Inadequate

Elysium Healthcare Limited

Rhodes Wood Hospital

Quality Report

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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)
1-2934136341	Rhodes Wood Hospital	Child and Adolescent Mental Health Wards	AL9 6NN

This report describes our judgement of the quality of care provided within this core service by Elysium Healthcare Limited. 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 Elysium Healthcare Limited and these are brought together to inform our overall judgement of Elysium Healthcare Limited.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Inadequate

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

Summary of findings

We rated Rhodes Wood hospital as inadequate because:

- Staff did not assess, monitor or manage risks to people who use the services appropriately. Ligature risk assessments did not identify all potential ligature risks. Mitigation was not robust. Ligature risk assessments were not held on the wards. Risk assessments were not always completed in a timely way following admission. Formal risk assessments were not comprehensive. Some patients did not have risk management plans.
- The hospital did not take sufficient action to minimise risk to patients and staff. We identified numerous reportable incidents involving the police, paramedic assistance, and patient transfers to general hospitals which had not been reported to CQC. Staff had not consistently informed CQC when they had raised safeguarding concerns. There were three mandatory training courses with compliance of 60% or under. Conflict resolution (60%); breakaway (59%) and basic life support at only 53%.
- Systems were not always reliable or appropriate to keep people safe. Staff did not routinely test or carry personal alarms, although there were call bells in most rooms. When an alarm was pressed, it only sounded in office areas. Staff reported that there would often be a delay in response when needed. Nursing staff checked emergency bags daily. However, we found discrepancies in what was recorded as being present, against what was present. This included emergency medication.
- Staff did not always adhere to the Mental Health Act Code of Practice. We identified two instances where staff had secluded patients for a short period of time. Staff did not recognise this as episodes of seclusion. It was therefore not reported as seclusion. We identified staff had not been managing section17 leave robustly. Staff were not always certain of the parameters of leave granted and recording of leave was often brief. Not all patients had contingency plans if things went wrong while on leave.
- The wards were dusty, unclean and poorly maintained. Some areas needed re-decoration. Some walls were scuffed in one area and had been written on by patients. Staff did not report or address maintenance issues consistently or in a timely way. There were significant gaps in the cleaning records. They did not indicate when Mymwood Place had last been properly cleaned. Staff used clinical waste bags for general rubbish. Nurses had disposed of rubbish in sharps bins. We were not assured that staff viewed infection control as a priority.
- There were gaps in management and support arrangements for staff. Managers were not providing nurses and therapeutic care workers with regular clinical supervision.
- Records sampled confirmed this. Not all eligible staff had received an appraisal. Some staff had not been supported following incidents.

However:

- There was an adequate number of staff and staff were a visible presence on all wards. Most bank and agency staff had worked at the hospital frequently and so knew the patients.
- Managers shared learning from incidents, investigations and complaints with all staff. They did this during team meetings, multi-disciplinary meetings, supervision (when it occurred) and through emails and posters. There was emphasis upon lessons learnt and striving to improve patient experience.
- Staff ensured that patients had easy access to independent advocates and supported patients as needed. Staff encouraged patients to keep in contact with families, carers and appropriate others. Staff accommodated visits at the hospital if patients were too ill to leave the hospital grounds.
- Patients and carers described staff as caring and helpful.
- Staff understood the individual needs of patients. Staff facilitated young people's access to education throughout their time on the wards. Each patient had a weekly individual time-table. This included education, therapy and leisure activities.

Summary of findings

- Leaders had the skills, knowledge and experience to perform their roles. They were visible and approachable for patients, staff and carers.

Summary of findings

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

Are services safe?

Inadequate

Summary of this inspection

We rated safe as inadequate because:

- The hospital had recorded numerous incidents involving ligatures over the past three months along with a high number of restraints. Despite this, ligature risk assessments were not available on the wards, did not highlight all risks, and had limited mitigation against risks which had been identified.
- The provider had not reported all notifiable incidents to the CQC.
- Staff did not always complete timely risk assessments upon admission. Risk assessments were not comprehensive. Not all patients had risk management plans in place. Staff had updated risk assessments over the past few weeks. Prior to this however, this was not consistent.
- Not all staff carried personal alarms. When assistance was called, the alarms sounded only in offices. Therefore, not all staff were aware that assistance was required. Staff told us that response times to alarms were not always timely.
- We identified two incidents of seclusion on one ward, which staff had not recognised as seclusion even though the patients involved were prevented, by staff, from leaving a room. Staff told us that with one patient, this was the agreed management plan and deemed to be least restrictive. However, staff failed to record this as seclusion.
- Not all staff were up to date with mandatory training. A total of seven courses had compliance under 75%. There were three courses with compliance of 60% or under. Conflict resolution (60%); Breakaway (59%) and basic life support at only 53%.
- The wards were not clean and not always well maintained. Dust was evident on surface areas, boxes and containers across the hospital. Some areas needed deep cleaning. Cleaning records showed significant gaps across all wards. We were unsure when Mymwood place had last been properly cleaned.
- Staff did not use clinical waste bags for clinical waste. We saw general rubbish in these. Staff used sharps boxes for general waste disposal. One box had not been dated or signed upon opening.
- We found two blanket restrictions. One related to a limitation of hot drinks on two wards. The second was that patients could not lock the toilet doors on one ward whilst staff sourced new double locks following a serious incident.

Summary of findings

- We found some missing items in one emergency bag on one ward, which staff had signed to indicate these were present. This included emergency medication. We were not assured that staff were checking the contents of the bag as expected.

However:

- On most occasions, planned staffing numbers were met. If there were shortfalls, senior staff would work on the wards.
- The hospital had an established pool of bank and agency staff who worked regularly at the hospital. These staff had the opportunity to attend additional training around autism and CAMHS.
- Escorted leave or ward activities were rarely cancelled due to staff shortages.
- There was adequate medical cover throughout the 24-hour period so that doctors could attend the wards in an emergency.
- Staff rarely used rapid tranquilisation. Administering staff followed national guidance with physical observations if rapid tranquilisation was administered to patients.
- Staff received feedback from investigations of incidents, both internal and external to the hospital. There was emphasis placed upon lessons learnt. There was evidence of change being made as a result of feedback.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all staff had received an annual appraisal of their work performance. We sampled staff records and found little evidence to support they had.
- Staff had not received regular clinical supervision. This was more apparent for nurses and therapeutic care workers. Staff reported that supervision had improved recently, but staff had not received this consistently.
- Management of Section 17 leave requirements were not robust. Staff did not always adhere to hospital policy. Parameters of leave granted were not always clear, and there were not contingency measures in place should things go wrong.
- We identified two errors in the Mental Health Act paperwork. This included the approved mental health act practitioner (AMHP) not indicating if the legal rights to order discharge of the patient was explained to the nearest relative. The second point was that neither of the assessing doctors had previous acquaintance with the patient prior to their examination.

However:

Summary of findings

- Patients received a physical examination upon admission, and staff continued to monitor physical health throughout admission until discharge.
- The hospital offered several different psychological therapies as recommended by the National Institute of Health and Care Excellence. This included cognitive behavioural therapy and family therapy.
- The team offered a full range of mental health disciplines and workers, who were appropriately experienced and qualified to work with the patient group.
- Staff held regular and effective multi-disciplinary meetings. Daily meetings were held at the hospital, Monday to Friday where the previous 24 hours was discussed. Consultants held regular patient review meetings and care programme approach meetings.
- Staff received mandatory training in the Mental Health Act (1983) and the Mental Capacity Act (2005).

Are services caring?

Requires improvement 

We rated caring as requires improvement because:

- Patients were not routinely involved in writing their care plans. There was a lack of patient voice, and language used was not always child friendly. Care plans had been written in third person. Patients told us that staff wrote care plans and then offered them a copy. Of the positive behavioural support plans reviewed, some were missing on each ward.
- Five patients commented that at the weekends, lots of agency staff tended to work. Two patients commented that some staff did not know what they were doing.

However:

- We observed numerous positive interactions between staff and patients throughout the inspection. Staff responded to patients' needs in a kind, timely, and sensitive way.
- The hospital admission process informed and orientated new patients to the ward and the hospital.
- Patients could access advocacy, and staff assisted them with this where required.
- The staff team involved families and carers where possible and appropriate, in the care and treatment of patients.
- Patients were offered copies of their care plans

Are services responsive to people's needs?

Good 

We rated responsive as good because:

Summary of findings

- The hospital had a range of rooms and equipment to support care and treatment.
- Patients had access to outdoor space.
- Patients personalised their own bedrooms with personal effects.
- Staff liaised well with alternative placements and services that would provide aftercare and appropriately managed the discharge care pathway.
- Each patient had their own weekly time-tables, which offered educational, occupational therapy and leisure activities.
- The hospital accessed translators or signers as and when appropriate for patients and carers.
- Staff knew how to manage complaints. Managers ensured that feedback from complaints and outcome of investigations were shared with staff.

However:

- Adjustments for people requiring disabled access would prove difficult, due to the building and restrictions, as it was a listed building.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The provider did not have effective oversight of safety. Ligature risk assessments, cleaning, timely maintenance, infection control or how staff responded to alarms was poorly monitored. Some Mental Health Act documentation was incorrect and audit processes were not robust.
- Not all staff were up to date with mandatory training, clinical supervision or appraisals.
- Not all staff knew what the whistle blowing policy was.
- The hospital had not routinely notified the CQC of safeguarding concerns raised, and other notifiable incidents.
- The provider was not aware that two seclusions had taken place.
- Staff had difficulty in relaying the organisational vision and values.
- Staff were aware of senior managers within the hospital, but not the more senior staff within the organisation.

. However:

- Staff participated in clinical audits to monitor quality. Senior staff put action plans in place.
- Staff felt able to raise concerns without fear of victimisation.
- Staff were given opportunities to develop.

Summary of findings

- Staff were open and transparent with patients and appropriate others if things went wrong.
- Staff had the ability to put forward concerns to be considered for the hospital risk register.

Summary of findings

Information about the service

Rhodes Wood hospital is a registered location under the provider of Elysium Healthcare Limited. The hospital comprises of three different wards:

Shepherd and Cheshunt wards can accommodate both males and females between the ages of eight and 18 years old, who have a primary diagnosis of an eating disorder.

Mymwood Place is a neurodevelopmental service, which can accommodate up to 12 patients (male or female) between the ages of 12 to 18.

The CQC registers Rhodes Wood Hospital to carry out the following legally regulated services / activities:

- 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 has been registered with CQC since 10 October 2016. Since this time, the service has been inspected once. This was carried out on 14 March 2017. The hospital received a rating of good in each key question, with an overall rating of good. There were no requirements placed upon the hospital.

The Hospital Director had made an application to become the registered manager of the hospital at the time of inspection.

Our inspection team

The inspection team consisted of one inspection manager, three inspectors, one Mental Health Act reviewer and one specialist advisor who was a nurse consultant.

We would like to thank the patients, staff and carers who took time to talk with us during this inspection.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, and asked some other organisations for feedback about the service.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- received feedback from three carers of young people who were using the service
- spoke with the hospital director and managers or acting managers for each of the wards
- spoke with 16 other staff members; including doctors, nurses, occupational therapist, psychologist and therapeutic care workers
- received feedback about the service from two care co-ordinators or commissioners

Summary of findings

- attended and observed one multi-disciplinary meeting, and two patient reviews
- looked at 18 care and treatment records of patients, nine of which we examined in detail
- looked at 11 patients leave records and six sets of Mental Health Act documentation
- carried out a specific check of the medication management on all three wards
- 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 spoke with nine patients and three carers at the hospital during inspection.

Most patients told us that staff treated them well, were kind and respectful.

Patients told us they were able to personalise their bedrooms.

Four patients told us that there were not enough activities out of school time, particularly during term breaks.

Four patients told us that they did not always get enough support from staff during meal times (unless this was a prescribed one to one).

Five patients commented that at the weekends, lots of agency staff tended to work. Two patients commented that some staff did not know what they were doing.

Five patients felt that there were not enough quiet rooms where they could sit alone if they did not wish to sit with peers.

Four patients talked about not being able to lock the toilet doors on one ward, which they felt was an invasion of privacy. Two patients had experienced others walk into the toilet when they were using it.

All patients were aware of how to make a complaint.

All patients were able to keep in touch with family, friends and significant others.

Patients told us that they were not involved in care planning. Staff wrote the care plans and then showed them to patients. However, patients did acknowledge that they could discuss these with staff if they wanted to.

One patient spoke about being woken up by night staff checking on them by shining a torch in their face, which alarmed them.

We received feedback from three carers:

All three carers had experienced some degree of difficulties with effective communication from the staff, in relation to care and treatment. One carer commented that they did not really know who to contact on a day to day basis, and often felt "out of the loop".

All three carers felt that staff were caring and helpful.

Two carers told us that some things had improved over the last few months. Examples given included the hospital brochure and information which had been updated, and the parent support group which had been reinstated.

Two carers spoke positively about the school, and education offered.

Two carers spoke about the family therapist and were pleased with work completed.

Two carers made comment about some of the wards looking "shabby", although they did acknowledge that some improvements had been made.

Good practice

The transfer of a patient earlier in the year was very well managed. The hospital director travelled with the patient and ensured that a comprehensive handover took place. Furthermore, the hospital director stayed in a hotel local to the placement, so that the patient had a familiar person around when adjusting to their new environment.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ligature risk audits identify all risks, are available on the wards, regularly reviewed and include robust mitigation.
- The provider must ensure that waste disposal is carried out appropriately and that all sharps bins are dated and signed.
- The provider must ensure that the emergency bags are robustly checked and signed for on all wards.
- The provider must ensure medicines are stored in line with guidance and policy and effectively audited.
- The provider must ensure complete and accurate documentation of the Mental Health Act in relation to AMHP and second opinion Doctors.
- The provider must ensure that staff understand the seclusion policy and that all episodes of seclusion are recorded in line with the hospital policy and the Mental Health Act Code of Practice.
- The provider must ensure care plans are written with the involvement of patients to ensure they contain the patient voice and non-clinical language appropriate for a young person.
- The provider must ensure that all staff carry alarms to ensure that emergencies are responded to promptly.
- The provider must ensure that risk assessments following admission are robust and are completed in a timely manner.
- The provider should review and ensure they work to the principles of the least restrictive environment by reducing blanket restrictions as much as possible.
- The provider must ensure that section 17 leave follows hospital policy and that all relevant documentation is fully and consistently completed.
- The provider must ensure that systems are in place to ensure that all wards are consistently kept clean and well maintained.
- The provider must review staffing numbers and procedures for the safe management of incidents
- The provider must ensure that supervision and appraisal is provided and recorded in line with hospital policy.
- The provider must ensure that all staff are compliant with targets for mandatory training.
- The provider must ensure that all incidents are signed off by a senior staff member in line with hospital policy.
- The provider must ensure that the CQC is notified about all reportable incidents.

Action the provider SHOULD take to improve

- The provider should ensure infection control posters are consistently available and visible to all staff.
- The provider should review shared sleeping arrangements and consider plans to provide single bedroom accommodation in the future.
- The provider should ensure all staff are consistently aware of the whistle blowing process.
- The provider should ensure that staff are consistently respectful towards the young people.

Elysium Healthcare Limited

Rhodes Wood Hospital

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Child and Adolescent Mental Health Wards	Rhodes Wood Hospital

Mental Health Act responsibilities

Detailed findings from this inspection

Mental Health Act responsibilities We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Training in the Mental Health Act was mandatory for all staff. Compliance at the time of inspection was 87%. Qualified staff had an awareness of the Mental Health Act, detentions for assessment and treatment, and legal documentation expectations in respect of this.

At the time of our inspection, there was a total of 35 patients across the three wards. Seventeen patients were detained under the Mental Health Act (1983). The remaining 18 were informal patients.

We examined six sets of Mental Health Act documentation. Five sets were complete and in order. The remaining record evidenced two errors that had not been picked up during the provider scrutiny process. This included the approved mental health act practitioner (AMHP) not indicating if the legal rights to order discharge of the patient was explained to the nearest relative. The second point was that neither of the assessing doctors had previous acquaintance with the patient prior to their examination. There was no explanation from the AMPH as to why a medical recommendation was not obtained from a doctor who did have previous acquaintance with the patient.

Staff provided patients with information about their legal position and rights as required under the Mental Health Act (section 132). Staff documented this in patient records and re-visited at appropriate intervals.

We examined 11 individual patients' leave records. All patients leave authorisations had been put in place and authorised by the patient responsible clinician. However, specific durations of leave were not entered on the authorisation forms for eight out of the 11 examined.

Seven out of the 11 records did not state the names of escorting staff, or the details of the home address for where patients were to reside with parents. Five records contained no contingency plans if things went wrong.

Two patients' records examined were informal. However, the doctor completed section 17 leave forms for these patients. Staff used the same section 17 recording forms for all patients, regardless of legal status.

Detailed findings

Staff had not implemented a specific leave care plan for any of the 11 patients.

We found that 11 forms did not state whether staff had given copies of authorised leave to patients.

In 10 out of the 11 records, staff had not recorded either staff or patient views on how the leave had gone. We also found that staff had not recorded any carer feedback on the tool provided for this purpose, upon return from day or overnight leave with carers or family members, on seven occasions.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act was mandatory. At the time of inspection, compliance with this was at 75%. Staff had variable knowledge about the Mental Capacity Act and the statutory principles.
- The staff team assumed that the patients had capacity to make decisions for themselves, before they assumed that they lacked capacity. Staff assessed and recorded capacity to consent appropriately where applicable, for those patients aged 16 years and over and understood the principles of Gillick competence as they applied to patients under 16**.** This was completed on a decision specific basis with regards to different decisions and recorded.
- The provider had a policy on the Mental Capacity Act, which included the Deprivation of Liberty safeguards. Staff had access to this electronically.
- There had been no Deprivation of Liberty Safeguarding applications made in the past 12 months prior to inspection.
- Staff knew they could contact the Mental Health administrators for advice around the Mental Capacity Act if required.

Inadequate

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

Our findings

Safe and clean environment

- The layout of the wards did not enable staff to consistently observe all parts of the ward effectively. There were mirrors located in some identified blind spots, but not all. We saw blind spots in the stairwells which led up to patient bedroom areas.
- Ligature points were across all wards. A ligature point is a fixed or static object that a ligature could be secured to and used for self-harming purposes. The provider had not identified all of these. The ligature risk assessment the provider used did not mitigate against all risks. There were no ligature risk assessments available on the wards that staff could refer to. Patients who were identified as a high risk were nursed under enhanced observations. The Hospital Director had kept the CQC updated with ward management plans for challenging patients. Between January and April 2019, there had been 34 incidents involving three patients attempting to harm themselves with ligatures. However none of these involved the use of a fixed or static point.
- The hospital complied with guidance on eliminating mixed-sex accommodation. The wards were mixed gender, with separate areas for males and females.
- We did not see staff with personal alarms during the inspection. Each room had call bells so that help could be summoned. However, the alarms only sounded in the staff offices. We were concerned that this could cause a delay with help in an emergency. The provider has since assured us that they had 35 individual alarms for staff use across the hospital. We received photographic evidence of this.
- The wards were not clean across the hospital. This was more evident on Mymwood place. Throughout the inspection we observed dust, unclean areas and some cluttered spaces. The provider did have some vacancies for cleaning staff at the time of inspection. Not all of the employed cleaning staff cleaned Mymwood place and one was reported to be afraid of the patient group, despite training provided about the needs of the patients. The hospital advised that they had recently put in a request for a deep clean. We saw evidence of this, although the date was to be confirmed for some time in April 2019. Areas of the wards needed re-painting. We saw scuffed walls and writing on walls in one area. Not all areas were well maintained although there was a planned and completed redecoration evidence log with photographs. We saw a boarded window, and a medication fridge door came off its hinges when opened by inspection staff. We viewed cleaning records which had significant gaps in daily cleaning schedules.
- Clinic rooms had hand washing facilities for staff. There was some alcohol gel available for staff and visitors. We did not see posters to highlight infection control in relation to hand washing.
- Each clinic room was equipped with accessible equipment and emergency drugs. Staff checked these daily. However, we observed that there were inaccurate records in relation to this on Mymwood ward. Staff had checked and signed that all contents and medications were correct and present. There were emergency drugs which should have been present, and were not. We bought this to the provider's attention, and they took immediate action to address this.

Safe staffing

- The provider estimated the number and grades of nurses required daily, dependent upon occupancy and levels of observations. The hospital held a meeting each morning when safe staffing across all three wards for the day was discussed. This gave ward managers the opportunity to adjust staffing levels in order to meet the needs of the patients.
- There were enough staff to undertake restraint. However, staff told us that assistance did not always come in a timely way when needed. We heard of one incident whereby a patient could not be given some requested medication, as the only nurse available at that time was involved in the restraint of the patient. We saw on an incident form, that three staff had responded to another incident, but had left their patients (who were on enhanced observations) unsupervised while they responded.
- Ward managers were expected to be a part of the day to day nursing numbers and were not supernumerary. However, at the time of the inspection the service lead and the interim ward manager on Shepherd Ward were both supernumerary to staffing numbers. At time of

inspection, there was one established ward manager on Mymwood place, one acting ward manager on Cheshunt ward, and one interim ward manager on Shepherd ward. The acting ward manager had been given the opportunity due to a vacant position. The interim ward manager was also still working as the hospital's clinical services manager. Both posts had been advertised and recruitment was ongoing.

- We examined the staff rotas and found that the number of nurses and therapeutic support workers matched the required numbers most days. When numbers were below the optimum, senior staff assisted on the ward to ensure patient needs were met.
- The hospital used regular bank and agency staff where possible. Agency staff used were familiar with the hospital and patient group. They were block booked so that the patients had some consistency in care. Data provided confirmed that between January and March 2019, the total bank hours used was 2,541, and agency hours totalled 2,096.
- Nurses tried to have allocated one to one time with their key patients, although reported that this could be more difficult if you had several patients allocated to you.
- During inspection, we saw that there were always staff in communal areas – although not all of these were freely available, due to undertaking observations.
- Escorted leave or ward activities were rarely cancelled because there were too few staff.
- There was adequate medical cover throughout the 24-hour period, who could attend the wards quickly in an emergency.

Mandatory training

- Staff completed some mandatory training during induction to the hospital, before commencing on the wards. Mandatory training consisted of 24 courses, to include equality, diversity and human rights; safeguarding adults and children; restraint training, basic life support, fire safety and infection control. Most training compliance as of 4 April 2019 was above 75%. Four courses were just under 75%. These were safeguarding children (Level 3); safe administration of medications; managing violence and aggression (MVA) and immediate life support. There were three courses for which compliance was 60% or under. Conflict resolution 60%; Breakaway 59% and basic life support at only 53%.

Assessing and managing risk to patients and staff

- The hospital did not have seclusion rooms and reported they did not use seclusion. However, we identified two patients on Mymwood place who had been secluded for a short period of time, by preventing a patient leaving a room. Staff did not recognise this as episodes of seclusion and therefore appropriate documentation was not in place to safeguard the patients, in line with the Mental Health Act Code of Practice. The provider reviewed this information and following the inspection agreed that this was correct. Senior staff had put measures in place to prevent this from re-occurring.
- At time of inspection, there were no patients being nursed under long term segregation.
- The provider gave us data around the number of restraints between November 2017 and November 2018. The ward with the highest recorded number of restraints was Shepherd ward, with 782. These involved 13 different patients. One resulted in prone restraint (face down), due to the patient unexpectedly descending to the floor. Staff changed the patients position immediately. Staff informed us that the number of restraints on Shepherd ward was high, due to patients often having to be restrained to receive essential nutrition. The number of restraints on Cheshunt ward was 273, involving 11 different patients, none of which involved the prone position. During the same time, there were 168 restraints on Mymwood Place involving ten different patients. Four of these resulted in prone restraint. Staff told us that they only used restraint as a last resort and only after de-escalation had failed. We reviewed a number of reports of incidents of restraint and these recorded that staff had attempted de-escalation before intervening. However, a high proportion of staff had not participated in the mandatory training relating to managing violence and aggression, conflict resolution and breakaway. This might indicate that staff did not have the skills required to minimise the need to use restraint.
- We specifically examined nine risk assessments within care records across the three wards. Nursing staff completion of these considered variably following admission. Of the nine, two were completed on, or the day after admission. The other eight varied between three days after admission and 235 days. We were told that the admitting doctor completed an initial admission risk assessment which was later scanned

onto the system. These were not located upon inspection, and a sample were sent through following inspection. While these were completed, they were not very comprehensive, particularly the plans to manage risk. For example, "close monitoring", or "support patient". They were also current risks only with no historical risks identified.

- We saw examples of blanket restrictions. For example, patients on Shepherd and Cheshunt wards were only allowed to have one hot drink per day, at a set time. On Shepherd ward, we also observed that the toilet doors could not be locked from the inside. Staff and patients told us that this was due to some incidents previously, when the locks were taken out, and had not been replaced. The hospital director was not aware of this during interview. However the locks were removed as a result of a serious incident, for the safety of the young people, whilst sourcing double locks to ensure that staff could access more quickly in an emergency.
- Initially we saw a lack of signs for informal patients telling them that they could leave the wards. However, on the second day of inspection, staff had put these up on exit doors of the wards. Informal patients we spoke with told us that they were not free to leave. The multi-disciplinary team explained that informal patients could ask to leave the hospital. The staff, including the doctor would discuss any requests with the patients, relatives and carers (where appropriate). If staff deemed this unsafe, the team would use the Mental Health Act to detain a patient while setting up further assessment.
- The provider had a policy and procedures for the use of observations. Staff were able to tell us the different levels of observations used. However, we became aware on two occasions that staff had left patients unsupervised. Once to attend to an incident. This was evidenced in care records and an incident form. There was a further incident whereby the staff member did not understand why the patient was on observations. This was lodged and dealt with as a complaint.
- The service rarely used rapid tranquillisation. Administering staff were aware of the National Institute of Health and Care Excellence guidelines following administration, in relation to physical health.

Track record on safety

- The provider reported ten serious incidents between February 2018 and November 2018. Most of these (seven) involved deliberate self-harm. One incident involved a transferred patient not having the correct legal documentation; one involved a medication error, and one related to a deterioration in physical health which led to admission to a general hospital.

Reporting incidents and learning from when things go wrong

- All staff were aware of when an incident form needed to be completed which they did electronically. Staff had reported most incidents as expected.
- The provider had a policy in place around the Duty of Candour. Staff informed patients and appropriate others if things went wrong. The manager had adhered to this when investigating complaints. The Duty of Candour was discussed during different mandatory training sessions. Primarily, the "suggestions, ideas and complaints" session and safeguarding training.
- Staff received feedback from investigations of incidents, both internal and external to the service. We saw the hospital had made changes as the result of feedback. One example of this was the banning of plastic bags, following a suicide attempt. A further example was additional training for staff around the emergency grab bags, as it became apparent during an incident that not all staff knew where these were located. Monday through to Friday the hospital held a morning multi-disciplinary meeting, with nurse representatives from each ward. During this meeting, all incidents over the past 24 hours were discussed. The nurses then disseminated appropriate information to staff on their wards. Incidents were also discussed during the hospital Governance meetings monthly. The hospital director also attended monthly regional CAMHS Governance meetings within Elysium, during which significant incidents were reported and discussed.
- However, we concluded the service had taken insufficient action to address two important issues relating to safety. The first is the failure to adequately assess and mitigate the risks from ligatures and ligature anchor points – despite the high number of ligature incidents. The second is the failure to ensure that staff were trained in the skills required to minimise the use of restraint, or to use restraint safely, despite the very high use of restraint within the service.
- Senior staff told us that incident forms were all reviewed within 24 hours, where possible. However, during inspection, we identified that there were 25 incident forms in total which had not been signed off by senior

Inadequate

Are services safe?

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

staff. The dates of these incidents were between January 2019 and April 2019. Managers explained that some of these would be due to awaiting confirmation or clarity of points from staff members who were on duty at the time of the incident.

- Not all staff received appropriate support and were de-briefed following serious incidents.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We examined nine admission records of patients. Staff completed a comprehensive mental health assessment of each patient upon admission, or shortly following admission.
- Staff assessed patients' physical health needs in a timely manner upon admission, and routinely thereafter.
- Staff developed care plans which met identified needs during assessment. Staff reviewed these regularly.
- Care plans were written by staff and then discussed with the patients, rather than written with the patients. Care plans did not contain the patient voice and were written in third person. Some language was clinical in nature and not always young person friendly. Patients told us that they were not involved in writing care plans but did see them and could have copies if they wanted. Care plans were holistic, and recovery orientated and included goal setting. This was more evident with physical health goals in relation to weight and eating. Of the positive behavioural support plans reviewed, two were missing on Mymwood ward and one was lacking a review date. On Cheshunt ward two positive behavioural support plans were missing and two were present but not dated.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Examples included family therapy, cognitive behavioural therapy and anxiety management.
- Patients had access to physical healthcare, including access to specialists when needed.
- Staff assessed and met patients' needs for food, drink, hydration and nutrition. The dietician advised and assisted both staff and patients.
- Staff supported patients to lead healthy lives and gave advice around diet and lifestyle.
- The multi-disciplinary team used recognised rating scales to assess and record severity and outcomes. Examples of this included Health of the Nation Outcome scales for children and adolescents (HoNOSCA) and children's global assessment scale (CGAS). Nurses and therapeutic care support workers were not all aware of what these were.
- The pharmacist undertook regular audits. Staff completed various other audits to monitor quality. These included care programme approach audits; Mental Health Act audits; infection control audits and physical health audits. The hospital director monitored compliance with these and put in relevant action plans.

Skilled staff to deliver care

- The team included a wide range of specialists required to meet the needs of the patients. This included doctors; nurses; dieticians; occupational therapy staff; psychology staff; a speech and language therapist, and a peer support worker. The provider worked with a pharmacy who attended the hospital weekly. Referrals for podiatrists, physiotherapists and dentists could be made locally.
- Some, but not all, of the staff who worked shifts on the wards were experienced and qualified to work with this patient group. The provider had a training package in place to address any gaps of knowledge specifically around eating disorders, mental health, learning disabilities and Autistic Spectrum Disorder. All staff were expected to attend this but the provider could not provide evidence that this had happened.
- Managers provided new staff with an appropriate and planned induction to the service. This consisted of a week of face to face learning. This incorporated a welcome to Elysium healthcare; working in CAMHS services; safeguarding; basic life support and health and safety. Week two was focused upon the electronic care notes system used, breakaway and the management of violence and aggression. New staff then spent time on the wards on a supernumerary basis, getting to know the patients and day to day structure. Senior staff had an agency staff induction in place also, to ensure that all new staff were appropriately inducted to the hospital before commencing shifts.
- We were not ensured that staff were receiving supervision. Some staff told us they had received regular supervision. Other staff had not, although said that this had improved recently. Therapy staff appeared to have regular supervision, whereas the nurses and therapeutic care workers did not. The provider

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

acknowledged that supervision was an important area and required constant attention. As a result, supervision had been scheduled into the daily task jobs for nurses each shift. As of March 2019, the provider gave an overall compliance rate of 63%. However, staff had made a real effort to get this percentage up. This had increased from just 45% in February 2019. We reviewed a sample of eight staff supervision records. Of these, one staff member had received monthly supervisions dating back to January 2019. One further staff member had received supervision for two consecutive months. There were no supervision records available for the remaining six staff, so we were unable to corroborate the compliance rate.

- Eligible staff should have received an annual appraisal in line with the provider's policy. The managers were aiming to ensure all staff were up to date. In February 2019 the provider reported a compliance rate of only 45%. We sampled 14 appraisals. Of these only four seen had been completed. Managers explained to us that there had not been many staff who had been employed for over 12 months, and therefore were not due for an appraisal.
- Managers held regular staff meetings to reflect on and learn from incidents, for support and to discuss any areas of concern.
- Managers identified the learning needs of staff and provided them with opportunities to develop skills and knowledge. Therapeutic care workers undertook the care certificate training. Managers were able to organise more ad hoc training for specific subjects, depending upon staff knowledge and patient mix. The clinical services manager ensured that qualified nurses were competent to pass naso-gastric (NG) tubes.
- The hospital director dealt with poor staff performance promptly and effectively. This was evident in a sample of human resource files seen, through meeting minutes, and audit outcomes.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team held regular and effective meetings to discuss patient care.
- Staff shared information about patients during a shift to shift hand-over. Qualified nurses attended the daily hospital morning meeting, and so had oversight of issues on other wards.
- The staff had developed effective working relationships internally, and with relevant teams external to the organisation. Examples included community mental health teams, general practitioners and commissioners.

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

- Mental Health Act training was mandatory for all staff. At time of inspection, compliance for this was 87%. Qualified nurses were able to relay the detentions for assessments and treatment and understood the rights of these patients.
- Staff had direct access to administrative support and legal advice on the implementation of the Mental Health Act. Administrators were on site during working hours. Staff knew who they were and how to contact them.
- The provider had relevant policies and procedures which reflected the most recent guidance. Staff had access to these electronically.
- Patients had access to information about independent mental health advocacy. Staff assisted with contacting these as appropriate.
- Staff provided patients with information about their legal position and rights as required under the Mental Health Act (section 132). Staff documented this in patient records and re-visited at appropriate intervals.
- Staff did not always adhere to the policy on Section 17 leave. All patients leave authorisations had been put in place and authorised by the patient responsible clinician. However, specific durations of leave were not entered on the authorisation forms for eight out of the 11 examined. Seven out of the 11 records did not sate the names of escorting staff, or the details of the home address for where patients were to reside with parents. Five records contained no contingency plans if things went wrong. In 10 out of 11 records viewed, staff had not recorded either staff or patient views on how the leave had gone. We also found that staff had not recorded any carer feedback on the tool provided for this purpose, upon return from day or overnight leave with carers or family members, on seven occasions.
- Staff had requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of detention paperwork and associated records appropriately. Wards held a paper file on the wards with section 17 documentation in. Electronic copies of these forms were also held.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The service had posters to tell informal patients that they could leave the ward freely. Patients were advised to discuss this with the nurses in the first instance, should they wish to leave.
- The Mental Health administrators undertook regular audits of legal documentation and gave feedback to the ward teams.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act was mandatory. At the time of inspection, compliance with this was at 75%. Staff had variable knowledge about the Mental Capacity Act and the statutory principles.
- There had been no Deprivation of Liberty Safeguarding applications made in the past 12 months prior to inspection.
- The provider had a policy on the Mental Capacity Act, which included the Deprivation of Liberty safeguards. Staff had access to this electronically.
- Staff knew they could contact the Mental Health administrators for advice around the Mental Capacity Act if required.
- The staff team assumed that the patients had capacity to make decisions for themselves, before they assumed that they lacked capacity. Staff assessed and recorded capacity to consent appropriately where applicable, for those 16 years and over. This was completed on a decision specific basis with regards to different decisions and recorded.
- Staff were aware of what Gillick competence was (a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge).

Requires improvement

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed some caring interactions between staff and patients during inspection. We saw that staff were discreet when needed, respectful of the patients, and offered emotional support at times
- Staff directed patients to other services, such as advocacy, when appropriate and supported them to access such services.
- Six of the nine patients we spoke with reported that staff treated them well, were caring and kind.
- Five patients said that they did not get enough privacy. Four patients talked about having no locks on the toilet doors. Five patients said that there was not always a quiet place to go to if you wanted to be alone and not sit with others. One patient said that they had experienced a torch in their face during the night when staff were checking on them.
- Regular staff we spoke with knew the patients well, including likes and dislikes, social and any religious / cultural needs. However, five patients commented that at the weekends, lots of agency staff tended to work. Two patients commented that some staff did not know what they were doing. Staff felt able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of consequences.
- Staff maintained the confidential information of patients.

The involvement of people in the care that they receive

- Upon admission, staff orientated patients to the ward environment and provided information about the service, verbally and in written form.
- Patients were offered a copy of their care plans. However, patients told us that they were not involved in writing these. Staff wrote them, and then discussed the content with them. Care plans were not written in first person and did not reflect patients views and wishes in all instances. Some contained clinical language inappropriate for a young person.
- Staff communicated with patients in a way that they understood. This included patients with communication difficulties.
- Staff told us that they included patients, where appropriate in decisions about the service. Patients were able to give feedback on the service they received through regular community meetings held on each ward. In addition to this, there was a post box where patients could leave feedback or suggestions. This was collected by the hospital director only.
- Staff ensured that patients could access advocacy as and when needed.
- Staff aimed to have weekly contact with parents and carers to provide an update (where appropriate).
- The hospital director held monthly relative / carer meetings to provide updates and receive feedback from the current patient group. These were recorded.
- Staff provided carers with information around how to access a carer's assessment where applicable.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Average bed occupancy between June and November 2018 was reported as between 95% and 99%.
- The provider accepted national referrals from all of England.
- There was always a bed available when patients returned from leave.
- Patients were not transferred between wards during an admission unless it was clinically justified, and in the best interests of the patient. Staff liaised well with alternative placements and services that would provide aftercare and were assertive in managing the discharge care pathway.
- Staff arranged transfers or discharge of patients at appropriate times of the day. Staff planned these for ease of transition.
- It was rare for any patients to require a psychiatric intensive care bed. If this did occur, the service would continue to care for the patient while a more appropriate bed was being sourced.
- The service reported one delayed discharge between January 2018 and August 2018. At the time of inspection there were two patients who were delayed discharges. The provider advised that these were due to locating a suitable alternative placement along with securing funding. We saw evidence that referrals had been received by external independent providers. Assessments had occurred, and placements not felt suitable. At the time of inspection, a bespoke community package was being put forward for one patient.
- Staff supported patients during referrals and transfers. One recent patient had been transferred to another unit. The provider ensured that the receiving hospital had a thorough hand-over and made familiar staff available for the first few days to help the patient orientate to their new environment.

The facilities promote recovery, comfort, dignity and confidentiality

- Bedrooms were either shared or were single. The service had eight twin rooms and one triple room. These were on Shepherd and Cheshunt wards. All bedrooms on Mymwood place were single occupancy. All but two bedrooms (on Shepherd ward) had en suite facilities. Staff informed us that some patients did not like to sleep in a bedroom alone. Particularly younger children. Shared rooms had not been voiced as a concern by the patients.
- Patients personalised their bedrooms. We saw numerous pictures, photographs, personal bedding and other personal items within rooms.
- Patients did not have a lockable space in their bedrooms to store valuable possessions. However, patients were offered a locker within the ward. Nurses also had a safe in the office where valuables could be stored for safe keeping.
- The hospital had a range of rooms and equipment to support care and treatment. Patients could not be physically examined in clinic rooms on the ward as they were compact and had no room for examination couches. There was one spacious medical examination room which was used across three wards, located centrally. We observed a lack of quiet spaces for patients to relax in. Patients told us that they could not always have private space, due to limited bedroom access out of school hours.
- There was a school on site, which needed re-decorating. However, work had commenced on a new school building. This work was in progress during inspection.
- Patients reported they were able to accept visitors within the hospital, either in designated rooms, or in bedrooms (depending upon staff agreement).
- Patients were able to make telephone calls in private. Any restrictions to this, staff risk assessed. Smart phones with cameras; video and internet features were not allowed in the hospital. The hospital provided basic mobile phones without such features for the patients to use on the wards.
- Patients had access to outside space. Many patients had regular walks as part of their time-tables. Staff supervised patients when out in the grounds.
- There were mixed views from patients around the food. Patients were unable to make hot drinks and snacks throughout the day and night. As Shepherd and Cheshunt were eating disorder units, meal and snack times were set. There was no free access to water, due to the risk of patients drinking excessively. Drink times were set. If patients wanted drinks around these times,

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

they asked the staff. Staff were able to facilitate one extra drink per day, per patient. Individual care plans did not reflect this. Staff explained that this was part of the treatment plan.

Patients' engagement with the wider community

- The hospital had a school on site and offered education to all patients. This had an Ofsted rating of good.
- Staff supported, and encouraged patients to keep in contact with friends, families and carers.

Meeting the needs of all people who use the service

- The hospital was an old building, so there were some restrictions in terms of size, shape of rooms and general layout. The hospital would have difficulties in making adjustments for patients who required a wheelchair. The provider took this into consideration during the referral process.
- Staff ensured that patients had access to written information around treatments local services, patient's rights and complaints. Staff provided easy read format to patients where required.
- Translators, interpreters and signers could be sourced by management as and when needed. A translator had been booked and used for a relative during multi-disciplinary meetings.
- The service catered for a wide range of dietary requirements. This included halal, vegetarians, vegan, gluten free, other intolerances and preferences. Patients had the opportunity to discuss menus with the staff, including the chef at regular intervals.
- Staff ensured that patients had access to appropriate spiritual support when requested.

Listening to and learning from concerns and complaints

- The service had received 11 complaints between August and December 2018. Of these eight were upheld, and three partially upheld. Complaint themes were reported to be a lack of, or breakdown in communication and staff speaking insensitively to patients. Of the 11 complaints, five were in relation to these issues.
- Managers ensured staff received the outcome of investigations of complaints and acted upon the findings. Examples of actions included communication systems had been improved; positive behavioural support plans had been implemented, and staff received supervision and training around communication and autism.
- Patients were aware of how to complain and knew who to raise their concerns with. Two patients told us that complaining was a waste of time, as nothing got done when you did. Some patients told us that they had not received feedback after a complaint. However, complaints examined showed that managers had followed policy, had responded in a timely way, sent outcome letters following investigations, and gave letters of apology where appropriate.
- All staff knew how to handle complaints, who to report to and where to document.
- Managers ensured staff received the outcome of investigations of complaints and acted upon the findings.

Are services well-led?

Inadequate

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- Leaders had a good understanding of the services they managed. They explained clearly how the teams were working to provide the best possible care.
- Patients felt able to approach the leaders within the hospital.
- Leaders were highly visible in the service. The hospital director undertook daily ward visits to support staff. Staff spoke highly about the open-door approach and felt they could approach both the hospital director and clinical services manager. The service lead was also visible and provided guidance to ward staff. However, staff reported they did not know who senior leaders of Elysium were.
- Leadership opportunities were available for staff below team manager level. The service was keen to develop staff.

Vision and strategy

- Staff were not able to consistently voice the vision and values of the organisation. Most spoke about delivering high quality care and aiming to discharge patients into the community at the earliest opportunity.
- Staff working on the wards did not always feel involved or able to contribute to discussions about the service. An example of this given by some staff, was the school re-build. Staff had been told this was happening but had not been asked to input ideas or suggestions.
- Managers demonstrated that they were working hard to deliver high quality care within available budgets.

Culture

- Most staff felt respected, supported and valued by their immediate team and senior staff within the hospital.
- Staff spoke highly of support given between peers at ward level. Most staff felt that the multi-disciplinary team worked well together and respected each other's opinions, skills and knowledge.
- Staff felt able to raise concerns with senior staff without fear of retribution. Not all staff knew how to use the whistle blowing process. However, substantive staff who had worked at the hospital for some time, did.
- Managers dealt with poor staff performance when needed. We saw letters of concern in staff files with clear expectations to the addressee.
- Annual appraisals gave staff opportunity to discuss career development, learning opportunities, and how the organisation could support them.
- All staff felt that the provider promoted equality and diversity in day to day work, and in providing opportunities for staff.
- Staff sickness and absence between January 2018 and December 2019 was reported to be between 2.3% and 2.5%. This had reduced significantly from previous data.
- The organisation had an employee assistance programme. This offered independent, free, confidential advice to staff. This could be work related or not. The service offered a
- telephone number, email address or skype options to contact. The service was available 24 hours a day, every day of the year.
- Complaint themes were reported to be a lack of, or breakdown in communication and staff speaking insensitively to patients. Of the 11 complaints, five were in relation to these.

Governance

- Systems and procedures in place to ensure that wards were safe and clean were not adequate. The provider did not have effective oversight of safety. Ligature risk assessments, medicines management and MHA documentation, cleaning, timely maintenance, infection control and how staff responded to alarms was poorly monitored.
- Managers ensured that important information such as lessons learnt from incidents and complaints was shared, discussed and learnt from.
- The provider ensured that their safe staffing numbers were met on a day to day basis. The organisation had recently introduced that ward managers were not supernumerary. Therefore, they were expected to work as a nurse within the safe staffing numbers, as well as undertake their management responsibilities. However, at the time of the inspection the service lead and the interim ward manager on Shepherd Ward were both supernumerary to staffing numbers.
- Teams adhered to the Mental Health Act and the Mental Capacity Act.
- Staff understood the importance of working within teams and external teams, to best meet patient needs.

Are services well-led?

Inadequate

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Management of risk, issues and performance

- The hospital had a risk register which staff reviewed regularly. Staff at ward level escalated any areas of concern to senior staff when required. Concerns raised by staff had been identified within the risk register.
- The provider had business continuity plans for emergency situations, for example serious adverse weather or fire.
- Leaders placed emphasis upon patient needs when considering cost improvements. If patient care was felt to be compromised, discussions occurred between senior staff within the organisation.

Information management

- Electronic systems used to collect data were effective and not over burdensome for ward staff. Staff had no concerns around the technology infrastructure.
- Information governance systems included confidentiality of patient records. If there had been any breaches, staff reported these in line with hospital policy.
- Ward managers were able to view information to support them in their roles, for example to capture training compliance and supervision compliance.
- We identified that there had been notifiable incidents within the hospital, for which staff had failed to submit notifications for to the CQC. This included incidents when the Police had been called, assistance from medial services sought via 999, and patients who had been taken to the general hospital for assessment or treatment.

Engagement

- The provider produced regular updates and bulletins via email to all staff. This included results of staff surveys. Important information which needed cascading was often printed off and placed at ward level so that bank and agency staff could see – if they had no internal email address.
- Staff had the opportunity to participate in local staff surveys and give feedback about the service. Carers and relatives also had the opportunity at regular scheduled meetings.
- Staff had access to feedback from patients, carers and other staff, which they used to strive to improve.
- Patient and staff had ample opportunity to meet with the hospital director on a face to face basis.
- Managers updated external stakeholders, such as commissioners, as and when required.

Learning, continuous improvement and innovation

- Staff had the opportunity to participate in research. The dietician had presented at a national conference in London around eating disorders and veganism. A paper had also been completed around NG feeding under restraint. This had been sent for publication. Psychology staff had ongoing involvement in research within CAMHS and eating disorders and had presented at a conference in New York. Rhodes Wood hospital had an established research group.
- The service was looking to continuously improve and try innovative ways of working. Treatment plans across Shepherd and Cheshunt were continually revisited and reviewed. The hospital was keen to develop closer working relationships with community teams, with the aim to get patients back into the community as quickly as possible with minimal disruption to education, and without compromising the relationship with the community teams in their local areas.
- The hospital had registered with the Quality Network for Inpatient CAMHS (QNIC). All three wards were pending a review which was scheduled for 2019.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not follow policy and internal quality assurance processes in relation to incident investigation. Not all incidents were fully recorded and signed off by senior management. The provider did not notify the Care Quality Commission of all reportable incidents. **This was a breach of Regulation 17(2)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that all wards were clean and well maintained. **This was a breach of Regulation 15(1)(a), (15)(2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that all staff had received documented supervision and appraisal in line with policy. **This was a breach of Regulation 18(2)(a)**

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **People who use services and others were not protected against the risks associated with unsafe care and treatment because:** Ligature risk audits were not available on the wards and audits did not identify all risks or contain adequate mitigation. Risk assessments on admission to the hospital were not completed in a timely manner. Staff did not recognise or document episodes of seclusion in line with hospital policy and the Mental Health Act Code of Practice. Staff did not always adhere to the Section 17 leave policy. On occasions documentation was incomplete. Not all staff were receiving regular and documented clinical supervision and appraisal in line with hospital policy. Emergency bags and equipment were not accurately checked to confirm all required items were present. Staff did not routinely carry alarms to ensure that emergency situations were responded to promptly. Not all staff were compliant with mandatory training in line with hospital policy. Waste disposal was not carried out appropriately and not all sharps bins were signed and dated. **This was a breach of Regulation 12(2)(a) 12(2)(b)**