Cygnet Health Care Limited

Cygnet Hospital Godden Green

Inspection report

Godden Green
Sevenoaks
TN15 0JR
Tel: 01732763491
www.cygnethealth.co.uk

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Cygnet Hospital Godden Green delivers Tier 4 Child and Adolescent Mental Health Service (inpatients CAMHS, Knole and Riverhill wards) and also provides a Psychiatric Intensive Care Unit (PICU, Castle ward) service for women.

On 23 September 2020, we undertook an unannounced focussed inspection of Knole and Riverhill wards. On 2 October 2020, we undertook an unannounced focussed inspection of Castle ward. This was following concerns raised with us by members of the public, complaints from relatives and other professionals. The concerns included the safety and wellbeing of the young people and patients, high levels of incidents resulting in harm, patients' dignity and sexual safety on the ward, cleanliness of the wards, staff training, complaints handling and leadership.

During our inspection, we had serious concerns about the safety and care of the young people and patients at the service, which we fed back to managers and asked that they took immediate action to address these. The Director of Nursing for Cygnet Health Care Limited commenced immediate action to ensure the safety of young people and patients.

On 5 October 2020, we served a Section 31 Letter of Intent which informed the provider that we were considering possible urgent action should they not provide documentary evidence to reassure us that the risks had been removed or were immediately being removed. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC could suspend a providers registration for a period of time, or impose, vary or remove conditions on the registration with immediate effect in response to serious concerns.

In response to the Section 31 letter the provider submitted an action plan that set out how some concerns had been addressed and how others were being addressed, including clear time frames for addressing those. No further enforcement action was taken against the provider and CQC continue to monitor the providers progress.

The provider also agreed to suspend admissions to the psychiatric intensive care unit until further notice and to provide us with a range of information that allows us to monitor the services closely. The provider agreed to meet with us on a weekly basis as part of that monitoring process.

In addition, CQC has also worked closely with the NHSE/I and the South East provider collaborative (responsible for commissioning child and adolescent mental health services) who, along with other stakeholders, decided that the Tier 4 child and adolescent unit should temporarily close and so young people would be moved to other appropriate settings, for example, discharged home or onward placement. Following this decision, Cygnet Health Care Limited decided to permanently close the child and adolescent mental health wards. On the 26 October 2020, all the young people had moved from the child and adolescent mental health services at Godden Green Hospital. The previous rating for this service will be rescinded once the service is closed.

CQC continued to work with the provider and stakeholder organisations to ensure safe care of the young people until they were moved to another placement or discharged home.

During the inspections we found:

- None of the ward environments were safe, clean or well maintained. Staff did not always assess and manage risk well. On Knole and Riverhill wards, environmental and ligature risk assessments did not always capture risks or have

appropriate mitigation. Repeated incidents occurred where young people suffered harm and injury. Staff were not always able to keep young people safe from avoidable harm. Restrictive practice was routinely used on Castle ward without any attempt at de-escalation. Incident management was poor on all wards and did not keep patients and young safe.

- Staff on all wards did not always develop care plans that appropriately reflected patients and young peoples' assessed needs. Care plans were not always personalised, holistic or recovery orientated.
- There was not enough staff deployed with the skills, expertise and experience to meet the needs of young people on Knole and Riverhill wards. Most of the staff had no experience of working with young people, and had not received sufficient specific training for their role. Staff did not receive comprehensive induction, and supervisions did not sufficiently support them. On Castle ward, the provider had not ensured the gender mix of staff was appropriate for a female ward.
- Staff from the different disciplines did not always work together effectively and this resulted in gaps in peoples' care.
- Physical health management was poor, and records were not an accurate reflection of people's needs. On Castle ward, we saw conflicting information about physical health diagnoses in patients care plans, and appropriate referrals to specialist services not being made. A number of patients and most young people across all wards did not always receive safe and appropriate physical healthcare. On Knole ward, staff did not always follow the provider's protocol when young people needed to attend Emergency Departments, resulting in delays to their treatment. On Knole and Riverhill wards, some staff were completing medical assessments, which they were not trained to do.
- The culture at the hospital was not open, transparent and did not support both staff and patients to raise issues of concern. On Castle ward, a culture of negativity towards patients had developed among some staff. We saw records where patients were referred to as 'difficult' and 'trouble-makers'. We saw some staff acting in an intimidating manner when patient's behaviour became disturbed with little attempt made to use a calm and considered approach to de-escalate the situation or reassure and comfort patients. Young people said they felt tensions on Knole and Riverhill wards that upset them and made them feel unsafe.
- Staff did not always treat patients and young people with compassion and kindness. Staff did not always respect patients' privacy and dignity. On Castle ward, there was a high ratio of male staff working closely with female patients despite them having asked for female staff. Staff did not always knock on bedroom doors before entering, and some patients were afraid to shower as a result. Staff did not always appropriately involve patients, young people, families and carers in care planning. On all wards, there was limited evidence of patient and young peoples' involvement in their care and treatment. Most patients, young people and their families told us they did not feel included in care decisions.
- The service did not adequately meet the needs of all patients. Patients did not receive adequate information, cultural needs were often not met, and patients had very limited access to outside space.
- Complaints were not managed well. The process was ineffective and did not produce good outcomes. There was not enough action taken to learn from complaints, and prevent future occurrences. Patients, families and carers told us they had no faith in the complaints process, as nothing changed as a result and concerns were often played down.
- On Riverhill and Knole wards, leaders did not have the skills, knowledge and experience to perform their roles, and were not always visible in the service. Leaders did not ensure staff received appropriate support. There was a poor culture on the wards and staff reported exceptionally low morale. Some staff told us they did not feel able to raise concerns without fear of retribution.
- Governance processes did not operate effectively, and performance and risk were not managed well. Oversight of incidents and complaints was poor, and the processes were not always effective as a result. The leadership team at the hospital had not recognised the concerns identified on the inspection In addition, the senior leadership team at Cygnet Health Care Limited did not have adequate assurance mechanisms in place. They had not picked up that young people and patients were not receiving the care that they should have been and had not acted to make improvements in a timely manner.

However;

Summary of findings

- On Castle ward an environmental ligature risk assessment was completed, with effective mitigation of identified risks. There had been no reported incidents involving fixed point ligatures since the ward opened in November 2019.
- On Castle ward, staff received appropriate training and effective ongoing supervision to support them in their role.
- Staff had good working relationships with professionals external to the organisation, such as local authority safeguarding team and community mental health teams.
- Patients, families and carers told us most staff on Castle ward were kind and respectful, and were doing their best.
- On Castle ward, staff felt respected, valued and supported. Staff felt confident that they could raise concerns with managers and that they would be listened to, without fear of retribution.

What people who use the service say

On the 23 September 2020, we spoke with six young people. Most young people told us they did not always feel safe on the wards. They spoke about how the ward had been very unsettled over the last few months. They said staff were not always responsive to their needs and sometimes staff did not respond to incidents in a prompt way. Young people told us staff were varied in their approach, and while there were certain staff who they described positively, there were also staff who they felt did not listen to their needs or helped them. They felt that some of the staff said the wrong thing to them and were not always supportive or responsive to their needs when they were having a challenging time.

Patients told us the ward environment was often dirty and not well kept, and bodily fluids from self-injurious behaviour was often left and not cleaned. They said the environment felt very bare and was not decorated for their age and did not feel welcoming.

Young people felt there were not enough activities to do during the week or at weekends. They said they felt staff were often too busy or there were not enough staff to help with activities, so they were cancelled. They told us they often felt bored and unmotivated so would just sleep during the day and be up at night and that is why so many incidents on the ward happened. They said some of the activities that were offered did not interest them.

Young people told us their physical health was not always appropriately managed, specifically if they needed to attend emergency department due to self-injuring behaviour. They said staff responses varied and some of them had experienced lengthy delays in staff making decisions and arrangements for them to attend and be assessed at emergency department . They said this caused them distress.

We spoke with 11 relatives/carers and received mixed reviews about their experience and the care and treatment their relatives received. Three relatives/carers feedback was mostly positive, saying they were invited to meetings and spoke with staff regularly. However, most relatives said that staff did not communicate well with them and they were not always kept informed of every aspect of their relatives care and treatment, including when incidents happened. Some relatives felt their child was not safe on the ward due to incidents and poor communication from staff. They were concerned that staff were not experienced to work on the wards.

On 2 October 2020 we spoke with four patients on the PICU. Feedback about the psychiatric intensive care ward was mixed. Most patients said staff were caring, respectful and were doing their best; however, some felt that staff were only nice because they were being watched and that some staff could be quite bullying towards patients. Feedback about the quality and choice of food was good; however, patients requiring specific diets told us they had limited choice and the hospital didn't always know what they could and couldn't eat.

Summary of findings

Most patients told us they were uncomfortable having so many male staff members caring for them, despite having asked for female staff. Feedback indicated that patients had not been given adequate information about their treatment and rights. Most patients also told us they had limited access to fresh air and would like to be able to go outside more. This had been repeatedly reported to staff. Some patients told us their belongings had gone missing, including clothes and toiletries.

Carers feedback was also mixed. Some people told us the staff were very caring and kept them appropriately involved. Others said they were not informed at all. Some people felt the process for raising concerns and complaints was effective, others said it was very lengthy, rarely produced a satisfactory outcome and that issues were played down. Most people we spoke with were concerned about physical health management on the ward.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inspected but not rated	• Neither ward was safe or clean. In addition, Knole ward was not well furnished, well maintained or fit for purpose. • Environmental and ligature risk assessments did not always capture risks or have appropriate mitigation. Repeated incidents occurred where young people suffered harm and injury. • Staff were not always able to keep young people safe from avoidable harm because many of them did not have the skills, knowledge or experience to care for young people. Staff felt the induction was poor, didn't prepare them to meet the needs of the young people, there was no assessment of staff competence and many staff on the ward didn't know how to safely support the young people. • Staff did not always assess and manage risks to patients and themselves well. Young people did not always receive timely access to emergency care when they needed it. Risk assessments and care plans did not always identify or address all of a young person's needs, despite being regularly reviewed through multidisciplinary discussion. • The wards did not have a good track record on safety. The service did not always manage patient safety incidents well. Staff did not always recognise or report incidents appropriately, and systems presented additional risk. Managers investigated incidents, however the quality and depth of investigations varied, and conflicting information showed that managers were not investigating incidents properly. Although learning from incidents was shared with the whole team and the wider service, this did not always appear to improve practice.

Summary of findings

- Staff who assessed the physical health of patients were not always appropriately trained to do so. Care plans did not always reflect the assessed needs, were not always personalised, holistic and recovery-oriented.
- Managers did not always support staff with supervision and opportunities to update and further develop their skills. Managers did not provide a comprehensive induction programme for new staff.
- Staff from different disciplines did not always work together as a team to benefit patients. They did not always support each other to make sure patients had no gaps in their care. The ward teams did not always have effective working relationships with other relevant teams within the organisation. However, we did see effective working with a community mental health team.
- Staff did not always treat young people with compassion and kindness. They did not always understand the individual needs of young people or support them to understand and manage their care, treatment or condition.
- Staff did not always involve young people in care planning and risk assessment and did not actively seek their feedback on the quality of care provided. Staff did not always inform and involve families and carers appropriately.
- The provider did not always treat concerns and complaints seriously or investigate them thoroughly. Despite some lessons from these being shared with the whole team and wider service this had not resulted in improvements to practice and the service. Outcomes were poor and patients, families and carers viewed the process as ineffective.
- Hospital leaders did not provide clear and robust leadership, and some did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed and were not always visible in the service or approachable. They did not have adequate support and oversight from the senior leadership at Cygnet Health Care Limited.

Summary of findings

- Staff did not feel respected, supported and valued. They reported that the provider did not always promote equality and diversity in its day-to-day work and in providing opportunities for career progression. They did not feel able to raise concerns without fear of retribution.
- Governance processes did not operate effectively at ward level, and performance and risk were not managed well. Oversight of incidents and complaints was poor. Leaders at the hospital had not identified the concerns we found during our inspection. There was poor oversight from senior leaders at Cygnet Health Care Limited and so missed opportunities to improve the service and manage risk.

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

- The ward was not safe or clean.
- The provider had not ensured the gender mix of staff was appropriate for a female ward.
- Staff did not always assess and manage risks to patients physical health well. Staff did not follow best practice in anticipating, de-escalating and managing challenging behaviour. Staff did not use de-escalation appropriately and often moved to restraint quickly or immediately.
- The ward did not have a good track record on safety. The service did not always manage patient safety incidents well. Staff did not always recognise or report incidents appropriately, and systems presented additional risk. Managers investigated incidents, however the quality and depth of investigations varied, and conflicting information showed that managers were not investigating incidents properly. Although learning from incidents was shared with the whole team and the wider service, this did not always appear to improve practice.
- Physical health management was poor, and patients did not have access to good physical healthcare. One patient's care records highlighted issues with swallowing but no

Summary of findings

speech and language therapy referral were made. In another patient's record, there was reference to skin lacerations but no wound management plan.

- A culture had developed among some staff in which patients were viewed negatively and this impacted on their care. Patients' privacy and dignity was not always respected.
- Staff did not always involve patients in care planning and risk assessment and did not actively seek their feedback on the quality of care provided. Staff did not always inform and involve families and carers appropriately.
- The provider did not always treat concerns and complaints seriously or investigate them thoroughly. Despite some lessons from these being shared with the whole team and wider service this had not resulted in improvements to practice and the service. Outcomes were poor and patients, families and carers viewed the process as ineffective.
- The provider did not meet the needs of all patients. Patients were not appropriately supported with communication, cultural or spiritual support. Specific diets were not properly catered for. People did not have enough access to outside space.
- Governance processes did not operate effectively at ward level, and performance and risk were not managed well. Oversight of incidents and complaints was poor. Leaders at the hospital had not identified the concerns we found during our inspection. There was poor oversight from senior leaders at Cygnet Health Care Limited and so missed opportunities to improve the service and manage risk.

However:

- Staff managed environmental ligature risk well.
- Staff assessed the mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- Staff from different disciplines worked together as a team. All ward teams included or had

Summary of findings

access to the full range of specialists. The ward team(s) had good working relationships with other relevant teams within the organisation and with relevant services outside the organisation, including local authority safeguarding teams and community mental health teams.

- Feedback received was that staff mostly treated patients with compassion and kindness.
- Patients said food was of a good quality and they generally had enough choice of food.
- Staff told us ward leaders were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They reported that they had been provided with opportunities for career progression. They felt able to raise concerns without fear of retribution.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Godden Green

Cygnet Hospital Godden Green has an integrated Tier 4 child and adolescent mental health service alongside a Department for Education, Ofsted registered school, the Knole development centre. Care is delivered from Knole and Riverhill wards. The hospital also operates a psychiatric intensive care unit (Castle ward) for females which opened in November 2019.

On the 23 September 2020, we undertook an unannounced, focussed inspection of the acute child and adolescent mental health service. This included Knole ward, which comprised 16 en-suite bedrooms, and Riverhill ward, which comprised five en-suite bedrooms. Both wards were general adolescent units and were for males and females aged between 12-18 years.

On the 2 October 2020, we undertook an unannounced, focussed inspection of the female psychiatric intensive care unit, Castle ward, which comprised 12 en-suite bedrooms.

Cygnet Hospital Godden Green is registered for the following regulated activities: assessment or medical treatment, for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury.

At the time of our inspection there was a registered manager.

We last inspected this service on the 9 April 2019 as part of our ongoing comprehensive mental health inspection programme. At that inspection, only the child and adolescent wards were open. The service was rated requires improvement overall and requires improvement in the safe and well-led domain. They were rated good in effective, caring and responsive domains. We found breaches of regulations and told the provider they must make the following improvements:

- ensure systems are embedded to allow staff to safely manage risks to young people, this remained a concern at this inspection
- ensure medicine management, including recording, auditing and training and competency checks for staff. This was not followed up as part of this inspection and remains an outstanding breach of regulation
- ensure staff personal alarms are fit for use, tested to make sure they work, and records maintained to show this. This was not followed up as part of this inspection and remains an outstanding breach of regulation
- ensure leadership across at the service is consistently managed and systems and processes are in place for effective compliance, this remained a concern at this inspection.

Some of the breaches of regulation remain from the April 2019 inspection, as we did not follow up on all these specific concerns.

How we carried out this inspection

Our inspection team

Summary of this inspection

On the 23 September 2020, the team that inspected the child and adolescent mental health wards comprised two CQC inspection managers, two CQC inspectors, a nurse specialist advisor who had extensive knowledge and experience in working in child and adolescent mental health and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example, as a patient or carer.

On 2 October 2020, the team that inspected the psychiatric intensive care unit comprised of two CQC inspection managers, three CQC inspectors, a specialist advisor who is a registered nurse with experience of working in mental health services, and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example, as a patient or carer.

Why we carried out this inspection

We undertook an unannounced, focused inspection of the child and adolescent mental health wards on 23 September 2020, following concerns raised with us from members of the public, complaints from relatives and other professionals. The concerns included:

- safety and wellbeing of the young people on the wards
- patient risk and management of risk
- high level of incidents and repeated types of incidents where young people were able to cause harm to themselves. Management of the incidents by staff
- poor cleanliness and maintenance of the wards
- training, experience of staff and lack of support for staff
- culture concerns and morale amongst staff
- leadership at ward and senior management level, including poor management and discrimination
- complaints and the providers response and action taken.

We undertook an unannounced, focused inspection of the psychiatric intensive care ward on 2 October 2020. This was following concerns raised with us from members of the public, and to ensure the concerns we had previously found on the Child and Adolescents Mental Health wards were not organisational, thereby impacting on the psychiatric intensive care ward. The concerns included:

- safety and wellbeing of patients on the ward
- management of risk
- management of incidents and levels of restraint used
- poor cleanliness and maintenance of the wards
- lack of respect for patients' dignity and sexual safety
- patients' cultural and religious needs not being met
- leadership at ward level
- management of complaints.

As this was not a comprehensive inspection, we did not pursue all our key lines of enquiry, therefore our report does not include all the headings and information usually found in a comprehensive report. We visited both child and adolescent mental health wards (Knole and Riverhill ward) and the psychiatric intensive care ward (Castle ward). However, Castle ward has not been previously inspected under our comprehensive inspection methodology and has not been

Summary of this inspection

previously rated. Therefore, this report does not show an overall judgement or rating of the core service. Our resources were focussed on inspecting the current areas of alleged concern and this should be considered when reading this report. The previous ratings for the child and adolescent mental health wards will be rescinded once the service is closed.

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 spoke with other organisations and professionals with knowledge of the service.

During the inspection visit to Knole and Riverhill wards on the 23 September 2020, the inspection team:

- visited both wards, looked at the quality of the ward environment and saw how staff were caring for patients
- spoke with six young people who were using the service
- spoke with 11 relatives or carers
- spoke with the registered manager and both managers for each of the wards
- spoke with eight other staff members; including doctors, nurses, ward clerk, and health care support workers
- attended and observed one multidisciplinary incident review (flash) meeting and a young person's ward round
- looked at eight care and treatment records of young people
- looked at closed circuit television as part of our review into incidents
- looked at 14 staff supervision records
- reviewed complaints, investigations and response to complaints
- looked at policies, procedures and other documents relating to the running of the service.

During the inspection visit to Castle ward on the 2 October 2020, the inspection team:

- took a tour of the ward, looked at the quality of the environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with four carers of patients using the service
- spoke with the ward manager and the deputy ward manager
- spoke with seven other staff members; including a consultant, health care assistants, an assistant psychologist and the maintenance manager
- looked at six care and treatment records of patients
- looked at policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve

Summary of this inspection

- The provider must ensure all ward environments are clean, well maintained and fit for purpose. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure the environment on Knole and Riverhill wards is safe and ligature risks are appropriately managed. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure that staff sufficiently assess risk and plan care to meet young people's needs. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure it has an effective incident management process. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure it has an effective complaints process. (Regulation 17 HSCA (RA) Regulations 2014 Good governance)
- The provider must ensure enough staff are deployed with the knowledge, skills, experience and competence to meet the needs of all young people. (Regulation 18 HSCA (RA) Regulations 2014 Safe staffing)
- The provider must ensure all staff receive an appropriate induction and training to ensure they have the skills and knowledge to keep young people safe. (Regulation 18 HSCA (RA) Regulations 2014 Safe staffing)
- The provider must ensure that there is an appropriate ratio of male to female staff on Castle ward, to meet assessed needs. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure that patients on Castle ward have regular access to fresh air. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure patients' privacy and dignity on Castle ward is supported and respected. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)
- The provider must ensure they foster an open, transparent and supportive culture. (Regulation 17 HSCA (RA) Regulations 2014 Good governance).
- The provider must ensure they have robust governance and assurance processes in place at all levels to make sure the hospital provides safe, good quality care to patients. (Regulation 17 HSCA (RA) Regulations 2014 Good governance).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Child and adolescent mental health wards	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Inspected but not rated

Safe and clean environment

The ward environment was safe, but it was not clean, well-furnished or well maintained.

The ward was dirty, and some areas were in a poor state of repair. The floors were unclean and there was dirt and debris along the edges. Walls were scuffed and marked with dirt and writing.

In the dining room, tables and chairs were grubby. The ward kitchen, which was used by staff for their own food storage and preparation, and also to make patients' breakfast, snacks and drinks, was very dirty. Cupboards had sticky grime on the insides and on the doors, and the fridge was dirty. We found a container which was used to store patients' biscuits, with the lid not secured, so the biscuits were exposed to the air and had gone soft.

The kitchen also served as the laundry room for the ward, and had a washing machine and tumble dryer. Open buckets were on the floor of the kitchen, containing patients' unwashed laundry. Staff told us that heavily soiled laundry was put into bags and washed appropriately elsewhere.

Patients' bedrooms were found to be unclean. We saw dirt and dead insects on woodwork and stained carpets. There were rusted panels in the bathrooms and limescale in the toilets. In the vacant bedroom there were marks on the mattress and bedding.

We saw cleaning records, but they were not an accurate reflection of what we saw on the ward.

Staff completed risk assessments to identify ligature anchor points. A ligature anchor point is something which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We looked at the most recent risk assessment which was completed in November 2019 and saw that risks were identified, and mitigation put in place. The ward had had no incidents since the ward opened in November 2019 involving fixed ligature points.

Safe staffing

The provider did not ensure the gender mix of staff was appropriate for a female ward.

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

Patients were often assigned male staff, in some cases an all-male care team, despite asking for female staff. On the day we visited, more than half of the staff on duty were male. There were three bedrooms where each patient was subject to round the clock observation by one or two staff members, as determined by their risk assessment. Male staff were providing all these patients' care, many of whom were newly admitted. Other patients had experienced trauma, which was reflected in their risk assessments. Most patients we spoke with were uncomfortable with the number of male staff on the ward and had concerns about their sexual safety.

Assessing and managing risk to patients and staff

Staff did not follow best practice in anticipating, de-escalating and managing challenging behaviour. Staff did not use de-escalation appropriately and often moved to restraint quickly or immediately.

Staff had identified risks around patients' mental health needs and carried out appropriate daily review of those risks. Risk reduction plans were in place. We saw that risks were clearly identified in the care plans.

Staff did not use appropriate de-escalation techniques before moving to physical restraint. We reviewed one complaint and one incident report which corroborated this, and one patient we spoke with confirmed this. We reviewed closed circuit television footage of an incident where a patient was restrained with minimal de-escalation taking place first. This meant that opportunities to avoid physically restraining patients may have been missed and had a negative effect on the patient's mental state and the therapeutic relationship.

Reporting incidents and learning from when things go wrong

The ward did not manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately, and systems presented additional risk. Conflicting information in incident records showed that managers were not investigating incidents properly.

The service had a process for managing incidents. Staff were able to tell us what this was and give us examples of what would constitute a reportable incident. However, we found evidence that not all incidents were reported or appropriately managed. One patient told us about a medication error, where a patient was almost given the wrong dosage of a medicine. This incident was known to two staff members but neither of them reported the incident.

One incident record had conflicting information about whether restraint was used or whether the incident was managed with de-escalation only. We reviewed a further incident on closed circuit television where restraint was clearly used, however, there was no reference to restraint in the incident report. Staff told us that the online incident management system prompted staff to indicate whether restraint had been used in any incident, but the drop-down menu defaulted to an answer of 'no', so if the person completing the report missed the question, no restraint report would be generated. This was a clear risk in the system, allowing incidents of restraint not to be investigated because of minor human error.

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Inspected but not rated

Assessment of needs and planning of care

Patients did not have access to good physical healthcare. However, staff assessed the mental health of all patients on admission, and developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.

Staff did not manage physical health issues effectively. In most of the records we viewed, there was conflicting information about physical health conditions, and appropriate care plans were not always in place. For example, one patient had deep lacerations to their arms with no wound care plan in place. Referrals to appropriate, specialist teams had not always been made when physical health issues were identified. One patient's records indicated that they had difficulty swallowing but no referral to a speech and language therapist was made. Two patients told us staff had given them the wrong medicines, and another had been given a medicine they were not prescribed. In all these cases, patients had to advise staff of the error. Another patient had been diagnosed as having several physical health problems, including diabetes; the patient denied these problems and identified other health issues they did have which were not recorded.

Staff completed and reviewed care plans appropriately. Risks were clearly identified and mitigated. However, care plan documents were very focused on management of behaviours rather than identifying strengths that can be built on or any goal planning.

Multidisciplinary and inter-agency team work

Staff from different disciplines worked together as a team. Ward team(s) had good working relationships with other relevant teams within the organisation and with relevant services outside the organisation. However, there were still gaps in patients' care.

The ward's multidisciplinary team consisted of the ward manager, deputy ward manager, consultant, ward doctor, assistant psychologist, occupational therapy assistant and, if appropriate, the safeguarding lead. Other staff, such as the clinical services manager, were invited as necessary.

The multidisciplinary team held morning board rounds to make plans for the day. Weekly ward meetings were held to have more in-depth discussions about each patient and review progress, and to discuss discharges. In addition, the multidisciplinary team would meet on an ad-hoc basis as necessary to discuss referrals.

Staff we spoke with reported the multidisciplinary team worked well together and was respectful. Everyone was encouraged to have input into the discussions, and felt their input was valued. The team worked closely with external partners, such as commissioners and the local authority safeguarding team.

However, there were gaps in patients' care, and therefore the effectiveness of the multidisciplinary team was variable.

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

A culture had developed among some staff in which patients were viewed negatively and this impacted on the care. Patients' privacy and dignity was not always respected. However, we were told staff mostly treated patients with compassion and kindness.

Staff, including male staff, did not always knock on bedroom doors and entered the bathrooms without permission. This did not promote peoples' dignity or sexual safety, and patients told us that they were afraid to shower as a result of this.

We found a culture where staff used language in care records that was disrespectful and inappropriate. A small number of staff labelled patients as 'difficult' and 'trouble makers'. We saw some staff acting in an intimidating manner when a patient's behaviour became disturbed, with little attempt made to use a calm and considered approach to de-escalate the situation or reassure and comfort patients.

Most patients and carers we spoke with told us staff are kind, respectful and caring. Patients spoke particularly highly of psychology and occupational therapy staff. However, two people said some staff had a tendency to act in a bullying manner towards patients, and were only nice when they knew they were being observed.

Involvement in care

Staff did not always inform and involve patients, families or carers appropriately.

Records did not always show that patients were involved in their care and treatment decisions. While there was evidence of patient input in some of the records we reviewed, others showed no involvement at all.

Patients told us they did not feel that they had any control over their care. Feedback from carers was mixed, with some saying they were kept well informed and involved, and others telling us they felt very excluded from their relative's care, and that staff did not value their input.

Weekly community meetings were held on the ward, and all patients were encouraged to attend. We reviewed the minutes of four recent meetings, which showed good participation and discussion of a range of topics, such as the environment, safety and caring. There were sections for feedback from previous meetings, and actions agreed from the current meeting. However, these did not appear to flow logically from one meeting to the next and in one record we reviewed, the feedback section was not completed at all. It was not clear what actions had been completed or what outcomes were achieved as a result of the meetings.

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

Inspected but not rated

Meeting the needs of all people who use the service

The service did not meet the needs of all patients who used the service. Patients were not appropriately supported with communication, cultural or spiritual support. People did not have enough access to outside space. Specific diets were not properly catered for. However, the food was of a good quality and patients generally had good choices.

Staff did not ensure patients had regular access to outside space and fresh air. Most patients we spoke with told us that they weren't able to access fresh air regularly, despite asking to be able to. Community meeting minutes record patients repeatedly asking to be supported to go outside more often.

Most patients we spoke with were uncomfortable with the number of male staff on the ward. On the day we visited, more than half of the staff on duty were male. Patients were often assigned male staff, in some cases an all-male care team, despite asking for female staff. Male staff was providing all these patients' care, many of whom were newly admitted. Staff confirmed, and we observed, that patients' privacy and dignity could not always be maintained or protected because they had male staff observing them. Patients told us this made them feel uncomfortable.

Most patients we spoke with told us their belongings had gone missing on the ward. This included toiletries, clothes and a drink bottle. Some items had been returned but many had not.

The ward was not equipped for patients with mobility needs, as it was accessed via several flights of stairs and did not have lift access. In emergencies, the lift in another ward could be used but this required considerable planning to manage the risks and caused disruption to the other ward. The ward manager told us that they had experienced issues where referrals and pre-admission assessments did not highlight mobility needs, and that on one occasion they did not know about a patient's mobility needs until they arrived on the ward.

Staff told us they could access interpreters and signers if needed, however feedback from one patient who required the services of an interpreter, did not support that this was the case. Information was not available in a format accessible to people with visual impairment. Staff told us this had never been necessary; however, they would refer to Cygnet senior management if this was ever needed.

Staff did not ensure patients had regular access to outside space and fresh air. Most patients we spoke with told us that they weren't able to access fresh air regularly, despite asking to be able to. Community meeting minutes recorded patients repeatedly asking to be supported to go outside more often.

The ward had information leaflets for patients about their treatment and what they could expect during their stay, however not all patients we spoke with had been given this information. Staff told us the leaflets could be accessed in other languages if needed, however feedback we received suggested this was not happening. There were display boards around the ward explaining patients' rights, advocacy services, how to complain and how to contact the Care Quality Commission. However, on the day of our visit, the advocacy information was out of date and the advocate identified on the posters had been changed some weeks before. The correct information was put on the boards when we pointed this out to staff.

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

Patients' feedback about the quality of the food was generally positive. Staff told us any diet was catered for, including vegetarian and vegan diets, and those required for religious or medical grounds. Staff completed diet sheets on admission, which were given to the kitchen. However, patients requiring specific diets, such as those on medical grounds or for religious reasons, told us the hospital struggled to accommodate these, and their food choices were limited.

The ward had a multi faith room, which was also used as a visiting room. The room had a bible but no other religious texts. Staff told us the ward had a Koran, but no one could locate it. Minutes of ward community meetings showed that patients wanted more extensive support with religion. There was a bag of clothes in the multi faith room, and staff did not know whose it was or why it was there.

Listening to and learning from concerns and complaints

The service did not manage complaints well. Outcomes were poor and patients, families and carers viewed the process as ineffective.

Patient and carer feedback about complaints was poor, and most people we spoke to did not have faith in the complaints process. People felt complaints were played down or ignored, that the process took too long, and nothing changed as a result of making complaints.

We reviewed complaint activity in August and September 2020. Castle ward had two complaints in September, none in August. Overall, we found that not all complaints were investigated fully or at all, and in some cases, responses were defensive and did not address all the points raised. One complaint we reviewed was unsubstantiated by the service; however, we found the same concerns on the ward during our visit as the complaint had raised.

The hospital had a complaints process. Posters were on the walls of the ward informing patients and carers how to complain, and staff were able to explain the process to us. Weekly service wide meetings were held, and each complaint was discussed, and the responsible investigator updated the meeting on progress. A central register of complaints was held.

A monthly newsletter was shared across the hospital, which detailed lessons learned from complaints during the past month. On the Castle ward, this was circulated to staff and discussed in team meetings. Ward managers on Castle also created documents containing more detail about what could be learned from specific complaints on their ward.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Inspected but not rated

Leadership

Leaders were visible in the service and approachable for patients and staff.

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

The ward had a manager and a deputy manager. Staff reported that wards managers were approachable and supportive. They told us that senior leaders within the hospital were visible in the hospital and visited the ward regularly.

Culture

Staff felt respected, supported and valued. They reported that the provider provided opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff told us they were happy in their roles, and felt respected, valued and supported, by colleagues and management. Staff we spoke with knew how to raise concerns and told us they felt confident to do so if they needed to. They knew the whistle-blowing process, and knew the organisation had a Freedom to Speak Up Guardian, although not everyone could name them.

Staff told us supervisions were held regularly, were effective and included conversations about career development and how it could be supported. Managers held weekly staff meetings. Agency staff were block booked and treated the same as directly employed staff. They were included in training, staff meetings and were given supervision. Agency staff were also given 'champion' roles on the ward.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well.

There was a lack of robust systems in place to monitor performance on Castle ward. Performance was measured against a range of indicators, which included care plans and risk assessments, complaints, safeguarding, incidents and types of incident. Oversight appeared based on simple figures with limited quality checking. For example, staff did not always review the information they had. We found examples where information was missing or inaccurate in care plans and risk assessments. Environmental concerns found during the inspection had not been escalated despite being known about, and complaints and incident management were not always adequately responded to or resulted in change to practice.

Despite the provider having an audit schedule, the outcomes of which were discussed at weekly governance meetings, audits failed to identify concerns we found on the day of our inspection. It was not always clear what action was taken to ensure performance improved. For example, finding themes and trends. The learning from complaints and serious incidents was not always identified and there were some missed opportunities to improve the service.

There was a lack of robust oversight and assurance by Cygnet Health Care Limited senior leaders. Therefore they had not picked up poor care at the hospital and acted to make improvements in a timely manner.

Inspected but not rated

Child and adolescent mental health wards

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Child and adolescent mental health wards safe?

Inspected but not rated

Safe and clean environment

Neither ward was safe or clean. In addition, Knole ward was not well furnished, well maintained or fit for purpose.

The provider did not ensure the safety of the premises. We found environmental risk assessments and ligature risk assessments did not always capture risks that needed escalation. A ligature anchor point is something which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We saw examples where incidents had occurred in the environment and assessments were not updated or had proper mitigation to manage or prevent similar incidents being repeated. For example, closed circuit television was recorded in the risk assessment as mitigation, but the closed circuit television was not reviewed in real time and was only used to reflect on incidents.

Environmental risk assessment about fixed ligature points such as door handles and hinges, said that there was no current technical solution available. Risk concerns identified during the inspection included window ledges in some of the young people's bedrooms and the counter tops in the kitchen on Knole ward that could be used to jump from, and loose, missing tiles from a roof overhanging the Astro turf. These did not feature in the environmental risk assessment. There have been several incidents involving young people self-harming with broken tiles and climbing on the kitchen worktops, bedroom sills and harming themselves.

There were poor lines of sight on Riverhill ward; however, the risks posed by these were mitigated by the use of convex mirrors. There was a clear risk of young people being able to barricade themselves in rooms such as the lounge and quiet room. There was an incident where a young person used a sofa to barricade themselves in the lounge. Because of this, the service has taken away the ability to lock this door now. However, there were no lines of sight into the room or quiet room when the door is shut. This was not identified or mitigated in the environmental risk assessment.

Cleanliness on Knole ward was poor. We found blood smeared up one of the walls in the de-escalation suite and residue from bodily fluids on some of the young people's bedroom walls where they had not been cleaned properly. The floor in

the sensory room was sticky to walk on and the whole ward needed a deep clean as a build-up of dirt and scuff marks were seen throughout the ward. On Riverhill ward there were many dead insects in between the windows and the shutters in the quiet room, which looked like they had been there for some time because of how many there were. We saw cleaning records, but they were not an accurate reflection of what we saw on the wards.

The environment on Knole ward was in a poor state of repair and there was a general lack of regular maintenance. Some of the decoration and furniture was worn and damaged. Several of the walls had stains on them, and plasterwork and paintwork, particularly in the young peoples' bedrooms, needed attention. Knole ward was very bare in decoration and did not feel a friendly or welcoming environment.

Safe staffing

Staff were not always able to keep patients safe from avoidable harm. However, the service had enough nursing and medical staff, who knew the patients and received basic training.

There was not enough staff with the knowledge, skills, experience and competence to meet the needs of all young people on the wards. Most of the staff working on the wards had no previous experience of working with young people, including the ward manager on Knole ward.

The registered manager told us that a staffing matrix was in place which identified the minimum number of qualified and unqualified staff needed on the wards. The registered manager reported minimal vacancies across the hospital and low use of agency staff to fill shifts. We were told the main reason for using agency staff was when added staff were needed to support increased use of clinical observations for young people. Ward managers told us agency staff who were requested to work at the service were mostly familiar with the service and wards.

Staff received basic mandatory training. However, they did not receive training specific to the needs of the people they were caring for, for example, trauma informed care. Managers did not assess staff competence, and many staff on the ward did not know how to safely support the young people. There were many incidents where young people had self-harmed using contraband items. Staff had received search training but were not confident or consistent in carrying out personal and environmental searches. The service did not look to review this despite many incidents.

Health care support workers (rather than doctors or registered nurses who should be completing observations) were completing a neurological checklist following episodes of head banging, which asked a series of questions but did not require any physical checks of young people's vital signs. Health care support workers lacked an understanding of the significance of monitoring young people following head banging incidents as they had not received training. This put young people at severe risk of harm. We raised this with the provider on the day of the inspection. They acknowledged this and took immediate action.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well.

We reviewed eight young people's risk assessments and risk management plans. In all eight records. staff did not always update risk management plans to reflect when the risk of a young person had increased or changed following an incident. They did not always address how those risks could be managed appropriately to respond to young people's

Inspected but not rated

Child and adolescent mental health wards

challenging needs. The risk assessment had a rating system to grade the level of risk as either Red (high) Amber (medium) or Green (low). However, we found the Red, Amber, Green rating for the risks did not always match the severity of risk or level of recent incidents that had happened. Staff were not always aware of the risks for the young people on the ward or what action was being taken to support the young people.

We observed a ward round and reviewed minutes and found risk assessments were reviewed weekly by the multidisciplinary team as part of the young person's ward round and discussed during complex case meetings. However, risk assessments were not complete, up to date or reflective of all the young peoples' risks. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or minimising the harm caused. Staff used a structured professional judgement risk assessment tool called 'Functional Analysis of Care Environments' (FACE) to support this model of working.

Reporting incidents and learning from when things go wrong

The wards did not have a good track record on safety. The service did not always manage patient safety incidents well. Staff did not always recognise or report incidents appropriately. Managers investigated incidents, however the quality and depth of investigations varied and although learning from incidents was shared with the whole team and the wider service, this did not always appear to improve practice.

Staffs' management of patient safety incidents was variable. Incidents were documented on the central wide incident management system and reviewed by the senior leadership team. However, staff did not always raise concerns and report incidents in line with the providers policy. We found some of the incident reports had conflicting information about what happened and did not match with other records, including young people's notes.

We reviewed three incidents and saw how staff managed the incidents on closed circuit television (CCTV). We had serious concerns that staff did not protect young people from risk of harm and in each of the incidents there may have been opportunities to prevent or avoid the incidents which were missed. For example, in all three incidents we reviewed, staff were seen on CCTV not taking prompt or appropriate action to manage the situation and support the young people. However, this poor practice had not been addressed in supervision with the staff involved or as part of an incident review. There was poor risk management which meant there was a theme in repeated incidents. No one from the hospital leadership team regularly reviewed the CCTV footage, despite there having been many serious incidents.

Are Child and adolescent mental health wards effective?

Inspected but not rated

Assessment of needs and planning of care

Staff who assessed the physical health of patients were not always appropriately trained to do so. Care plans did not always reflect the assessed needs, were not always personalised, holistic and recovery-oriented. However, they were reviewed regularly through multidisciplinary discussion.

Care plans were mostly generic and not always specific to the young person's individual needs. We reviewed eight care plans and found they were not always personalised, holistic or recovery-orientated. They lacked input from the young people or their relatives and families. Young people that we spoke with told us that they were not involved in creating their care plans and were not provided with a copy of their care plan.

Young people had positive behaviour support plans in place.

We were concerned that young peoples' physical health needs were not being met. During the inspection we focussed on the protocols used and action taken by staff when a young person needed to attend Emergency Departments for assessment or treatment. We found the young peoples' written records did not reflect the procedure as outlined in the protocols. We saw several incidents where young people needed to attend emergency department for further assessment due to self-injury. However, the timeliness in which the staff sought help from emergency department varied greatly and the records did not show why. For one young person, they did not attend emergency department for several days after being injured and when they did an ambulance was then requested. Care plans and risk assessments did not reflect young peoples identified physical healthcare needs. For example, young people who were at risk of harm from self-injury, no wound management plans were in place.

The headbanging protocol was not clear about which staff could carry out the initial assessments to check for potential head injury. This was a neurological assessment and the records did not show if only trained staff were assessing the young people. During the inspection, we were informed by staff that staff without the appropriate training were also completing the assessments which we were significantly concerned about. We checked training records and details of the training modules and this corroborated their concerns.

Skilled staff to deliver care

Managers did not always support staff with supervision and opportunities to update and further develop their skills. Managers did not provide a comprehensive induction programme for new staff. However, the ward teams included or had access to the full range of specialists.

We reviewed 14 staff management supervision records for nurses and healthcare support workers. Standard templates were used but we found no content of on-going conversation from the previous supervision record to identify if previous issues had been resolved or met. For example, we saw a concern raised about staff not adhering to observation policies and the pressure this put on other staff and patient risk. However, no follow up discussion was recorded. The detail varied across the records and action plans were more self-directed than supportive to address the topic discussed.

Staff did not receive a comprehensive induction. Staff told us the induction programme was run over two weeks. Staff spent the first week at home looking at organisational policies and procedures. Staff said this was because of a shortage of IT equipment. The second week they were on the wards but supernumerary to ward staffing numbers. Staff said they were unfamiliar with the wards and service and, due to the wards being remarkably busy and lack of availability of existing staff to show them what to do, they did not feel well prepared or supported.

Wards included or had access to the full range of specialists. The team consisted of doctors, nurses, health care support workers, occupational therapists, psychologists a family therapist, a social worker and a visiting pharmacist.

Multidisciplinary and inter-agency team work

Staff from different disciplines did not always work together as a team to benefit patients. They did not always support each other to make sure patients had no gaps in their care. The ward teams did not always have effective working relationships with other relevant teams within the organisation. However, we did observe effective working with a community mental health team.

Inspected but not rated

Child and adolescent mental health wards

We found daily meetings and multidisciplinary team meetings didn't always identify where incidents had happened. Where incidents were identified and discussed, appropriate action was not always taken to safeguard young people and prevent reoccurrence.

Ward rounds and complex case management meetings took place weekly. Members of the clinical team met to discuss any issues of concern with a young person's care or treatment. We observed a flash meeting where incidents and safeguarding concerns were discussed and found staff were respectful in their discussions with each other. However despite this, gaps in peoples' care remained.

We observed a young person's ward round. Overall, the ward round was good and showed good multidisciplinary working. The ward round showed good working relationships with the community team and focussed on discharge planning.

We saw several different professions supported the young people on Knole and Riverhill ward and those we spoke with confirmed this. A multidisciplinary team meeting (MDT) is composed of members of health and social care professionals. The MDT collaborates to make treatment recommendations that help quality patient care.

Are Child and adolescent mental health wards caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat young people with compassion and kindness. They did not always understand the individual needs of young people or support them to understand and manage their care, treatment or condition.

We spoke with six young people. Most young people told us they did not always feel safe on the wards. They spoke about how the ward had been very unsettled the last few months. They said staff were not always responsive to their needs and sometimes staff did not respond to incidents in a prompt way. Young people told us staff were variable, and while there were certain staff who they described positively, there were also staff who they felt did not listen to their needs or helped them. They felt that some of the staff said the wrong thing to them and were not always supportive or responsive to their needs when they were having a challenging time.

Young people told us the ward environment was often dirty and not well kept and bodily fluids from self-injurious behaviour was often left and not cleaned. They said the environment felt very bare and was not decorated for their age and did not feel welcoming.

Young people told us their physical health was not always appropriately managed, specifically if they needed to attend the Emergency Department due to self-injuring behaviour. They said staff responses varied and some of them had experienced lengthy delays in staff making decisions and arrangements for them to attend and be assessed at emergency department. They said this caused them distress.

Staff spoke with us about young people and discussed them in a respectful manner. During the inspection we saw they appeared interested and engaged in providing good care to the young people. We saw staff interacting with young people in a positive, caring and compassionate way when in the communal areas or carrying out observations.

Inspected but not rated

Child and adolescent mental health wards

On Knole ward they had recently launched safe wards for kids' programme. Staff told us this was part of a co-production with the young people called 'CAMHeleon', which focussed on making a positive difference to young inpatients by supporting staff to enable young people to really make the most of their time when away from home. There was a notice board in the corridor on Knole ward, which had some basic information about what CAMHeleon meant.

Involvement in care

Staff did not always involve young people in care planning and risk assessment and did not actively seek their feedback on the quality of care provided. Staff did not always inform and involved families and carers appropriately.

We observed a young person's ward round. They young person did not attend on this occasion, but little was spoken about or acknowledged in terms of the young person's wishes.

Staff did not always involve young people in decisions about their care. Staff recorded minimal involvement from young people in their care plan. Care plans were generic and were not always person-centred and recovery orientated. They did not always identify goals or detail the support the young person needed to achieve their goals. Young people told us they did not feel engaged in writing their care plans with staff and they did not have a copy of their care plan. However, we saw young people had their care plans regularly reviewed with the multidisciplinary care team at ward rounds. Young people did not always attend ward rounds; however it was not clear from records whether this was the young person's choice.

We spoke with 11 relatives/carers and received mixed reviews about their experience and the care and treatment their relatives received. Three relatives/carers feedback was mostly positive, saying they were invited to meetings and spoke with staff regularly. Some relatives felt their child was not safe on the ward due to incidents and poor communication from staff. They were concerned that staff were not experienced to work on the wards.

The ward manager told us a member of staff on each shift was assigned to speak to each young person's relative daily so they could hear regular updates about their relative's care. However, the records we reviewed did not always document that discussions had taken place. Nine of the relatives we spoke with said that staff did not communicate well with them and they were not always kept informed of every aspect of their relatives care and treatment, including when incidents happened.

Both wards had weekly community meetings where the young people could attend and voice their concerns and suggestions. However, attendance had not been good. The registered manager told us they were keen for daily planning meetings to take place again, which would improve communication with the young people.

Are Child and adolescent mental health wards responsive?

Inspected but not rated

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously or investigate them thoroughly. However, where the service had identified learned lessons from the results they were shared with the whole team and the wider service.

Inspected but not rated

Child and adolescent mental health wards

The hospital had a complaints process. Posters were on the walls of the wards' informing young people and carers how to complain, and staff were able to explain the process to us. Weekly service wide meetings were held, and each complaint was discussed, and the responsible investigator updated the meeting on the progress of investigation. A central register of complaints was held. However, one complaint we reviewed reported concerns about staff not taking action when a young person needed medical support. As part of the complaint review, Closed Circuit Television and incident records were reviewed by the investigator. However, the responsible investigator and the oversight from the providers weekly meetings failed to highlight that no incident had been reported by staff, records did not match what had been observed as part of the complaint review and there was no follow up with staff involved in the incident.

Patient and carer feedback about complaints was poor, and most people we spoke to did not have faith in the complaints process. People felt complaints were played down or ignored, that the process took too long, and nothing changed because of making complaints.

We reviewed complaints received in August and September 2020. There had been five complaints for the CAMHs wards for August, three for Knole and two for Riverhill. In September there were four complaints, three for Knole ward and one for Riverhill. Overall, we found that not all complaints were investigated fully or at all, some had no outcome, and, in some cases, responses were defensive and did not address all the points raised. Recommendations made did not always ensure that enough action was taken to mitigate future occurrences.

Staff told us, and we saw, a monthly newsletter that was shared across the hospital, which detailed lessons learned from complaints during the past month. The ward managers told us this was circulated to staff and discussed in their team meetings. However, staff could not tell us whether there were any changes in practice because of this.

Are Child and adolescent mental health wards well-led?

Inspected but not rated

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed and were not always visible in the service or approachable for young people and staff.

There had been several changes in the ward management and senior leadership at the service. One of the ward managers had been moved from another ward to support Knole ward. Although they had previous ward manager experience, they had never worked with children and young people and had not been supported by the service in accessing training to develop their skills and knowledge.

We were informed the registered manager was onsite an average of three days per week as they were needed to work elsewhere in the organisation. Their deputy would then take over senior leadership for the service. Staff told us when the registered manager was not at the service, they noticed a difference in how poorly the service operated and how decisions were made.

Most staff we spoke with said they did not feel supported by the hospital's local management and senior management structure, or that of the provider. They felt there was a bullying and blame culture at the service which was led by some of the senior leadership team.

Inspected but not rated

Child and adolescent mental health wards

We found that there was a lack of leadership at ward, hospital and provider level. During our inspection, we did not see senior leaders on the wards. Leaders were not aware of all the concerns we found during the inspection and had not identified concerns through spending time on the wards. The senior leadership team at Cygnet Health Care Limited did not provide adequate support and oversight to the hospital and had failed to identify and act on concerns.

Culture

Staff did not feel respected, supported and valued. They reported that the provider did not always promote equality and diversity in its day-to-day work and in providing opportunities for career progression. They did not feel able to raise concerns without fear of retribution.

There was a poor culture on Knole and Riverhill ward. Staff told us morale was exceptionally low due to the culture at the service, feeling unsupported and many incidents that happened on the wards. Staff felt cliques had formed within teams and they did not always feel comfortable in speaking with colleagues when they had concerns. Staff told us they did not always feel able to speak up for fear of reprisals, such as losing their jobs. They described cliques within the staff groups and not feeling confident to always speak with some managers and some of their peers about poor work, such as observations not being carried out properly and the management of incidents. Staff described racial divides across the staff group, with discrimination felt, in particular job opportunities and how fairly they were treated with personal development.

Staff said they felt the last few months had been particularly challenging, with changes to staff teams including managers, lack of communication and high level of incidents on the ward. They felt emotionally drained and this had caused work related stress. They did not feel the service supported their health and wellbeing.

Staff did not feel supported with their training needs and development. They said there was minimal face-to-face training and they did not feel invested in by the service in developing their skills and knowledge to enable them to deliver the right care needed to the young people. They did not feel they could share their ideas and were not encouraged to make suggestions for the service to change and improve.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well.

There was a lack of robust systems in place to monitor performance on Knole and Riverhill wards. Performance was measured against a range of indicators, which included care plans and risk assessments, complaints, safeguarding, incidents and types of incident. Oversight appeared based on simple figures with limited quality checking. For example, staff did not always review the information they had. We found examples where information was missing or inaccurate in care plans and risk assessments. Environmental concerns found during the inspection had not been escalated despite being known about, and complaints and incident management were not always adequately responded to or resulted in change to practice.

Despite the provider having an audit schedule, the outcomes of which were discussed at weekly governance meetings, audits failed to identify concerns we found on the day of our inspection. It was not always clear what action was taken to ensure performance improved. For example, finding themes and trends. The learning from complaints and serious incidents was not always identified and there were some missed opportunities to improve the service.

Inspected but not rated

Child and adolescent mental health wards

There was a lack of robust oversight and assurance by Cygnet Health Care Limited senior leaders. Therefore they had not picked up poor care at the hospital and acted to make improvements in a timely manner.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have an effective complaints process.** **The provider did not ensure they had an open, transparent and supportive culture.** **The provider did not ensure they have robust governance and assurance processes in place at all levels to make sure the hospital provides safe, good quality care to patients.** **17(1) (2) (a) (b) (c) (e) (f)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure all ward environments were clean, well maintained and fit for purpose.** **The provider did not ensure the environment on Knole and Riverhill wards was safe, and ligature risks were not appropriately managed.** **The provider did not ensure staff sufficiently assessed risk and planned care to meet young people's needs.** **The provider did not ensure it had an effective incident management process.** **The provider did not ensure there was an appropriate ratio of male to female staff on Castle ward, to meet assessed needs.** **The provider did not ensure that patients on Castle ward had regular access to fresh air.**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	The provider did not ensure patients' privacy and dignity on Castle ward were supported and respected. **12 (1) (2) (a) (b) (c) (d) (h)**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure enough staff were deployed with the knowledge, skills, experience and competence to meet the needs of all young people. The provider did not ensure all staff received a proper induction and training. Staff did not have the skills and knowledge to keep young people safe. **18 (1) (2) (a)**