

# Cambridgeshire and Peterborough NHS Foundation Trust

## Child and adolescent mental health wards

### Inspection report

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Date of inspection visit: 19 October 2021 to 3 November 2021  
Date of publication: 31/03/2022

### Ratings

Overall rating for this service

Good 

Are services safe?

Requires Improvement 

# Our findings

## Child and adolescent mental health wards

Good   

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services.

We inspected the trust's three children and adolescent mental health wards based at Ida Darwin Hospital in Cambridge: Darwin, Phoenix and the Croft.

We did not rate all key questions of this core service, however, our rating for safe went down and is now requires improvement because:

- There were not always sufficient staff at the service. There were significant vacancies for nurses, healthcare assistants and other support staff. For the two weeks ahead of our inspection there were many occasions where the staffing levels on the ward fell below the safer staffing levels set by the trust. The trust did not record all occasions when staff were moved during shift to accommodate cover arrangements, so it was not possible to be assured that there was sufficient staffing at all times. We noted occasions where leave was cancelled due to staffing levels and there were not always sufficient staff on Phoenix ward to accommodate physical intervention.
- Not all staff had undertaken required mandatory training on Phoenix ward. Physical intervention training completion rates were 66% on Darwin, 44% on Phoenix and 32% on Croft.
- The quality of care plans and risk assessments was variable and not all incident information had been captured. For two young people who had been involved in multiple potential self-harm incidents' the risk of self-harm was recorded as low. Not all risk assessments had been updated following significant incidents. We noted incidents within contemporaneous records that had been included on the risk assessments.
- Seclusion rooms on Darwin and Phoenix wards did not meet all of the requirements of the Mental Health Act code of practice.
- Managers had completed and updated ligature point risk assessments of all wards areas however we found that these were not available to all staff.

However:

- Most ward areas were clean, well maintained, well-furnished and fit for purpose.
- There had been minimal use of physical intervention or rapid tranquilisation at the service in recent months. There had been no use of seclusion since August 2021. Physical health checks had been undertaken following restraint and rapid tranquilisation.
- Staff knew what incidents to report and how to report them. Managers debriefed and supported staff after any serious incident and investigated incidents thoroughly. Children, young people and their families were involved in these investigations where appropriate. Staff received feedback from investigation of incidents and were included in learning discussions looking at improvements to care. There was evidence that changes had been made as a result of feedback.

# Our findings

## How we carried out the inspection

- Reviewed the environment of all wards
- Spoke with the service director, service manager and modern matron for the child and adolescent mental health service
- Spoke with the deputy ward manager and clinical team leader for Darwin and the nurses in charge of Croft and Darwin wards
- Spoke with key stakeholders including the East of England Provider Collaborative
- spoke with four other staff
- spoke with three children and young people and joined a community meeting on Darwin Ward
- spoke with two young peoples' parents
- looked at care and treatment records for five young people
- reviewed incident and physical intervention records
- reviewed staffing rotas for the three wards
- reviewed observation records
- and reviewed a range of policies and procedures, data and documentation relating to the running of the service.

You can find further 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>

## Is the service safe?

**Requires Improvement**  

### Safe and clean care environments

#### Safety of the ward layout

Managers had completed and updated ligature point risk assessments of all wards areas in September 2021 however we found that these were not available to all staff. The risk assessments were stored electronically, and not all staff were able to access these. Paper copies found by staff were dated 2019 and did not demonstrate some changes to the environment that had occurred at the wards.

Potential ligature anchor points in the service were included in the latest risk assessments. Staff were able to demonstrate that they knew about the risks and mitigated these to keep young people safe.

The wards complied with guidance and there was no mixed sex accommodation at the time of the inspection. On Darwin ward a swing corridor separate from the female corridor was being used to accommodate male young people while essential work was undertaken on the male bedroom corridor.

#### Maintenance, cleanliness and infection control

# Our findings

Most ward areas were clean, however, we noted that the visitors' room on Darwin ward had not been sufficiently cleaned following an incident in which bodily fluids had been spilt.

Croft and Phoenix wards were well maintained, well-furnished and fit for purpose. Following a previous incident on Darwin ward there had been significant damage to the environment. A programme of building works was underway to address these issues and will be completed by February 2022. To manage the work safely there were reduced number of young people admitted to the ward and areas of the ward were locked off from young people's access to ensure safety.

Darwin ward had no curtains at any of the windows however the bedrooms had been obscured with frosted privacy glass on the external windows. New curtains had been on order and were fitted immediately following the inspection.

Staff followed the infection control policy, including handwashing and appropriate arrangements were in place to manage risks from Covid 19. Staff had access to personal protective equipment (PPE) and regular testing and all young people, staff and visitors entering the service were checked for Covid status and symptoms.

## Seclusion room

The seclusion room on Phoenix ward did not meet all requirements of the Mental Health Act code of practice as there was no clock and there was a potential risk from protruding metal work around the door.

On Darwin ward work had commenced to provide a new seclusion area. In the interim the staff would use either the seclusion room on Phoenix ward or a bedroom in Darwin ward. The bedroom on Darwin ward contained standard electric sockets and there was no ability to control temperature or lighting externally. However, there had been no episode of seclusion required in previous months.

## Safe staffing

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

## Nursing staff

All wards had vacancies for registered nurses and healthcare assistants. Across the service there were vacancies for nine nurses and twelve healthcare assistants. In addition, there were vacancies for psychologists, psychological assistants, a family therapist and a social worker. The trust confirmed that four nurses had recently been recruited and would soon commence employment and that recruitment was underway for the other posts.

We reviewed staff rotas for the two weeks ahead of our inspection that showed many occasions where the staffing levels on the ward fell below the safer staffing levels set by the trust. Managers told us that safer staffing levels had not been reviewed and adjusted in line with reduced patient numbers across the service and that overall staffing was sufficient as staff moved across the wards as required to ensure adequate cover. The trust did not record all occasions when staff were moved during shift to accommodate cover arrangements, so we were unable to check whether there was always sufficient cover. Following the inspection, the trust confirmed that they were implementing a system to record where staff were deployed throughout their shift and that they would monitor this. The trust had begun to review safer staffing levels against patient capacity.

# Our findings

From our review of notes we found occasions when the young people had not been able to undertake planned leave due to insufficient staffing levels.

Not all staff were up to date with mandatory physical intervention training. At the time of the inspection, physical intervention training completion rates were 66% on Darwin, 44% on Phoenix and 32% on Croft. In addition, not all agency staff received physical intervention training from the trust. Phoenix ward did not always have enough staff with physical intervention training on each shift. This meant that staff from Darwin and Croft were needed to help with physical intervention including when nasogastric (NG) feeding was required.

## **Mandatory training**

Staff had completed and kept up-to-date with most of their mandatory training on Darwin and Croft wards. However, on Phoenix ward overall training completion rates were at 60%.

## **Assessing and managing risk to young people and staff**

### **Assessment of patient risk**

We reviewed care plans and risk assessments for five young people. The quality of these documents was variable and not all incident information had been captured. For two young people who had been involved in multiple potential self-harm incidents' the risk of self-harm was recorded as low. Not all risk assessments had been updated following significant incidents. We noted incidents with contemporaneous records that had been included on the risk assessments.

### **Management of patient risk**

Staff knew about any risks to each young person and acted to prevent or reduce risks. However, we remain concerned about the level of continued potentially serious incidents with some young people. Following the inspection the trust told us that they had provided staff with additional training in risk management and had implemented the situation-background-assessment-recommendation (SBAR) approach and a new handover process to ensure all risk was highlighted to staff in a timely way.

Staff could observe young people in all areas of the wards and staff followed procedures to minimise risks where they could not easily observe the young people.

### **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 the young person or others safe. Levels of restrictive interventions were low during the previous two months.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. There had been three episodes of rapid tranquilisation in the previous two months, these had been managed appropriately. Following administration of rapid tranquilisation staff had undertaken required physical health monitoring.

# Our findings

There had been no episodes of seclusion since August 2021. Following recommendations made since a visit by a Mental Health Act Reviewer in August 2021 the service had devised and implemented seclusion packs and staff had received additional training in seclusion practice. The trust had since devised an audit programme however this was yet to be tested as no seclusion had occurred.

## **Staff access to essential information**

The service had changed the electric records system in previous months. Staff told us that some essential forms including seclusion and physical intervention records had not yet been made available on the system. This meant that staff used both paper-based or electronic records and did not always have easy access to clinical information. In addition, some agency and education staff did not have access to the clinical records system. Following the inspection, the trust told us they were working with the system provider to ensure that the forms are made available.

## **Track record on safety**

### **Reporting incidents and learning from when things go wrong**

In the month prior to the inspection there had been 39 incidents across the service. There had been no serious incidents.

Staff knew what incidents to report and how to report them. Staff had reported incidents in line with trust policy and reports made were detailed. Managers had investigated incidents thoroughly. Young people and their families were involved in these investigations where relevant.

Managers debriefed and supported staff after any significant incident. Following a serious incident that occurred at Darwin ward in June 2021 the trust had developed a new process around debriefs which was being piloted at the service and the staff team had been given access to an external facilitator.

Staff received feedback from investigation of incidents at team meetings and were included in learning discussions looking at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, following the serious incident on Darwin in June 2021 staff had received additional training in managing incidents and meetings had begun with the local police to discuss emergency response. Following an absconsion by a patient a step by step guide was developed and training sessions were run to improve staff awareness of how to respond in this situation.

# 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 deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons who receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (1) 18 (2a) (HSCA (RA) Regulations 2014 Staffing).
- The trust must ensure that all relevant staff receive training in physical intervention including the de-escalation of incidents. (Regulation 18 (1) 18 (2a) (HSCA (RA) Regulations 2014 Staffing).
- The trust must ensure that risk assessments and care plans include all relevant information and are reviewed and update following any significant incident or patient concern. (Regulation 12 (2) (a-b) (HSCA (RA) regulations 2014 Safe care and treatment)
- The trust must ensure that seclusion rooms meet the standards set out in the Mental Health Act code of practice. (Regulation 12 (2) (d) (HSCA (RA) regulations 2014 Safe care and treatment)

### **Action the trust Should take to improve:**

- The trust should ensure that all staff have timely access to patient and other relevant records including environmental risk assessments.
- The trust should ensure that sufficient cleaning is undertaken following any incidents in which bodily fluids are spilt.

# Our inspection team

The team that inspected the service comprised a CQC inspection manager and two CQC inspectors.



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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing