciplinary team and senior staff assisted to maintain the safety of the children and young people on the ward

Five members of the nursing team out of the 11 we spoke with talked about staffing being an issue. Two felt that there was not always enough to meet individual needs of young people. Three spoke about the ward needing more permanent and regular staff, stating that there continues to be a heavy reliance upon bank and agency staff.

The service had reducing turnover rates. The trust reported the total staff turnover rate in June 2022 as 36%. Although high, this had improved since the last inspection. Numerous staff told us that staff had left the ward over the last six months to work elsewhere for various reasons, including to take up new opportunities in different areas.

Managers supported staff who needed time off for ill health. The trust reported the sickness rate to be 10% in June 2022. Managers had supported three staff who had required longer time off work due to ill health. Managers had continued to support these by regular telephone contact and had signposted to occupational health and other support services where appropriate. Most staff sickness had been short term.

Children and young people had regular one to one sessions with their named nurse when able to do so. However, staff had not consistently recorded this in the correct place within clinical records. Therefore, we could not be sure how regularly these took place..

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Staff made every attempt to ensure children and young people used their leave. On occasions staff had to postpone leave, but patient's leave was facilitated as soon as was possible.

The service usually had enough staff on each shift to carry out any physical interventions. Nurses reviewed the staffing and mix daily. On occasions when staff identified there was a lack of appropriately trained staff to assist with physical interventions, the trust had a process in place where staff supported from other areas.

Staff shared key information to keep children and young people safe when handing over their care to others. We observed a handover between shifts which was comprehensive.

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**.** Outside of regular working hours the trust had an on-call rota.

Managers could call locums when they needed additional medical cover, although this had not been required. Managers had a system in place for medical staff to have an induction to the service before commencing shifts.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Most training compliance was at 100%, none of the mandatory training course figures were below 91%. This was an improvement upon the previous inspection.

Our findings

The mandatory training programme was comprehensive and met the needs of patients and staff. This included subjects such as basic life support; fire safety; infection prevention and control; safeguarding and equality, diversity and human rights.

Managers monitored mandatory training and alerted staff when they needed to update their training via email and through supervision.

Assessing and managing risk to children and young people and staff

Staff completed trust risk assessments for each child and young person on admission / arrival, and reviewed these regularly, including after any incident. This was an improvement upon the previous inspection. Therefore, we could not be assured that all risk assessments were accurate, up to date and fully reflected identified risks.

Management of patient risk

Staff we spoke with knew about risks to children and young people and acted to prevent or reduce risks. Staff handed over risks during handover meetings and discussed during multi-disciplinary meetings.

Staff identified and responded to changes in risks to, or posed by, children and young people. Staff reviewed and made changes to care to reflect any changes in risk. Examples of these were increasing safe and supportive observations or having supervised access to personal items.

Staff increased observation levels to minimise risks where they could not easily observe children and young people. In the bedroom corridor, sight was aided by the use of mirrors. Staff supervised children and young people in some ward areas, in line with individual risk assessment.

Staff felt that the addition of the new high dependency unit (HDU) could reduce the use of out of county HDU beds; assist to manage higher acuity of children and young people and could assist in the step down of psychiatric intensive care placements'

Staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. However, staff did not undertake proper searches of allocated bedrooms used to seclude children and young people consistently, prior to seclusion commencing.

The ward routinely used a searching device which detected potentially prohibited items concealed on a young person. The unit was trialling a newer version, which detected metal, as well as the area of the body this was located. Staff sought consent prior to searches being undertaken.

Use of restrictive interventions

Staff worked hard to minimise the use of restrictive interventions. There had been 19 occasions when children and young people had required care in seclusion between January and July 2022. These related to six different children and young people.

When a child or young person was placed in seclusion, staff kept clear records of each episode within the clinical notes. Staff recorded episodes in line with best practice guidelines.

Our findings

On eight occasions, staff had cared for children and young people under the long-term segregation (LTS) framework. This refers to caring for young people in a separate area away from others. Staff knew the difference between long term segregation and seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was nursed in long-term segregation. Records showed regular nursing and multi-disciplinary reviews.

The ward in this service participated in the provider's restrictive interventions reduction programme, which met best practice standards. The number of restraints had reduced since the last inspection. There had been 55 physical interventions (restraint) recorded between January and July 2022. The most common forms of physical interventions used included a two-person standing escort (from one area to another); restraint in the supine position (young person restrained on their back); and the use of a safety pod for supine restraints. A safety pod is a large bean bag that young people can be laid on when restrained to reduce the risk of harm. Staff discussed using the safety pod and where possible planned the use. Staff reflected the use of the safety pod within individual care plans. The staff had not used prone restraint at any time.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young people or others safe. All staff we spoke with confirmed that they would always try to talk to the children and young people initially when upset. Staff knew what personal items provided comfort, such as a teddy bear, which staff used to help where appropriate.

Staff understood the Mental Capacity Act definition of restraint and worked within it. The staff team had a trainer for the management of violence and aggression who provided advice as and when required.

Staff followed NICE guidance when using rapid tranquilisation. Nursing staff regularly checked and recorded children and young people's physical health following any administration. If this had been refused, staff recorded this and monitored what they could through observations. This was an improvement upon the previous inspection.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. All staff had received and were up to date with training in safeguarding children and adults (100%)

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 recorded any concerns through the trust incident reporting procedure.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The social workers communicated with the relevant local authorities and external social workers as and when required.

Staff knew how to make a safeguarding referral and who to inform if they had. Managers had developed a flow chart for all staff to refer to which was visible in the nursing office.

Our findings

Managers took part in serious case reviews and made changes based on the outcomes. Staff had no recent learning to share at the time of this inspection.

Staff access to essential information

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

Patient notes were comprehensive, and regular staff could access them easily. Not every staff member who worked for an agency had electronic access to clinical notes, although were able to access these through regular staff.

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

Records were stored securely. Staff used some paper records, which they uploaded electronically in a timely way.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medical staff followed best practice when prescribing. Nurses administering medicines did so in line with trust policies.

Staff reviewed children and young people's medicines regularly and provided specific advice to children and young people about their medicines during multi-disciplinary meetings. Staff discussed individual medicines prescribed and effectiveness of these regularly during multi-disciplinary meetings.

Staff stored and managed medicines and prescribing documents in line with the trust policy. Staff stored medicine records and medicines securely in a locked clinic.

Staff followed current national practice to check patients had the correct medicines. Upon admission to the service, staff ensured they completed appropriate checks with GP services.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. These were cascaded to staff during regular governance meetings and displayed in the clinic room.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Doctors did not prescribe medicines that sedated routinely. Any concerns around potential side effects were discussed during multi-disciplinary reviews, with the children and young people.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. Nurses routinely undertook physical observations of each child and young person and recorded these. Any concerns were escalated to the doctors.

Our findings

Track record on safety

Reporting incidents and learning from when things go wrong

Managers had identified that not all incidents that staff should have been reported had been, in line with trust policy.

Staff had not reported all incidents that they should have reported. Senior staff undertook an incident audit in February 2022, to see if staff had reported incidents in line with policy. This was following a concern raised to the Care Quality Commission. The audit identified a number of incidents which staff had not been reported. As a result of this, staff continued with the audits over a further four week period. During this time, 14 further incidents were identified as having not being reported. Staff reported these retrospectively. Of the incidents not reported, five were around deliberate self-harm; one safeguarding concern; two failing to return from authorised leave; three related to searches being conducted; one medical deterioration of a young person; one related to a patient's behaviour and one was around the discovery of a prohibited item.

Team leaders undertook weekly incident reviews. Safety meetings occurred two weekly. We were assured at the time of inspection that senior staff were reviewing and signing off incidents regularly.

Staff interviewed knew what incidents to report and how to report them. It was unclear why staff had not reported all incidents. Regular staff had access to the electronic notes system. Nursing staff talked about the ward being continually busy, with healthcare support workers undertaking a lot of safe and supportive observations throughout each shift, and escorting children and young people on leave when they could. While most bank and agency staff had electronic access to clinical records, some staff confirmed that they did not.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff reported serious incidents clearly and in line with trust policy via the national reporting system. Managers allocated suitably skilled staff to undertake any investigations. We were not made aware of any recent significant incidents which had occurred on the ward.

The service had not reported any never events.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families an explanation if and when things went wrong. Staff recorded relevant information within individual clinical notes, which included conversations or meetings held. This was demonstrated in a set of clinical notes viewed, around a medicine's administration error.

Managers offered debriefs and support to staff after any serious incident where possible. This was not always immediate, due to the business of the ward, but senior staff did offer de-briefs at the earliest opportunity. The ward had a weekly reflective practice meeting which was open to all and could be used for de-briefs.

Managers investigated incidents. Children, young people and their families were involved in these investigations as and when this was appropriate. Investigators offered to meet with children, young people and family members at the beginning of any investigation.

Our findings

Staff received feedback from investigation of incidents, both internal and external to the service. Managers relayed information regularly through the local governance meetings.

There was evidence that changes had been made as a result of feedback. One example was around a young person using a dressing to engage in deliberate self-harm. Staff looked at alternative dressings and undertook risk assessments for children and young people who required these dressings, to minimise any re-occurrence.

Managers shared learning with their staff about never events that happened elsewhere through regular staff meetings.

Is the service effective?

Requires Improvement 

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. Staff recorded these in clinical notes and discussed at multi-disciplinary meetings.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Doctors physically assessed all new admissions and monitored physical health routinely.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. Care plans viewed were holistic and detailed. They had been written in first person. Staff encouraged children and young people to be involved in care planning from admission to the service.

Staff regularly reviewed and updated care plans when children and young people's needs changed. A named nurse system was in place, which ensured that staff regularly reviewed care plans. Senior nurses undertook regular care record audits, which included reviewing care planning.

Care plans were personalised, holistic and recovery orientated. Care plans viewed were wide ranging and comprehensive.

Best practice in treatment and care

Staff provided a range of treatment and care for the six children and young people who were on the ward at the time of inspection. They ensured that children and young people had access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Our findings

Staff provided a range of care and treatment suitable for the children and young people in the service. The team included a psychologist, occupational therapist, art therapist and a family therapist.

Staff aimed to deliver care in line with best practice and national guidance. Managers cascaded any reviewed or new trust / national guidance relating to the care of children and young people.

Staff identified children and young people's physical health needs and recorded them in their care records. Staff ensured all patients had care plans relating to physical health which they updated regularly.

Staff made sure children and young people had access to physical health care, including specialists as required. Staff maintained links with community services, social services, education, paediatrics and other relevant teams.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. The ward had one part time dietician and were recruiting two dietician assistants.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. The ward displayed information around the benefits of healthy eating and regular exercise.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. Therapy staff used tools to measure progress. For example, the occupational therapists used the model of human occupation screening tool (MOHOST). Psychology staff had the revised children's anxiety and depression scale (RCADS).

Staff used technology to support children and young people. Some meetings had been held virtually through video conferencing facilities. Children and young people used mobile telephones or tablets to see family and friends through video calls.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers had a rolling audit programme which they adhered to.

Skilled staff to deliver care

The ward team included or had access to a full range of specialists required to meet the needs of the six children and young people on the ward at the time of inspection. Managers continued with ongoing recruitment but reported appointing suitably qualified staff had remained a challenge.

Managers had offered some posts conditionally, dependent upon ongoing recruitment checks. While this meant that managers had appointed some staff, they were not yet employed by the trust or had a confirmed start date.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward. The service had one part time consultant clinical psychologist. This left one further full-time clinical psychologist post (which they had recently successfully interviewed for) and one part time. The family therapist was assisting with providing psychological support. Additionally, the ward had one psychology assistant. This was an improvement upon the previous inspection. In view of the reduced occupancy, this was in line with the quality network for inpatient CAMHS standards for services.

The ward had occupational therapy staff, a counsellor, and a part time art therapist. A further counsellor and creative therapist were out to advert.

Our findings

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers tried to 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. All trust staff had the required and necessary training. Managers sought assurances from the agencies used that any staff working at the service had undertaken expected mandatory training, and where possible, had experience in caring for children and young people.

Regular staff gave each new member of staff an induction in the form of an orientation document to the service before they started work. Staff were supported to complete local induction. Regular staff went through the document with each new staff member, which included lots of information, such as environmental risk, levels of observations, health and safety and documentation. This was an improvement upon the previous inspection.

Managers supported all staff through regular, constructive appraisals and clinical supervision of their work in line with trust policy. Staff recorded these. All regular staff had received an annual appraisal and regular supervision, in line with trust policy.

Managers made sure staff attended regular team meetings or gave information from those who could not attend. Relevant information was relayed through notices in the staffroom, through bulletins, emails, multi-disciplinary meetings and through supervision.

Managers identified any training needs their staff had and gave them the opportunity to develop their skills and knowledge. Examples of this included physical observations training and recording for young people.

Managers made sure staff received any specialist training for their role. Staff had undertaken training in autism and eating disorders. This was an improvement upon the previous inspection.

Managers recognised poor performance, could identify the reasons and dealt with these. Support was offered via the trust human resources department as and when required.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Meetings occurred weekly. Staff recorded discussions around ongoing care and treatment in clinical records. Family members and carers were encouraged to attend, either in person, or through video conferencing.

Staff made sure they shared clear information about children and young people with relevant team members regarding changes in their care, including during handover meetings. Social workers communicated with external professionals and agencies as and when needed.

Ward teams had effective working relationships with other teams in the organisation. Examples of which included the trust safeguarding team and quality and governance team.

Our findings

Ward teams had effective working relationships with external teams and organisations. Staff invited external healthcare professionals to multi-disciplinary meetings where appropriate to discuss individual care needs of children, young people and their families.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Compliance with training at the time of inspection, was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The ward had a Code of Practice which staff could refer to.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Senior nurses were available in the evenings and over the weekends to offer advice in the absence of administrators.

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. Staff could access these electronically.

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 ward had displayed relevant information regarding this.

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. Nursing staff did this upon admission to the service and intermittently following admission throughout a young person’s stay.

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. This was particularly important as direct access to outside space had been limited due to ongoing refurbishment.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. The second opinion was recorded and stored with the medicine charts in the clinic.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. Staff scanned original copies onto the electronic system for ease.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed information to tell them this. On occasions doctors and nurses had utilised the Mental Health Act to detain a child and young person to keep them safe, whilst arranging a Mental Health Act Assessment for further detention.

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. The multi-disciplinary team considered this as part of the discharge process.

Our findings

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Mental Health Act administrators supported this.

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 the five principles. Training compliance at the time of inspection, was 100%.

There had not been any Deprivation of Liberty Safeguards applications made in the last 12 months. Staff were aware of how to make an application if they needed to.

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

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Social workers and Mental Health Act administrators were available to advise and support staff.

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. Clinical notes evidenced capacity about care and treatment and showed that staff supported young people to make decisions for themselves.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Doctors discussed consent with the children and young people on an individual basis, or during weekly reviews of care with the multi-disciplinary team.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. Clinical records viewed evidenced this.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this. Members of the multi-disciplinary team discussed this regularly during multi-disciplinary reviews.

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. We did not view any best interests' decisions at the time of inspection, but staff were aware of this process.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. The Mental Health Act administrator assisted the staff team with this.

Is the service caring?

Requires Improvement 

Our findings

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

Kindness, privacy, dignity, respect, compassion and support

Most staff treated children and young people with compassion and kindness. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Feedback from young people and carers around the kindness of staff was mixed. The three young people we spoke with said staff treated them well and behaved kindly. Two carers spoke positively about the staff.

Some staff were discreet, respectful, and responsive when caring for children and young people. Two carers told us about some unacceptable behaviours their relatives had experienced. One related to inappropriate comments made around one person's appearance, which caused upset. Another example given, was a poor and uncaring response a staff member made when a young person was engaging in deliberate self-harm. These incidents had been reported to senior staff at the time, who took appropriate actions with the staff members involved.

We observed on two occasions, staff entering the clinic room without knocking, while a staff member was inside with a young person. A young person talked about a staff member leaving the clinic door open while they were having some observations undertaken, which they had not been happy about. We fed this back to senior staff. On our return visit, managers had put up a sign at the clinic door to indicate when this was in use.

Staff gave children and young people help, emotional support and advice when they needed it. The three young people we spoke with told us the staff were usually around when they needed them.

We observed some kind and caring interactions between staff and young people during the inspection. It was clear that some staff had a good rapport with the young people they were caring for. Staff understood the individual needs of each child or young person, which was evident during some interactions seen, and through staff discussions.

Staff supported children and young people to understand and manage their own care treatment or condition. Staff evidenced such interactions in clinical daily notes.

Staff directed children and young people to other services and supported them to access those services if they needed help. Regular staff understood the individual needs of each child and young person. Bank and agency staff referred children and young people to regular staff for advice as and when needed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. Staff were able to tell us who they would report any concerns to and felt confident they could do this.

Staff followed policy to keep patient information confidential. Data security awareness was mandatory training for all staff.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that children and young people had easy access to independent advocates and to child helplines.**

Our findings

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. Young people and carers confirmed that the staff were welcoming and showed them around the ward upon arrival.

Staff involved children and young people and gave them access to their care plans and risk assessments, and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines. This was an improvement upon the previous inspection.

Staff made efforts to ensure children and young people understood their care and treatment. Interpreters were used for young people whose first language was not English. Therapy staff could create easy read material if needed.

Staff involved children and young people in decisions about the service, when appropriate. Examples of this included murals and colour schemes within the ward, and some input into the food menus. Staff provided children and young people with weekly updates about the building works and progress.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Staff held daily community meetings. Additionally, the ward held weekly improvement meetings, where young people were encouraged to write the minutes. A nurse and a member of staff from the therapy team attended these meetings, to ensure representation from the staff team.

Staff supported children and young people to make decisions around their care. Each young person could make requests during their weekly multi-disciplinary meeting and were given the opportunity to discuss their care and treatment.

There was a designated involvement lead who regularly visited the service and spent time speaking with young people. The involvement lead offered regular feedback to senior staff.

Staff made sure children and young people could access advocacy services. We saw written information about this on display in the service.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately. Three carers told us that they had not always been informed of updates or of incidents which had occurred involving their relatives in the past. However, two of these said that this had improved in recent months. An allocated staff member kept them updated on a weekly basis.

Staff aimed to support, inform and involve families or carers of children and young people. Staff invited them to multi-disciplinary meetings where they could offer feedback about the care and treatment. Some carers attended in person, and others via video conference.

Carers knew who they could contact if they had any concerns or queries. Most told us they would speak with the senior nurses / matron of the ward.

The social workers were able to give carers information on how to find the carer's assessment.

We noted an update on the building works / refurbishment had been placed in the reception area of the unit for visitors to see.

Our findings

Is the service responsive?

Requires Improvement 

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

Access and discharge

Staff planned and managed the discharge of children and young people as best as they could, with ongoing placements and care packages not always being available at the point they were needed. They worked well with services providing aftercare to manage children and young people's move out of hospital.

Managers made sure bed occupancy did not go above 85%. Managers had reduced bed occupancy in 2022 due to the building works and acknowledgement of staffing capacity.

Managers regularly reviewed length of stay for children and young people and tried to facilitate discharge or transfer to another service at the right time for each patient.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Staff planned discharge in a coordinated way with the young people, carers and external organisations as appropriate.

When children and young people went on leave there was always a bed available when they returned. Managers did not accept new admissions if there were no vacant beds.

Staff did not move or discharge children and young people at night or very early in the morning. Staff ensured that discharges occurred at an appropriate time of day.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed and took action to reduce these. Any delays in discharge or transfer had been due to resourcing of beds externally. The shortage of specialist beds for children and young people, is a national issue, which the trust had no control over.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. As part of the discharge planning, staff invited relevant agencies and professionals into the service to plan effectively.

Staff supported children and young people when they were referred or transferred between services. Staff discussed plans so that each young person knew what would happen and when.

Staff generally completed safety plans with each patient prior to discharge. However, we noted that staff had not completed these comprehensively on two occasions in February 2022. Staff were unable to explain the reason for this.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward had not always supported children and young people's treatment, privacy and dignity. Refurbishments to the unit had reduced quiet and outside space on a temporary basis.

Our findings

Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There was a quiet room for privacy. Children and young people gave various feedback about the food provision. Children and young people could make hot drinks and snacks when they wanted.

Each or young person had their own bedroom, which they could personalise if they chose to. We saw some rooms had personal items within them which had been important to the young people.

Children and young people had a secure place to store personal possessions. The ward had locked areas where valuables could be stored outside of the bedrooms if preferred.

The service had some quiet areas / rooms where children and young people could meet with visitors in private. Visitors were able to book available rooms through the administrative staff at reception, if they were available. One carer talked about the lack of available visiting space on occasions.

Children and young people could make phone calls in private using their mobile phones. A ward telephone was also available if needed.

Some carers and staff told us that there had only been one quiet room for children and young people to use for several months during some of the building works. Staff initially had accommodated more time for children and young people in their bedrooms, but this had not been consistent. We were told that this impacted negatively upon one young person who needed space alone when upset.

The ward had no direct access to garden space. These areas had been deemed unsafe to use throughout the refurbishment. Carers and staff confirmed that some children and young people did not always have access to fresh air. The onsite school had a garden which children and young people could access out of school hours. However, not every child and young person at Forest House were attending school. New admissions who were detained under the Mental Health Act, would not have Section 17 leave initially. This meant that some patients had no access to fresh air at all for periods of time. Following this inspection, the trust confirmed that as of 14 September 2022, one outside space had been made safe for patients to use under staff supervision.

The consultants gave leave when it was assessed as safe to do so. Some children and young people had leave suspended following incidents of deliberate self-harm, for example for a two day period, in line with care plans. We were made aware of one patient who had not experienced fresh air for over two weeks. Contractors were working towards getting the outside areas safe to use, progress was observed during our inspection.

The trust officially opened a new “wellbeing sensory garden” during our inspection. This had been created, in collaboration with children and young people, for children and young people community services, families and staff. The gardens were also available for children and young people at Forest House to enjoy.

Children and young people could make their own hot drinks and snacks and were not dependent on staff. Each young person had an individual snack box which they could access as and when they wanted.

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.

Our findings

Staff made sure children and young people had access to opportunities for education and supported them. The site had an on-site education centre where children and young people could continue with their education. This is rated as outstanding by OFSTED.

Staff helped children and young people to stay in contact with families and carers. Young people and carers we spoke with confirmed this.

Staff encouraged children and young people where possible to develop and maintain relationships both in the service and the wider community. Children and young people were encouraged to maintain relationships of importance to them while in hospital.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff could access a speech and language therapist to gain advice and support for young people who experienced communication difficulties.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. Young people were aware of how to make a complaint about the ward and also knew they could contact the Care Quality Commission to give feedback about care.

The service could access information leaflets available in languages spoken by children, young people and the local community. Nursing staff printed these off for young people as and when appropriate.

Managers made sure staff, children and young people could get help from interpreters or signers when needed. There was ongoing evidence of this within clinical records viewed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. Feedback about the quality and variety of food had been mixed from young people.

Children and young people had access to spiritual, religious and cultural support. Staff supported and encouraged young people to maintain their faith and worship. Doctors agreed leave for this if safe to do so.

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. This was evident during interviews undertaken.

The service clearly displayed information about how to raise a concern in patient areas. We observed this in communal areas of the ward.

Staff we spoke with understood the policy on complaints and knew how to handle them. Staff were familiar with the complaints policy and knew who to escalate to and how to record.

Our findings

Managers investigated complaints and themes. Between January and July 2022, the service had received five formal complaints. Four of these included complaints around care and treatment, two included concerns around the attitude of staff and one included concern around building works / environment.

Staff had investigated and completed three of these. Two complaint investigations were ongoing, the progress of which we reviewed. Staff had acknowledged a complaint in April 2022 within expected timescales. We noted that the outcome had not been finalised. The anticipated date of the outcome was 25 June 2022. Staff had acknowledged this to the relevant individual and had apologised for the delay. Senior staff told us on 07 July 2022 the response would be sent out within the next week. However, staff had still not actioned this when we returned to the unit on 24 July 2022. This had not met the trusts complaint response time. During the investigation process, the complainant, on 24 May 2022, asked for additional concerns to be addressed as part of the complaint. The trust advised this was why the complaint took longer to finalise. The trust sent out the final response letter on 08 August 2022.

Staff had acknowledged the most recent complaint within expected timescales. The trust was in the process of completing a draft response. Staff were on track to have this completed in line with policy.

Children, young people and their families received feedback from managers after the investigation into their complaint. Managers offered to speak or meet with those who had raised a complaint, and the outcome of the complaint was sent out in writing upon completion.

Managers shared feedback from complaints with staff and learning was used to improve the service. One example was around the lack of snack boxes for each young person. This was raised as an issue by young people on the ward. As a result, staff purchased additional boxes to ensure each young person had adequate space to store snacks.

The service used compliments to learn, celebrate success and improve the quality of care. Managers shared compliments and thanks during staff meetings. Thankyou cards had been displayed in the office for the staff team to see.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

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

The core management team were aware of ongoing challenges within the service and met regularly to discuss progress relating to ongoing improvement plans, which they regularly monitored and updated. Leaders had managed mitigations of risk around the ongoing refurbishment. However, leaders had not incorporated direct access to fresh air for children and young people as a priority during the planning.

Our findings

Staffing continued to be a challenge for this service. Leaders had recruited different multi-disciplinary staff members since the last inspection. Managers had reduced bed numbers, taking into consideration the refurbishment, along with staffing capacity. Substantive staffing numbers for the number of patients at the time of this inspection were adequate. The number of unfilled nursing shifts were decreasing. Leaders were aware that staffing needs to be a consideration for when bed numbers increase.

Leaders talked about seclusion in bedrooms not being an ideal scenario. Leaders authorised use of the S136 suite when possible to minimise risks. All staff talked about the complex care many young people required during admission, with seclusion sometimes being necessary to maintain the safety of all. Staff were pleased that the refurbishment included two high dependency beds, which they felt was needed for young people who presented as high risk to self or others.

Staff confirmed that different members of the trust executive team had visited the service regularly over recent months. Trust staff also had the opportunity to interact with the executive team during regular scheduled catch up calls, which were open to all.

The head of nursing and the service manager had been working closely with the unit and had maintained contact with the service outside of regular working hours as necessary to offer support to operational staff.

Vision and strategy

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

The overarching values of the trust were welcoming, kind, positive, respectful and professional. Permanent staff were aware of these values. The overall vision of the trust and staff was to deliver great care and achieve great outcomes – together. It was clear that staff we spoke with strived to offer the best care possible.

Culture

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

Most staff we spoke with felt supported and valued by the trust. Numerous nursing staff acknowledged that there had been difficulties in terms of workload; staff injuries and generally the ward being a challenging environment to work in. All staff told us that there had been improvements over the past few months which had resulted in them feeling more positive about their roles and their work.

Leaders encouraged staff to raise concerns. Staff we spoke with felt able to raise concerns without fear of any repercussions. The trust had a freedom to speak up policy, freedom to speak up advocates and a freedom to speak up guardian. Staff were aware of these. Between January and July 2022 there had been two concerns raised in relation to Forest House. Both concerns had elements around the booking process for bank and agency staff, which staff had addressed. A further element of concern was around the care and treatment of one young person, which clinical staff addressed with the multi-disciplinary team.

Senior staff had arranged and facilitated a staff team development day which they reported as being well received. A further day is to be organised.

Our findings

Governance

Our findings from the other key questions demonstrated that governance processes had been introduced at team level and that performance and risk were being routinely monitored and managed.

The senior team had managed the ward environment as safely as possible during the ongoing building works. The safety of children and young people had been a priority, with other risks related to the works being monitored and managed. An action plan with risk mitigation was ongoing.

Some of the senior clinical team were relatively new. The service manager commenced their role at Forest House in February 2022. The lead nurse commenced their role in December 2021. Both were new to this service, although had both worked within the trust in other roles prior to starting at Forest House. All reported they were working well as a team, and they were proud of achievements and improvements made to date.

Senior nursing staff along with various members of the multi-disciplinary team met monthly at the ward's quality and risk meeting. The agenda was comprehensive and covered areas such as safety alerts; incidents and learning from; restrictive practice; involvement of young people and staff wellbeing. During this meeting, staff shared feedback from the regular patient safety meeting, which staff had introduced earlier in the year.

The non-reporting of incidents had been addressed and monitored by senior staff at the service. It was clear that improvements had been made around performance and risk in recent months. Ongoing monitoring of this was evident with the regular meetings staff had set up.

Management of risk, issues and performance

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

The trust maintained a risk register for the Forest House. Risks identified included the national shortage of specialist beds for children and young people; staff vacancy rates; reduced numbers of staff appropriately trained in the management of violence and aggression and the levels of violence and aggression displayed by children and young people. The Trust Board were aware of these risks and the mitigations in place. Senior staff reviewed these regularly.

Information management

Staff engaged actively in local and national quality improvement activities.

Staff undertook regular and routine audits which included infection prevention and control; case file audits; medicines audits; observation audits and therapy audits. Staff had implemented appropriate action plans and continued to work hard to provide good quality care.

The trust had just approved some additional specialist training for staff, to commence in the autumn. Modules relate specifically to the care and treatment of young people. Senior staff had plans to introduce this as mandatory for all staff working in this area and were enthusiastic about this further training being offered.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Our findings

Learning, continuous improvement and innovation

The trust remains a member of the Quality Network for Child and Adolescent Inpatient Services (QNIC), and last participated in a peer review in March 2021.The trust informed us that in August 2022, QNIC reviewers had a planned meeting with senior staff to discuss arranging a peer review in the autumn of 2022. The Forest House team were undertaking a benchmarking exercise of current service provision against the QNIC standards in preparation for this.

Our findings

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that there is adequate recruitment of substantive staff across the multi-disciplinary team to ensure young people's care and treatment needs are fully met. Regulation 18 (1).
- The trust must ensure that complaints are investigated and completed in line with timescales set out in trust policy. Regulation 16 (1) (2).
- The trust must ensure that children and young people have access to a nurse call system. Regulation 12 (1).
- The trust must ensure that rooms used for seclusion are safe, with objects removed which could be used to cause harm. Regulation 12 (1) (2)(a)(b)(d).

Action the trust Should take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that young people are given access to fresh air.
- The trust should ensure that staff record all 1:1 key sessions with young people.
- The trust should ensure agency staff can access clinical records.
- The trust should ensure that staff report all incidents in line with trust policy

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialised nurse advisor. The inspection team was overseen by Craig Howarth, Head of Hospital Inspection.

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
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