The Huntercombe Hospital Norwich

Quality Report

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

Overall summary

The Care Quality Commission carried out an urgent and focussed unannounced inspection of Huntercombe Hospital on 16, 17, 18, 20, 21, 24, 28 November 2017 and 7 December 2017.

The Care Quality Commission has a duty under Section 3 of the HSCA to consider the immediate safety and welfare of the young people at the hospital. We looked at this throughout our unannounced inspections.

We found significant and immediate concerns that required immediate action. We worked closely with NHS England and The Huntercombe Group senior management team to ensure that immediate concerns for the health and wellbeing of the young people were acted on. We took enforcement action to stop any new patients from being admitted to Huntercombe Norwich. The Huntercombe Group made the decision to remove all of the young people from the hospital. NHS England found alternative placements for all the young people. We then took further enforcement action to ensure that services could no longer be provided at this location.

During inspection we found that:

- The hospital did not manage risk to young people effectively or protect young people from carrying out acts of self-harm and aggression. Staff failed to manage the safety of the hospital's physical environment. As a result, young people had access to dangerous items as weapons or for acts of self-harm.Although staff reacted to incidents on the wards, they did not take action to prevent incidents occurring or escalating.
- The hospital did not learn lessons from serious incidents or take effective action to reduce the risk that a similar event would happen again.Staff failed to report some incidents in line with the provider's policy. Managers did not review or investigate all serious incidents robustly, openly and transparently. When the provider did investigate an incident, it did not take effective action to address the findings of these investigations. Despite giving repeated assurances that it had put measures in place, serious incidents of a similar nature continued to happen.
- The hospital did not take the necessary action to protect young people's physical health.We identified

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several incidents were staff did not carry out physical health observations on a young person whose breathing had been compromised, following an act of self-harm.The provider failed to ensure there was adequate emergency oxygen on the wards at all times.

- The provider failed to ensure that there was a sufficient number of skilled and experienced staff on the wards to meet the needs of the young people.
- Staff did not always treat the young people with dignity and respect.
- The ward environment was unclean and without an effective system in place to maintain cleanliness.

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Background to The Huntercombe Hospital Norwich

The Huntercombe Hospital Norwich is a low secure and psychiatric intensive care facility providing inpatient child and adolescent mental health services (CAMHS) for young people aged between 5 and 18. The service provides care to people with a range of mental health disorders and who are detained under the Mental Health Act.

The regulated activities are:

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

The hospital provided assessment and treatment for up to 36 young people. At the beginning of the inspection, there were 30 young people on three wards, all of whom were detained under the Mental Health Act.

Rainforest and Coast Ward had 12 beds each. Both were mixed sex low secure units, each supporting young people with mental health conditions.

Sky Ward was a psychiatric intensive care unit. This ward supported up to 12 young people. Five of these beds were commissioned by NHS England. There were also four young people from NHS Wales on the wards at the time of the inspection.

The site had a total area of 17 acres and there was a range of horticultural and recreational facilities. Each ward had a locked door to maintain the security of each unit and the grounds.

A registered manager was in place at the location. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

CQC last inspected the hospital in March 2017. We rated the hospital overall as requires improvement (we rated safe as inadequate, effective and well led as requires improvement and caring and responsive as good). We issued Requirement Notices against Regulation 12 safe care and treatment, Regulation 17 good governance and Regulation 18 staffing.

Our inspection team

Our inspection team was led by:

Team leader: Jane Crolley, Inspector, supported by Mental Health Head of Hospital Inspections, Julie Meikle.

The team that inspected the service comprised two further inspectors, two Inspection Managers, one of whom is an enforcement lead, an enforcement inspector and a specialist advisor with CAMHS expertise.

Why we carried out this inspection

This urgent, unannounced focussed inspection was carried out in response to serious concerns to the safety and wellbeing of the young people at this location. We do not give new ratings following this type of inspection.

There had been two serious incidents within a short period time on 11 and 14 November 2017. We found that the hospital had failed to response adequately to the first incident. Had they done so, this could have prevented the second incident were a young person was air lifted to hospital in a critical condition following an act of self-harm. We found other incidents that, had they been acted upon, may have prevented the further incidents from happening.

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When we inspected the hospital in March 2017, we identified a number of breaches and issued Requirements notices against the Regulations as follows:

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

- Patients' physical health was not monitored following the administration of rapid tranquilisation medication.
- Medical prescribing of rapid tranquilisation did not meet the provider's own policy
- Care plans were not always reviewed and updated following an identified change to risk
- Supportive observation levels were not reviewed as per policy, for instance they were not reviewed daily nor were they reviewed for each patient following increased risk.
- The supportive observation policy was not reviewed and was out of date.
- Accommodation did not meet the mental health act code of practice for mixed sex guidance.

Regulation 17 HSCA (RA) Regulations 2014 good governance

- The provider did not comply with all the policy and practice to meet the requirements set out in the Mental Health Act Code of Practice

Regulation 18 HSCA (RA) Regulations 2014 staffing

- The provider did not ensure that the wards were staffed by a trained nurse at all times.

Following publication of the report in May 2017, the Hospital Director provided the CQC with an action plan on 23 June 2017 advising how the hospital would achieve compliance with the Regulations. The provider set their own deadline for compliance for each regulation. The latest date for compliance was 31 August 2017. Therefore, the provider should have been compliant with these actions at the time of this unannounced inspection.

How we carried out this inspection

This focussed inspection was due to the urgent requirement to inspect under Section 3 of the Health and Social Care Act 2014 to determine if there was an immediate risk to the young people at this location.

We asked the following questions of the provider:

- Is it safe?
- Is it well led?

Before the inspection visit, we visited the site with our NHS England colleagues on 14 November 2017, in response to a serious incident on 11 November 2017. The visit on 14 November 2017 was a joint CQC and NHS England visit to meet the hospital director, head of nursing and quality and the lead consultant psychiatrist.

We listened to the provider's response to the incident. We raised concerns about staffing. We also sought assurance that a psychiatrist had reviewed the young people in the days immediately following the incident, and that the psychiatric review included a review of the observations of those young people involved in the incident. Whilst we were given this assurance, we later found any action taken was not clearly evidenced in clinical records. Within a short time of the CQC leaving site there was a second serious incident. Given the extremely serious concerns and our findings from the initial visit we convened an inspection team and attended site on 16, 17, 18, 20, 21, 24 and 28 November 2017 and 7 December 2017.

During the inspection visit, the inspection team:

- visited all three wards at the hospital over a period of 25 days, looked at the quality of the ward environment and observed how staff were caring for the young people
- spoke with the managers and clinical team leads for each of the wards
- spoke with 21 qualified staff on the wards – both agency and directly employed staff
- received feedback about the service from NHS England who are the commissioners for most of the young people
- spoke with five young people
- attended and observed three hand-over meetings and a morning meeting
- looked in detail at 15 care and treatment records of the young people
- reviewed incident information.

Summary of this inspection

- carried out a specific clinic room check of all three wards
- looked at the security systems on each ward
- looked at a range of policies, procedures and other documents relating to the running of the service
- Met with senior managers of both Huntercombe Norwich and the Huntercombe Group.

Throughout this inspection, the Care Quality Commission continued to monitor the safety and wellbeing of the young people who used the service. The provider response to some concerns was slow and the number of incidents continued to be of concern. The hospital made a commitment to move all of the young people from the hospital by 8 December 2017.

What people who use the service say

We did not directly speak to the young people unless they expressed a wish to speak to the inspectors. We made this decision due to the recent incidents on the ward and through listening to the concerns raised by the provider.

Four young people did choose to approach an inspector individually, all of whom voiced concerns and said they did not feel safe.

A fifth young person spoke positively about their care and treatment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas that the provider needed to improve:

- Serious incidents occurred affecting the safety and wellbeing of the young people in the hospital. We saw that some of these incidents might have been prevented if lessons had been learned from previous, similar incidents.
- Measures to protect young people from carrying out acts of self-harm and aggression were ineffective.
- We found several incidents were staff did not carry out a young person's physical health observations when breathing had been compromised following an act of self-harm. This created a risk of staff not detecting and treating serious injury in a timely manner.
- The ward environment was not safe. There was access to dangerous items due to poor systems for staff to report problems and completion of maintenance work was not always timely. This resulted in young people using items as weapons or for acts of self-harm.
- The ward environment was unclean without an effective system in place to maintain cleanliness. We saw faeces in the seclusion room and staff could not assure us that young people had not used the room whilst in this state of uncleanliness. There were no accurate and completed cleaning records.
- The provider failed to ensure there was adequate emergency oxygen on the wards. Following an incident, there was no oxygen on site for two days. During this time, there was a risk of a serious incident that may have required oxygen. There was no contingency plan in place and staff were unaware of this being the situation.
- There was not adequately skilled and experienced staff on the wards. From a five-week period of rota's we viewed, we saw that on 16 occasions, numbers fell below their own safer staffing requirement.
- We saw that staff reacted to incidents on the wards but did not take action to prevent incidents occurring or escalating. Staff did not proactively engage with the young people. This was particularly evident when we reviewed CCTV footage of two serious incidents.
- Staff did not report all incidents via the hospitals own reporting system. During the period from 1 November 2017 to 30 November 2017 there were three serious incidents relating to staff conduct towards the young people in their care. The

Summary of this inspection

hospital responded to these concerns on two occasions. Managers did not fully investigate the third incident at the time; however, the provider retrospectively reviewed the incident and reopened the investigation.

- Contemporaneous records are entries that required staff to report on a young person's progress, mental state, activities undertaken, incidents, overview of observation levels and any other clinically relevant information. We found many entries were poorly written and repetitive. There was also evidence of entries in the notes for the wrong patient, without correction. Staff documented the wrong incident reference numbers on occasion. Staff did not always correctly document the observation levels. As a result, clinicians viewing this information to help in clinical decision-making may not have accurate information.

Are services well-led?

We found the following areas that the provider needed to improve:

- The hospital did not manage risk to young people effectively or protect young people from carrying out acts of self-harm and aggression. Staff failed to manage the safety of the hospital's physical environment. As a result, young people had access to dangerous items as weapons or for acts of self-harm.Although staff reacted to incidents on the wards, they did not take action to prevent incidents occurring or escalating.
- The hospital did not learn lessons from serious incidents or take effective action to reduce the risk that a similar event would happen again.Staff failed to report some incidents in line with the provider's policy. Managers did not review or investigate all serious incidents robustly, openly and transparently. When the provider did investigate an incident, it did not take effective action to address the findings of these investigations. Despite giving repeated assurances that it had put measures in place, serious incidents of a similar nature continued to happen.
- The hospital did not take the necessary action to protect young people's physical health.We identified several incidents were staff did not carry out physical health observations on a young person whose breathing had been compromised, following an act of self-harm.The provider failed to ensure there was adequate emergency oxygen on the wards at all times.
- The provider failed to ensure that there was a sufficient number of skilled and experienced staff on the wards to meet the needs of the young people.

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- Staff did not always treat the young people with dignity and respect.
- Staff training figures fell below the organisational target of 80% in many areas. Only 64% of staff had received training in how to manage self-harm. 75% of staff had basic training in understanding of CAMH. Other classroom based training such as relational security, interpersonal difficulties, Basic life support, intermediate life support and security training fell below 75%.
- Governance arrangements for frontline staff were not robust. For example, there was no system for monitoring whether staff had undertaken allocated cleaning duties at night. There was no evidence of cleaning having taken place and we saw many areas were dirty.
- The provider had not ensured that staff reported all incidents in line with their own policy.
- We were not assured of incidents being reviewed robustly, openly and transparently.
- A system was in place to ensure that front line staff read out the lessons learned bulletin at handover. This bulletin did not cover the most recent risks relevant to the ward.
- The provider showed us evidence of monitoring incidents and their frequency. We were not assured that the information was accurate as we saw incidents in patient records that had not been reported. As a result, we concluded that any thematic reviews were based on flawed information and may not be accurate.

Detailed findings from this inspection

Mental Health Act responsibilities

This was a focussed, unannounced inspection and we did not review the application of the Mental Health Act or Mental Capacity Act.

Child and adolescent mental health wards

Safe	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Staff could not observe all areas of the ward to maintain patient and staff safety. The hospital had some mitigation to risk by locking rooms, installing mirrors and CCTV was installed in the main areas. Managers viewed the CCTV retrospectively to review specific incidents. The nurse office did not have any observation of corridors partly due to staff putting up posters on the windows. We had raised this at the previous inspection.
- All wards had many fixed ligature points that the young people could use to self-harm. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. There was a ligature risk assessment for each ward to try to reduce the risk these posed but staff had not documented all environmental risks on the assessment within the risk care plan. There was an incident on 7 and 10 November 2018 where a young person attempted to ligature using the wardrobe door hinge. A third incident occurred using the same method, causing a life-threatening injury one week later. Staff could have prevented this incident if appropriate measures had been taken following the first or second incident.
- All three wards were mixed sex, although at the time of inspection Coast ward had female young people only. On Sky ward, the two male young people were accommodated in different corridors; both corridors then housed both male and female young people. There was increased supervision on the ward to monitor this situation.
- The hospital used Coast clinic room to hold stock medication for all the wards. There was a serious incident on 11 November 2017were four young people accessed this room using force. Staff called police to take control of the situation. A nurse had left the medication fridge unlocked. The young people were able to access the contents and used items in acts of self-harm. This resulted in all four young people requiring treatment at hospital where one young person required admission for a period of days. On 14 November 2017, CQC and NHS England visited the site. Extra locks had been added to the hatch of the clinic room at this time (the access point by the young people) however; on one ward, a nurse had not engaged all of the locks. There was a failure of managers to check that staff were aware of and implementing the new system.
- When we inspected the wards on 16 November 2017, Rainforest ward staff had not locked the medication fridge. We saw records from a morning meeting on 27 November 2017, which again referred to staff not locking the fridges on two wards. This was evidence that staff were not learning from incidents.
- There was a serious incident on 14 November 2017. Staff had used all the oxygen on site during this incident. When we visited on 16 November 2017, there was no oxygen on site. During the period between 14 and 16 November 2017 we confirmed that if there had been a further incident during this time, there would not have been any oxygen available to the young people if it were required.
- Other items of equipment remained unlocked in the clinic room. On 14 November 2017, the hospital told us that all items would be stored in locked cupboards in the clinic room immediately. The hospital response to this risk was slow. When we revisited on 28 November 2017, risk items such as needles and sphygmonometers were still not in a locked cupboard. The sharps bin cupboard was still unlocked on 18 November, one week after the incident. Stock medication remained on coast ward on 24 November 2017, despite assurances there was a plan to move this off the ward. When we visited on 7 December 2017, managers had dealt with this concern. We were not assured that the extra locks were always engaged.
- The emergency bag was sealed with a number on the seal. Staff checked this number daily and staff checked the contents of the bag weekly. As this small oxygen cylinder was kept in the bag staff did not check it daily. There was a risk that the oxygen cylinder lever could be

knocked when the bag was moved. Staff would not be aware of a leak of oxygen until the event of an emergency. By this time there may be insufficient oxygen left in the cylinder.

- There was no evidence that staff cleaned the clinic room. Staff told us that the night staff were allocated this to do and we saw a plan for this. However, there was no evidence of the work having been done. There were no cleaning stickers and no system for staff to confirm cleaning had taken place.
- There were two seclusion rooms on site. Both were dirty and the Sky seclusion room had faeces smeared on the intercom. We raised this concern immediately to the senior managers on 16 November 2017. On 17 November 2017 inspectors revisited the ward and whilst there was evidence of cleaning having taken place, this was not thorough and there still were traces of faeces in the room.
- We found soft furnishings that were torn. This was a risk as some young people used the torn material to self-harm. There was evidence in the young peoples' clinical records of this happening on several occasions. We saw an incident in the daily report provided to us on 4 December 2017. This was after we had highlighted the soft furnishings as a risk on 17 and 23 November 2017 and reminded the managers of the risk on 28 November 2017.
- There were broken dispensers on the wards in the bathrooms. These were sharp and young people had used the parts to self- harm. We revisited on 28 November and there remained broken items in place and accessible.
- We saw that several smoke detectors in the rooms had been tampered with by young people and were not working. There was no clear plan on how to address this concern.
- We saw carpet that had been wet, from a leak, and was stained and dirty. We saw several walls with bare plaster and walls that had damage to them. Staff reported that maintenance repairs were slow and could take several weeks. We saw evidence in patient records of young people using plaster from the walls to self-harm. Following serious incidents, immediate remedial work was completed to try and make the area safe. However this was not always successful.
- The system for reporting maintenance concerns was on line or via direct email. There was no log on the ward for when staff requested work to be completed.Staff could not demonstrate to us that there was any feedback on progress.
- The small kitchens on the ward had items of food that were either unlabelled or out of date. We saw this on more than one visit despite bringing it to the attention of staff.
- All staff had access to alarms. However, on Sky ward we saw that not all alarms were working. We raised this immediately with the provider on 16 November 2017 and again on 23 November 2017. On 4 December 2017 we were advised of an action to order rechargeable batteries to address the concern. The action was still not complete by the 7 December 2017.
- We saw that keys did not always work and staff had a struggle to open some doors. This could slow staff response to serious incidents. We found this to be the case even on our last visit to site on 7 December 2017 on Sky ward.

Safe staffing

- The provider showed us a safer staffing matrix that identified that there would be a minimum of two registered nurses on duty per ward during the day and one registered nurse per ward at night with a senior nurse at night extra to the ward numbers to provide management oversight and support. At a site meeting on 14 November 2017 in the presence of CQC and NHS England, we asked managers about the staffing levels at the time of the incident. The hospital director assured us that on 11 November 2017 the hospital was adequately staffed. The hospital director also advised that the staffing of registered nurses was within their own policy and QNIC (Quality Network for Inpatient CAMH's) guidelines. The hospital policy allowed for increasing of staffing according to the clinical complexity and risk of the young people. There was no evidence of a review of registered nursing staffing and when this was put to the team, there was no recognition that this may be of benefit. Later, we found out that the staffing on site was one staff short, an entry to this effect was written in all young people's care records. Whilst the ward, were the incident occurred, was staffed to the agreed numbers, another ward was not and there were

other incidents on site. We found that in answering questions the senior team focussed on a very narrow view of what was being asked and did not consider wider learning.

- We saw that the psychiatric intensive care ward had one qualified staff for seven young people at night. NAPICU (National Minimum standards for Psychiatric Intensive Care Units for young people 2015) recommend that one third of the nursing staff should be registered mental health nurses with no fewer than two nurses per shift. The providers own staffing policy specified there should be a minimum of one qualified mental health nurse for twelve young people during the night, this was in contradiction to national guidance. In a sample of five weeks rota's we saw five day shifts that were staffed with one nurse only. There was only ever one nurse at night allocated to the ward.
- Staff told us that at times there was no senior nurse on site during the night. This made it impossible for staff to take a break, as the ward would then not have a registered nurse. In response to those concerns, we reviewed five weeks' worth of rotas over a three-month period and saw that there were seven nights were there was no second qualified staff member allocated to the ward. There were eight day shifts with only one registered nurse on the ward for the same period. On 31October 2017, there were only two registered nurses on site to cover three wards. This meant one ward did not have a registered nurse on the ward that night.
- The hospital had developed a senior support worker role to help ensure there were knowledgeable staff on duty during the late evenings. The hospital had recognised that late evening there was an increase in incidents and less experienced staff available. The purpose of the role would be for these staff to work until midnight. At the time of the serious incident on 11 November 2017, there were no senior support workers on site.
- We found that while there were registered nurses working on the wards, not all nurses were suitably qualified. There were registered adult nurses and children's nurses without any mental health qualifications. Managers and staff told us they would always be the second nurse on shift. However, we saw evidence of these nurses working as the only nurse on the ward, particularly at night. This meant the ward did not always have suitably skilled and trained staff on duty. Some registered mental health nurses told us they felt unsafe and lacked support. They also raised a concern that the head of nursing and quality had not worked in any type of mental health service prior to taking the post at Huntercombe Norwich. Staff did not feel assured of strong clinical leadership.
- Ward managers advised they could adjust staffing according to their staffing matrix, however, this did not include increasing the registered nurses per shift. Ward managers could only book extra support workers in response to patient observation levels increasing.
- There was a high use of agency nurses as there were ongoing difficulties in recruiting staff. We saw adverts to recruit. These adverts requested any trained registered nurse, not specific to mental health. We saw an advert on 27 November 2017 requesting all nurses. This was after we had raised concerns about the skills of staff.
- The hospital used a core group of agency staff. The provider told us these staff received the same training and support as permanent staff.
- During inspection, we saw an increase in staff in response to our concerns and requirement for the hospital to improve staffing. These staff were registered mental health nurses, many of whom had CAMH experience. This was a short-term measure in response to specific concerns. NHS England also provided clinical leadership to the site.
- There was a serious concern for the safety and wellbeing of the young people in this location. Staffing and skills was not adequate to meet the needs of this very challenging and complex patient group.

Assessing and managing risk to patients and staff

- We reviewed 15 patient records and found that all records had a risk assessment and risk plan however these were not all up to date. Not all risks that we found had been addressed within risk management plans. In all records we reviewed, we saw staff had not recorded incidents in the risk assessment. Some but not all incidents were recorded in the risk plan. Sometimes the risk assessment was updated but not the risk management plan. The risk plans were confusing. Some plans had dates that related to when staff added the information, not when the incident occurred. There were undated entries and it was not always clear what was the most recent update.

Child and adolescent mental health wards

- Following an incident, we did not see timely review by the consultant psychiatrist in all the care records we reviewed. Where reviews did take place there was a lack of detail to understand how the doctor reached a decision.
- The care records inconsistently recorded the level of observations a patient was on. For instance, we routinely saw reference to a patient being on Level 2 observations. According to their practice, this could mean that staff should check on the patient every five minutes or every ten minutes. Records did not clearly state which it was.
- Following the serious incident on 11 November 2017, we visited the site. We specifically asked if there had been a clinical review of observations. The hospital assured us that this had taken place. The hospital director said that there was no evidence of increased risk with the young people involved. We again sought assurance regarding the need to increase observations and we were given assurance by the consultant psychiatrist, head of nursing and quality and the hospital director that they were confident in their review. Within an hour of leaving site, one of the children had used a fixed ligature point and was critically ill in hospital.
- We reviewed in detail the records of those children involved in the 11 November 2017 incident. Following the incident we saw that there had not been a review of observations until 13 November 2017 for one of the young people and 14 November 2017 for another. We saw that the review on 14 November 2017 was after the second incident and a decision was made to increase the observations to level 3 (1:1) observations. This young person had self-harmed on more than one occasion between 11 and 14 November 2017 with no documented review until 14 November 2017.
- We saw that there were several incidents of self-harm, carried out by these four young people after the incident on 11 November 2017. We could not see a plan to reduce the immediate risks that were posed.
- Due to concerns regarding management of risk, we reviewed incidents of other young people in the location. We found many serious incidents of self-harm. Responses to these incidents fell short of what we would expect to keep people safe. For instance, we saw an entry were a ligature was noted to be around a young person's neck. The entry went on to say the young person refused to allow the staff to remove the ligature so as the patient was moving around in the bedroom, the patient was left alone. We saw an entry in the notes were a doctor questioned an incident which compromised a young person's breathing. The doctor was not assured that staff were carrying out the correct observations at the time of the incident.
- The provider showed us graphs that indicated the number of incidents occurring across site was reducing each month since March 2017. We were not assured by this information. We saw reports of serious incidents consistently over a 12-month period. The level of severity and risk did not reduce, even if the number of incidents had. We also saw incidents in care records that staff had not reported using their own reporting system, making the figures unreliable.
- The service would use anti-tear clothing on occasions were a young person's risk escalated. This clothing was not fit for purpose. We saw incidents where the clothing had been shredded and used for incidents of self-harm. The provider had not taken action to address this issue, despite there being several reports in patient's records of using anti-tear clothing to self-harm. We raised this with the provider who took action after two further prompts by the inspection team.
- We found that staff were using a room known as the 'soft room' also as a seclusion room. The hospitals own policy allowed for this room to be used for up to one hour. We saw evidence in one patient record of a patient being in the room for one hour and thirty minutes. The room on Coast, was airless, had a strong odour, was filthy, had no temperature control and had no ventilation, window or viewing panel, clock or intercom. It was not clear if there was a doctor review at the time seclusion was implemented with three of the records we reviewed.
- We saw evidence in the records of staff not following the seclusion policy. For instance, on 29 September 2017 a doctor did not attend to the patient and sign for the four-hour review. On 30 September 2017, there was no evidence that the doctor attended following commencement of the seclusion paperwork. We saw in a young person's record that they were able to self-harm with glass whilst in the seclusion room. This meant the young person or room was not thoroughly searched for risk items prior to being secluded.
- There were few documented entries by medical staff following incidents. We reviewed four patient records in detail for the period 1 October 2017 to 17 November 2017. There were 66 reportable incidents. On 34

occasions, there was no record of medical review following an incident. On sixteen occasions the incident did not warrant medical review. There was a medical review on 16 occasions within 24 hours of the incident taking place. This showed there lacked an effective system of reviewing the young people following incidents.

- For the same sets of records, we saw no evidence of enhanced observations reviewed by a doctor following an incident. We did see some action taken to restrict risk items or areas of the ward such as the bathroom.
- We saw incidents were young peoples' breathing was compromised, but no evidence of a doctor review of the patient in many cases. We saw many cases where physical observations were not carried out following incidents were breathing was compromised. This meant there was a risk that staff could overlook injury until the situation was critical.
- We saw one entry were vital signs was of concern and the nurse monitored them for two hours. Despite the physical health observations still indicating these were outside the normal range, the monitoring stopped and there was no evidence of review by the doctor at the time or the following day. This was of particular concern as extra medication had been given due to disturbed behaviour and the patient had self-harmed in the form of banging their head repeatedly.
- We saw evidence that some young people attempted to hide medication. Where this was noticed, there was an entry in the clinical records; however, this was not recorded as an incident. One ward manager we spoke with advised this was not a reportable incident. The head of nursing and quality, when asked, advised that it was. There appeared to be confusion regarding what staff considered reportable and what was not. This meant that any figures provided by the hospital regarding the number and type of incident, could not be relied on as accurate.
- We saw that staff gave one young person incorrect advice to lie down on two separate occasions following severe nose bleeds. There was a risk the young person could aspirate which could cause severe chest infection. Staff recorded that the young person spat out blood that had been swallowed.
- The contemporaneous notes were entries that required staff to report on a young person's mental state, activities that have happened during the shift, any incidents and overview of observation levels and any other relevant information. We found many entries were poorly written and repetitive. There was also evidence of entries in the wrong notes, without correction. Staff documented the wrong incident reference numbers on occasion. At times entries were confusing as the same incident was recorded twice but with different accounts. A different word used can change the context of an event. This made the entries confusing to read. Other clinicians, in order to gain insight into a young person's clinical presentation, and to help in clinical decision-making would review these entries. There was a risk that the information that was reviewed was not always accurate.
- During the inspection, the provider made us aware of three safeguarding incidents. These involved staffs' unacceptable behaviour. Two were incidents of reported assault and one of inappropriate behaviour of a male staff toward a female patient. The hospital escalated the concerns and removed the staff from site in order to carry out a full investigation. The appropriate authorities were alerted. The provider had originally reviewed one of the incidents and had deemed that the staff to have taken appropriate and proportionate action. However, senior managers, external to Huntercombe Norwich reviewed the footage and felt that action taken by staff was not proportionate, and further investigation was required. This investigation was to include the original decision made by the staff member who felt the action was proportionate.
- The two incidents we reviewed on CCTV footage demonstrated a lack of staff skills and engagement with young people in managing the incidents. There was no evidence of leadership on the ward at the time of the incidents. We also saw behaviour toward a young person that required further investigation and referral to the local safeguarding team. The provider took action to do this.

Track record on safety

- There had been concerns regarding patient safety in the 12-month period leading to this inspection. NHS England had placed an embargo on admissions in the summer of 2016 followed by a period of monitoring. The embargo lifted on the low secure wards then two months later lifted on the psychiatric intensive care unit (PICU). The number of beds commissioned by NHS England reduced to five beds as part of their review of beds region wide.

Child and adolescent mental health wards

- In March 2017, there was a death of a young person at the hospital. The ensuing investigation included a police investigation which had not yet concluded at the time of writing this report. Within the providers own investigation, the report raised concerns regarding the management of the young people, specifically regarding managing risk and observation levels. Following the death, the provider voluntarily and temporarily suspended admissions in agreement with NHS England.
- In May 2017, NHS England again ceased admissions to the hospital whilst they investigated an anonymous concern. Following investigation there were no concerns found.
- In July 2017, there was a further serious incident where a young person required resuscitation following a serious ligature incident. NHS England again visited the site and liaised with CQC regarding their findings.
- In September 2017, the provider shared the detailed report of the incident that occurred in July 2017. The CQC wrote to the provider expressing concern that lessons had not appeared to have been learned from the incident in March 2017.

Reporting incidents and learning from when things go wrong

- There was not a consistent approach to reporting incidents. A ward manager and the head of nursing both had different views of what was reportable when asked. This confusion was evident in staff reporting at ward level.
- There were at least 82 notifications of incidents reported by the hospital to CQC since 1 October 2017. During inspection we also saw incidents in clinical records, some that had been reported on their own incident forms system and some which should have been but were not. This was in addition to the 82 notifiable incidents. The true number of incidents was difficult to assess.
- We were not assured that following incidents lessons were being learned and actions implemented.
- The incident on 11 November 2017 involved young people breaking a bed base and using this as a weapon. This was not an isolated incident. We have seen many references to bed bases being broken and used by young people as weapons. One staff member, when questioned, told us it had happened frequently. There had been no action to address this known risk.
- There was a serious incident on 14 November 2017. This occurred despite a similar incident happening only one week before with the same young person.
- We attended three handover meetings on 17 November 2017. Staff read out lessons learned in all three handovers. These lessons were from the previous week. The lessons discussed did not include the serious two incidents that had occurred earlier that week and no immediate lessons were shared. This was of concern as there were immediate actions that were taken but staff were not aware of them. This meant that the risks remained.
- We did not find evidence that the hospital fully reviewed incidents and understood wider risks and potential for lessons learned. For instance, there had been a previous incident where a young person accessed a clinic room several months prior to the incident in November 2017. As the intent of the young person was to assault the nurse and not access the medication, the risk review was focussed on the risk of aggression and security issues. There was no wider consideration of what could have happened such as the young person accessing equipment or medication that could be used to self-harm. This was one example of many.
- The final investigation report into the tragic death of a young person was not shared with CQC until we requested it in November 2017 (having previously requested it in September 2017 and being advised it was not yet ready). We spoke to the police who advised they also needed to request the report as the hospital had not forwarded it to them. NHS England had also not received it when asked on 6 December 2017. The CQC had received an email in September 2017 from the hospital director advising that the draft report had been shared with the hospital and that they had already addressed many of the concerns raised within it. We did not review all actions from the report during this inspection; however, this inspection did raise concerns that were also raised in the report. Specifically we raised concern regarding the use of enhanced observations and management of risk. Therefore, we can conclude that the hospital had not learned the lessons as advised.
- Some staff we spoke to did not feel supported following incidents. Some also said they did not feel safe.

We did not see evidence of debrief after incidents, although some staff reported this would sometimes happen. There lacked an effective system of ensuring this took place.

Child and adolescent mental health wards

Are child and adolescent mental health wards well-led?

Good governance

- The senior management had failed to address all of the serious concerns that had been reported to them in March 2017. The breaches of regulation identified at our previous inspection had not been resolved. The senior management did not ensure that the services provided at the hospital were safe. The senior management had needed to take further and more timely action to address areas of improvement.
- The hospital did not effectively manage areas of risk to the young people. For example, the provider had not proactively identified areas of poor practice identified throughout this report.
- Staff training figures, provided by Huntercombe Norwich for the period up to 31 October 2017, fell below the organisational target of 80% in many areas. Only 64% of staff had received training in how to manage self-harm . 75% of staff had basic training in understanding of CAMH. Other classroom based training such as relational security, interpersonal difficulties, British life support, intermediate life support and security training fell below 75%. E-learning mandatory figures showed compliance of 85% or more.
- We raised concerns on 14 November 2017 regarding the appropriate staffing levels and skills of the ward based teams. We raised concerns again on 16 November verbally. On 17 November, when the provider responded to our concerns, they made plans to increase staffing levels. The managers showed us safer staffing tools they used to base their staffing. Staffing was not always at the correct level against their own staffing tool. Where the ward was staffed with two registered nurses, one of the nurses may be an adult or children's nurse.
- The provider gave assurances of measures in place following serious incidents that were insufficient to reduce serious risks to the young people. Serious incidents continued to happen. Measures were ineffective in reducing the risk of serious harm to the young people.
- Anti-tear clothing in use was not effective. The hospital was slow to respond when this concerns was raised directly with them on 17 November 2017. The response was a slow and inadequate as there was no action to remove the items of concern. New items were circulated of the same brand. After we raised further concerns on 23 November 2017, the existing risky items were removed and a different design was sourced and purchased.
- Governance arrangements for frontline staff were not robust. For example, there was no system for monitoring whether staff had undertaken allocated cleaning duties at night. There was no evidence of cleaning having taken place and we saw many areas were dirty.
- We saw safeguarding incidents that the hospital had not investigated. For instance, a staff member reviewed CCTV footage and made a decision that what was seen was proportionate action. This was closed down without further review. The provider reopened and reviewed the incident during the inspection and made the decision to investigate more robustly. The concern was that there might have been other incidents that the hospital had not reported and investigated effectively.
- The provider had not ensured that staff reported all incidents in line with their own policy. Therefore, reviews on themes and trends were not carried out with accurate information. This showed that the hospital data was unreliable.
- We were not assured that managers reviewed incidents robustly, openly and transparently. We saw there was a tendency of the Huntercombe Norwich managers to reassure the Commission, NHS England and other agencies that the young people were safe and lessons implemented. The seriousness was downplayed. We received emails assuring of action taken where concerns were raised. However, during inspection these assurances proved to be inaccurate. One specific example related to the hospital manager sending an email advising that following a joint meeting with the hospital, NHS England and CQC that both organisations 'were not unduly concerned about the safety of the young people'. We immediately corrected the misrepresentation. As this was not a reflection of the meeting, it raised concern on how the hospital relayed information to key stakeholders.
- A system was in place to ensure that front line staff read out the lessons learned bulletin at handover. This bulletin was not comprehensive and did not cover the most recent risks relevant to the ward.

Child and adolescent mental health wards

- The provider showed us evidence of monitoring incidents and frequency. We were not assured that the information was accurate as we saw incidents in patient records that had not been reported. Therefore, the reviews were based on flawed information.

Leadership and Morale

- We asked staff if they felt able to raise concerns. Three staff when asked this question advised that they wouldn't raise concerns as they did not feel listened to. Two staff told us that where they had raised concerns they were told to stop complaining. Three staff felt able to raise concerns and felt listened to.