Tees, Esk and Wear Valleys NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

West Park Hospital
Edward Pease Way
Darlington
County Durham
DL2 2TS
Tel: 01325 552000
Website: www.tewv.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX3LF	West Lane Hospital	Westwood Centre	TS5 4EE
RX3LF	West Lane Hospital	Evergreen Centre	TS5 4EE

This report describes our judgement of the quality of care provided within this core service by Tees Esk, and Wear Valleys NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Tees Esk, and Wear Valleys NHS Foundation Trust and these are brought together to inform our overall judgement of Tees Esk, and Wear Valleys NHS Foundation Trust.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated safe as inadequate following the inspection in June 2019. We did not rerate safe, for wards for children's and adolescent mental health at this focussed inspection.

We found the following issues that the trust needs to improve:

- Staff did not always record observations of young people with the 24-hour time frame in line with the trust's policy. As such, we found some gaps when observations were not documented in the young people's records, which was not in accordance with the trust policy.
- Service managers had not implemented an effective control system to record the names of staff responsible for young people on each shift. Not all of the days that we reviewed had a record to provide an effective audit trail.
- Staffing levels over a two week period prior to our inspection were not always in line with the agreed staffing establishment, although had improved since our last inspection. There was still a heavy reliance on agency staff .

However:

- There was an improvement in the quality of young people's care records, intervention plans, and risk assessments. These were present for each young person and reviewed and updated regularly.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as inadequate following the inspection in June 2019. We did not rerate safe for wards for children's and adolescent mental health at this focussed inspection.

We found the following issues that the trust needs to improve:

- Staff did not record young people's observations in line with trust policy. There were unexplained gaps in young people's observation records.
- Managers failed to comprehensively record and retain the names of staff responsible for young people's observations as an audit trail when there were gaps in records.
- In the two weeks prior to inspection there were four shifts where the number of qualified staff was not in line with the staffing establishment that had been identified as required to staff the wards safely.

Summary of findings

Information about the service

Tees Esk and Wear Valleys NHS Foundation Trust provides specialist assessment and treatment for children and young people who have severe and complex mental health conditions, learning disabilities, autism and eating disorders that require treatment in hospital. These types of services are also called tier four services.

We inspected two of the trust's three child and adolescent wards at West Lane Hospital:

- The Westwood Centre is a 12-bed ward, providing assessment and treatment for young people within a low secure environment. The ward accepts young people between 12 and 18 years of age. At the time of the inspection there were four young people receiving care and treatment on this ward.
- The Evergreen Centre is a 16-bed ward, providing specialist eating disorder treatment for children and young people. At the time of the inspection there were seven young people receiving care and treatment on this ward.
- The Newberry Centre was a 14-bed ward, providing assessment and treatment for young people aged between 12 and 18 years of age experiencing serious mental health problems. At the time of inspection this was closed, and the young people formerly admitted to the Newberry Centre were receiving care in the Evergreen Centre.

We had previously inspected the wards at West Lane Hospital twice in 2019. We undertook a comprehensive unannounced inspection on 20-24 June 2019 which looked all five key questions. This inspection was undertaken in response to concerns raised about low staffing levels and a concerning culture as well as a serious incident. We rated these services as inadequate overall with ratings of requires improvement for the effective and caring domains and inadequate in the safe, responsive and well-led domains. We identified:

- The service was not safe. Young people were at high risk of avoidable harm due to breaches of regulation which included but was not limited to: inadequate assessment and management of individual and environmental risks, frequent staff shortages, unexplained gaps in observations of young people, and poor practice in relation to blanket restrictions, recording restrictive interventions and medication management.
- The care and treatment of young people was not appropriate and did not meet their needs and reflect their preferences. Care and treatment of young people was not always provided with the consent of the relevant person. Carers at West Lane Hospital were not fully involved in their relatives care where this was appropriate.
- The service was not well-led. Systems and processes were not established and did not operate effectively. The service did not assess monitor and improve the quality and safety of the services provided. The service did not assess and monitor and mitigate the risks relating to the health, safety and welfare of young people. The service did not provide sufficient numbers of suitably qualified, competent, skilled, experienced and appropriately supervised staff.

Because of our findings the trust was issued with a Notice of Decision to impose conditions on the trust's registration and Section 29A Warning notice.

A Notice of Decision to impose conditions is a legal enforcement action available to CQC to ensure that providers comply with their legal obligations and hence ensure that people who use services are kept safe, receive an acceptable standard of care and to ensure that providers take action to manage specific risks. We can serve a warning notice under section 29A of the Health and Social Care Act 2008 when we identify concerns across either the whole or part of an NHS trust or NHS foundation trust and we decide that there is a need for significant improvements in the quality of healthcare.

Because of the action we took the trust was not able to admit any new young people and the trust has to provide CQC with specific information to allow us to closely monitor the care and treatment of the young people currently admitted.

Summary of findings

Our inspection team

The inspection team that inspected this service comprised two CQC inspectors and an assistant inspector.

Why we carried out this inspection

We undertook this focused inspection as a result of an incident which resulted in the sad death of a young person at West Lane Hospital. We inspected the two wards at West Lane Hospital and specific aspects of the key question "Are services safe?". The key areas of focus was the recording of staff observations of young people, up to date care plans and risk assessments, staffing levels and the safety of the environment.

Prior to this a focused unannounced inspection took place between 20 June 2019 and 24 June 2019 for all five key questions at this location as a result of concerns raised about low staffing levels and a concerning culture as well and a serious incident. Because of our findings the trust was issued with a Notice of Decision to impose conditions on the trust's registration and Section 29A Warning notice.

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How we carried out this inspection

This was an unannounced inspection where we focused on specific key lines of enquiry in the safe domain.

During the inspection visit, the inspection team:

- visited both wards at the West Lane Hospital to look at the quality of the ward environment
- spoke with nine staff members including the deputy director of nursing, a psychiatrist, a psychologist, modern matrons, nurses and health care support workers
- attended and observed a multi-disciplinary meeting
- looked at nine care and treatment records of young people including young people's risk assessments
- carried out a review of the records of observations of young people and the records for staff allocation to observation
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We did not speak with young people during this inspection. This was because we focused on staffing numbers and the quality and completeness of care records and observation records.

Tees, Esk and Wear Valleys NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Evergreen Centre	West Lane Hospital
Westwood Centre	West Lane Hospital

Mental Health Act responsibilities

We did not review the provider's compliance with Mental Health Act responsibilities during this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the provider's compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe staffing

We spoke to staff during our inspection and they described the staffing overall on both wards as improving since the previous inspection. Some staff had relocated to the West Lane Hospital site from other services within the trust and both wards utilised staff from the trust's bank. Agency staff were also regularly employed for shifts on the ward.

Managers used a staffing tool to calculate the required staffing establishment levels and this had recently been reviewed. At the time of our inspection the staffing establishment levels were as follows:

Westwood Centre

Day shift:

Two registered nurses (WTE)

Six healthcare assistants or equivalent (WTE)

Night shift:

One registered nurse (WTE)

Six healthcare assistants or equivalent (WTE)

Evergreen Centre

Day shift:

Three registered nurses (WTE)

Five healthcare assistants or equivalent (WTE)

Night shift:

One registered nurse (WTE)

Six healthcare assistants or equivalent (WTE)

We reviewed staffing levels for both wards for both day and night shifts over the two week period prior to our inspection. Out of the 56 shifts there were two occasions, both on a Westwood Centre day shift, where the staffing level was one person below the minimum of eight staff.

Over the same period, there were two day shifts on Evergreen Centre when the number of registered nurses was one short of establishment, one of which was the same day that the two required registered nurses for Westwood Centre were not present. This resulted in one day shift, between the two wards having a total of two registered nurses out of the required joint total of five registered nurses.

The service had a senior nurse who acted as a site coordinator at West Lane Hospital. Their role was to ensure both Evergreen and Westwood Centres were adequately staffed at all times and to support staff following incidents. The managers on each ward were supernumerary to the above figures. There were also supernumerary clinical nurse specialists on both wards. Evergreen Centre had three, due to reduce to two in October 2019 and Westwood Centre had two.

Managers told us that when agency staff were used they tried to ensure they were familiar to the ward. During the 56 shifts, over the two week period reviewed, 23% of staff were agency staff on average. This comprised 17 agency staff, 11 of whom worked more than one shift and up to six shifts. There were four shifts during the period when no agency staff were present.

Assessment of patient risk

We reviewed nine young people's care records in total from both wards. There was some improvement from the last inspection as risk assessments, were in place and up to date for every young person. We saw examples where risk assessments had been updated following incidents.

Management of patient risk

We reviewed nine young people's care records on both wards. These all had intervention plans including a risk management plan which had been updated recently.

The trust supportive engagement and observation policy (last amended 29 March 2017) was in place at the time of

our inspection. However, this was in the process of being updated. The trust's policy referred to continuous observations of a young person by one or more members of staff as continuous supportive engagements.

We found the system for recording of observations was in its infancy and still being developed. On each shift, two staff were allocated to a young person for observations as appropriate. This was a relatively new process for staff and designed to work as a buddy system to ensure continuity of care for the young person on each shift. Staff recorded observations on a paper chart comprising 24 one-hour slots in which to record activity. A summary was subsequently recorded in the electronic record and checked by the modern matron.

On inspection, we checked the records of six young people for a specific 24 hour period, four records had no gaps in recording observation and of the remaining two one had a one-hour gap and the other had two separate one-hour gaps, when no observation was recorded.

As a result of the inspection in June 2019, managers audited observation records daily and forwarded the details to the CQC as a requirement of the conditions we placed on the trust. The audit for the period 1 July 2019 to 4 August 2019 highlighted that there continued to be issues with the recording of observations.

Staff told us, and we saw that, if an observation record once uploaded to the electronic system had a missing entry, this was marked in the managers audit as a fail. This could mean that a one-hour entry out of the 24hours had not been completed, or more were missing. As an example, we checked further observation records for four young people from a different date and found this to be the case. Three records had completed observations for the 24hour period and one young person's record had two gaps, one at 6am and the other 7am.

Overall during this inspection, we saw numerous gaps in the recording of observations which was not in line with the trust policy. Trust policy stated, "staff who are allocated to deliver continuous observation will record in the contemporaneous clinical record their involvement, time of their involvement, any evaluation based on the time spent with the service user and whom they handed responsibility over to".

Following our inspection in June 2019, managers introduced a system of recording daily staff allocations to each young person to provide an audit trail if there were observation gaps in the young person's records. However, we found this was not fit for purpose. The system was still in the development stage and had been based on a workbook which only allowed for the recording of three observations in a 24 hour period. Therefore, a paper sheet was in use and attached to the workbook with additional staff allocations. In the trust audit provided for the period 1 July 2019 to 4 August 2019 there were eight days where allocation sheets were not held. The trust confirmed there was ongoing work to develop a more effective system to prevent any future gaps in recording and ensure the system had greater capacity for all young people when required.

The trust had recently introduced a staff safety brief document to highlight key issues to staff at the start of every shift. The brief included the number of young people on the ward or leave, engagement levels, physical health issues, medication, the young people's risk of harm to self and others, safeguarding and other risks such as seclusion and absconsion. As an example, we checked the brief on the day of a serious incident and the brief included the specific risk. Therefore, the new system of alerting staff of ongoing risks at the start was ineffective in this case.