Associated Wellbeing Limited

The Lighthouse

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Inadequate**

Summary of findings

Overall summary

The Lighthouse is a four bed child and adolescent mental health unit based in Darwen, Lancashire. The service aims to provide step-down from child and adolescent mental health inpatient units as well as a placement for children to be admitted to during a crisis to avoid a hospital admission.

Following this focused inspection, we have rated safe as inadequate. There were large gaps in the service provision that meant the service was unsafe for children. We served The Lighthouse with a warning notice following this inspection. The provider is required to make improvements by 4 March 2022.

At the last inspection, we rated safe as inadequate due to concerns about:

staff not being trained in restraint,

not having enough staff to safely restrain children

there was no nurse call alarm system

disclosure and barring service checks were not completed prior to employment

positive behaviour support plans were not based on functional assessments and contained negative punishment strategies

not all incidents involving the police were reported to the Care Quality Commission

We carried out this focused inspection of the safe key question only to see if the service had made the required improvements following safe being rated as inadequate in the March 2021 inspection. We did not inspect the other key questions at this focused inspection and the ratings for these remain the same:

Effective (requires improvement)

Caring (requires improvement)

Responsive (good)

Well-led (requires improvement)

The service was not safe for children and young people. The service did not have enough nursing and support staff to keep patients safe. From 1 September 2021 to 30 November 2021, there were 102 shifts out of a total of 182 shifts where staffing establishment levels were not met. Staff were also required to support a child in another property (an annexe – but considered as part of the Lighthouse) across the road. This meant the staffing ratios in both buildings were unsafe.

There was a high risk of children being exposed to avoidable harm. There were not enough staff to safely support children during incidents of restraint. If a child required two members of staff to support them, there was often not a third member of staff to care for the other children.

Summary of findings

Managers did not comply with the incident reporting system and process. There was a significant number of police incidents that were not reported to the Care Quality Commission. The incidents related to children being reported as missing or behaving in a violent and aggressive manner towards staff.

Staff did not always adequately manage risks to patients. The service had admitted an 18 year old for two nights. We were not assured the risks of admitting the 18 year old had been assessed or managed at the time of admission. Documents relating to this admission had been created after the admission.

However,

Staff had received training in restraint prior to direct work with children, which was an improvement since the last inspection.

Staff and patients had access to nurse call alarms, which was an improvement since the last inspection. However, the volume on the nurse call alarm system could not be heard by staff required to respond. The service had received quotes to make repairs. There was a plan for the repair to be completed week commencing 10 January 2022.

The service had developed good positive behaviour support plans for children. They no longer contained negative punishment strategies and were now based on functional assessments.

All staff now had disclosure and barring service checks completed prior to starting employment. There was a system in place to cross reference each new employee with dates of employment and dates of DBS checks.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to The Lighthouse

The Lighthouse is a four bed child and adolescent mental health unit based in Darwen, Lancashire. The service aims to provide step-down from child and adolescent mental health inpatient units as well as a placement for children to be admitted to during a crisis to avoid a hospital admission. The provider also owned another property across the road which had been used to accommodate children and at which staff had provided care and treatment. There were no children in this property at the time of inspection and we did not visit this property at part of this inspection. This property is not registered separately and is considered an extension of The Lighthouse.

The service was registered in December 2019 and admitted its first child in January 2020.

The service is registered to provide the following regulated activities:

Treatment for disease, disorder or injury

Accommodation for persons who require personal and/or nursing care

At the time of inspection, the registered manager had left the service. A new registered manager had been appointed and was applying to the Care Quality Commission to become the new registered manager.

This service has been inspected on two previous occasions. At the last inspection the following requirement notices were issued and the safe key question was rated inadequate:

Regulation 9 HSCA (RA) Regulations 2014 Person centred care

The service failed to ensure that all positive behaviour support plans were completed using functional assessments. Positive behaviour support plans included negative punishment strategies that was detrimental to children's wellbeing. Regulation 9(1). This had improved at the time of this inspection.

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

The service failed to ensure that restraint was always carried out safely. Staff involved in restraint were not appropriately trained and there was not sufficient numbers of competent staff available to use restraint. Regulation 12(1). Staffing levels were still a concern at this inspection, although staff were now trained in restraint.

The service failed to ensure that a system was available to children and young people so where needed they can call for assistance. Regulation 12(1) This had improved at this inspection, although we were concerned about the audibility of the alarm system.

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service failed to ensure that all staff had the correct disclosure and barring service checks prior to starting employment. Regulation 17(1). This had improved at this inspection.

Summary of this inspection

The service failed ensure that there were systems and processes in place that captured any failures in governance. This included not checking all staff were appropriately trained and that the necessary employment checks were conducted prior to employment. Regulations 17(1). We did not review the governance systems and processes in detail at this inspection, however staff were now appropriately trained and employment checks were carried out.

What people who use the service say

We spoke to two children about their experiences of The Lighthouse. One child was a current inpatient and another had been recently discharged but received ongoing outreach support.

Both children spoke very highly of the staff and the team. Children spoke of the many activities available to them and the independent life skills that they had acquired. This support allowed children to move on to semi-independent living in the local community.

Children said they were treated kindly by staff and enjoyed the advice and support provided to them.

How we carried out this inspection

This was a focussed inspection to review the concerns that led to the inadequate rating of the safe key question. The overall rating for this service remains requires improvement.

Before the inspection visit, we reviewed information that we held about the service and engaged with other stakeholders.

During the inspection visit, the inspection team:

visited the service and observed how staff were caring for children and young people during the day

spoke with two children who were using the service

spoke with the three senior managers

spoke with two other staff members

received feedback about the service from two local authorities

looked at two care and treatment records of children and young people

reviewed three positive behaviour support plans

looked at a range of policies, procedures and other documents relating to the running of the service.

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

Summary of this inspection

Areas for improvement

Action the service MUST take to improve:

The service must ensure that there are enough competent and trained staff available on each shift to keep children safe. Staffing levels must match the required staffing establishments levels on each shift. Policies and practice should reflect nationally recognised best practice in de-escalation and restraint. (Regulation 18 (1))

The service must ensure that all police incidents are reported to the Care Quality Commission. (Registration regulation 18 (2) (f))

Action the service SHOULD take to improve:

The service should ensure that the nurse call alarm system is always audible to staff.

The service should ensure that it has clear policies and procedures in place for the admission of young people who are 18 years of age.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Not inspected	Not inspected	Not inspected	Not inspected	Requires Improvement
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Not inspected	Requires Improvement

Requires Improvement

Child and adolescent mental health wards

Safe | Inadequate

Are Child and adolescent mental health wards safe?

Inadequate

Our rating of safe stayed the same. We rated safe as inadequate.

Safe and clean care environments

The ward environment was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Children now had easy access to nurse call systems. An electronic nurse call system had been installed. There were alarms in each bedroom. However, on the day of our onsite inspection the volume of the alarm system was too low and could not be heard. Managers agreed to rectify this issue. There was a plan for the alarms to be repaired week commencing 10 January 2022.

Safe staffing

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

Nursing staff

The service did not have enough nursing and support staff to keep children safe. Due to our concerns and the need for the provider to make significant improvement we served a warning notice. This requires the provider to ensure there are sufficient numbers of staff to safely manage an incident that may require physical intervention with a child.

At our inspection in March 2021, we were concerned that there were not enough trained staff on duty to safely manage a restraint. A member of staff who had not received recognised training in de-escalation and restraint had been involved in restraining a child. We told the provider there must be enough staff to safely restrain a child if needed and to support other children in the service.

Staffing levels had been reduced since our last inspection. The registered manager left the service in August 2021 and staff were unable to clarify the staffing establishment levels prior to August. However, a review of the rotas showed the following concerns:

On 15 July 2021 the only nurse on shift was completing her induction.

On 10 August 2021 there was no registered nurse cover at night.

At the time of inspection, staffing establishment levels during the day and night were one nurse and two support workers. During the day there were additional staff such as a manager and a safety lead. Three staff is not enough to safely restrain children should they be in a floor position.

From 1 September 2021 to 30 November 2021, there were 102 shifts where there were not three staff for a whole shift or a substantial period of time out of 182 shifts. This included:

41 shifts during the day when there were only two staff

57 shifts during the night when only two staff

Three occasions where there was only one staff

The provider owned another property, which was across the road from the registered location of The Lighthouse. This property had been used to support children and young people, who had been moved to this property from the registered location for a period of time, during which care and treatment was provided by staff from The Lighthouse. Despite reviewing rotas and asking the provider, it was unclear how often staff at The Lighthouse had been called to support children and young people in this other property, which meant staffing levels at The Lighthouse could have been further reduced. This property was not registered separately and was classed as an extension of The Lighthouse.

There was a risk that significant avoidable harm could occur because there was not enough staff to ensure children could be safely managed if there was a need to undertake a physical intervention. The service did not have enough staff to safely manage physical interventions because there were often only two staff on shift. Staffing levels must be sufficient to enable staff to safely carry out physical interventions whilst still attending to the needs and safety of the other patients. If a child required restraining, that would need at least two staff to support the child and at least one other staff member to ensure the safety of the other children.

The National Institute of Health and Care Excellence guideline NG10 states that health and social care provider organisations should define staff: patient ratios and the numbers of staff required to undertake restrictive interventions and ensure that restrictive interventions are only used if there are enough trained staff available. There were a significant number of shifts when there were only two or less members of staff on duty which meant that staff could not have safely managed a physical intervention and maintained the safety of the other children.

The service was not clear about what types of restraints were used by staff and the policies did not reflect what staff said they provided, which could put patients at risk. The clinical director and the safety and development lead explained that restraint on the floor, such as supine or prone restraint, was no longer used at The Lighthouse. This was given as justification for the reduction in staffing establishment levels. However, the restrictive intervention policy did not reflect this position and staff had received training in these holds, which meant they could potentially use them with children without sufficient staff to support this.

The managers stated they would only admit children who were not complex and did not require high levels of physical interventions or restraint on the floor. However, this was not reflected in the admission policy or in practice. A child was a patient at the time of inspection who had required high levels of physical intervention just prior to admission. This meant the service was admitting patients who could require high levels of physical intervention and restraint on the floor, without having sufficient staff to carry that out safely.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. We reviewed the positive and safe restrictive interventions training received by staff. All staff had received the appropriate training. Staff now completed this training prior to starting direct work with children. There were systems and processes in place to monitor this. We reviewed the staff training tracker. It was documented and cross referenced to ensure staffs' positive and safe training had been completed before starting their first shift.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Use of restrictive interventions

Levels of restrictive interventions were low and reducing and the last restraint had taken place on 7 August 2021 with a child who had since been discharged . However, there were not enough staff available to safely carry out physical interventions if needed.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Safeguarding

The Lighthouse owned another property across the road, which had been used to accommodate children and young people and at which staff had provided care and treatment. There were concerns about the suitability of the environment of this property and the provider agreed to not use the building to accommodate children. Improvements had been made in relation to disclosure and barring checks and positive behaviour support plans.

The Lighthouse had accommodated children in a property across the road and staff had provided care and treatment for them. At the time of the inspection, no children were accommodated at this property. Following inspection, we were concerned that about the environment, suitability and staffing arrangements at that property and the provider agreed to not accommodate any children in that property.

During the onsite inspection, an 18 year old, who had previously been a patient of The Lighthouse, had been admitted for two nights as part of a crisis prevention plan. The provider acknowledged this was not a typical admission and that their statement of purpose does state they support children between the ages of eight and 18. We sought assurance from the service that this person had been formally admitted to the hospital and that safeguards were in place for children and adults to share accommodation. The provider shared a crisis management plan, however it was dated at the time of our request, rather than at the time of admission. This means that we could not be assured that the safety of the other children had been considered when admitting an 18 year old.

There were now the appropriate safeguards in place to ensure disclosure and barring service checks were completed prior to staff employment. The service had developed systems and processes to audit this to protect children.

Requires Improvement

Child and adolescent mental health wards

Staff now followed best practice when developing positive behaviour support plans with children. At the last inspection positive behaviour support plans contained negative punishment strategies and were not based on functional assessments. Children were no longer at risk of harm from receiving negative punishments. We reviewed three care records of children with positive behaviour support plans. These plans were appropriate and met the needs of each child. They were based on functional assessments.

Reporting incidents and learning from when things go wrong

Staff recognised incidents but they were not always reported appropriately to outside agencies.

Not all police incidents were notified to the Care Quality Commission (CQC). There were ten instances where the service needed to contact the police for support with a child between 21 May 2021 and 28 July 2021. Six of these incidents were not reported to the CQC. This included two incidents of reporting a child missing and four incidents of reporting assault on staff and aggressive behaviour.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The service did not ensure that all police incidents were reported to the Care Quality Commission.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not ensure that there were enough competent and trained staff available on each shift to keep children safe. Staffing levels did not match the required staffing establishments levels on each shift.