Cygnet Health Care Limited

Cygnet Joyce Parker Hospital

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Cygnet Joyce Parker hospital is provided by Cygnet Healthcare Ltd. The hospital provides care and treatment for children and adolescents between the ages of 12 and 18. This was a planned comprehensive inspection to follow up on our previous inspection and enforcement activity.

Our rating of this location improved. We rated it as requires improvement because:

- Two of the three seclusion rooms were out of use due to damage. Maintenance staff informed us the materials that were needed to repair these areas were on order and that they would be repaired as soon as they arrived. We were informed shortly after the inspection that the rooms had been repaired and were able to be used.
- Not all care plans contained input from the young person and were not always written in collaboration with the individual. Every young person had a range of care plans covering all aspects of their care. As part of the care plan package for each young person, all positive behavioural support care plans had been created in collaboration with the young person, however other care plans had not.
- We identified some blanket restrictions across the unit. Children and young people could not make their own hot drinks and snacks on Mermaid and Pixie wards which meant they were dependent on staff. We also found young people were not given keys to their bedrooms which meant they could not access them without a member of staff. We were told that this was due to risk management factors.
- The provider had not addressed breaches in regulations, around blanket restrictions, from previous inspections. At our previous inspections we also found that there were blanket restrictions in place concerning access to bedrooms.

However:

- All staff were given a complete induction before they started working with young people. In cases where new starters had not worked in healthcare or with young people before, they were given formal independent training with an external education provider.
- The service provided a range of care and treatment options. There were regular multi-disciplinary team meetings and review meetings to ensure that care and treatment plans fully met the needs of the young person.
- We observed that staff were caring, discreet and respectful. We saw high levels of positive staff interaction with young people. Young people were supported to understand and have input into their own care. People were encouraged to give feedback on their carer and the service in general. Carers and young people we interviewed were complimentary of the service and spoke highly of staff and management.
- Staff and young people we spoke with were complimentary of senior managers and stated that they were visible and approachable. They also stated that they felt that they were listened to by managers.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	Cygnet Joyce Parker hospital is provided by Cygnet Healthcare Ltd. The hospital provides care and treatment for children and adolescents between the ages of 12 and 18. This was a planned comprehensive inspection to follow up on our previous inspection and enforcement activity. Our rating of this location stayed the same. We rated it as requires improvement because: • Two of the three seclusion rooms were out of use due to damage. Maintenance staff informed us the materials that were needed to repair these areas were on order and that they would be repaired as soon as they arrived. We were informed shortly after the inspection that the rooms had been repaired and were able to be used. • Not all care plans contained input from the young person and were not always written in collaboration with the individual. • We identified some blanket restrictions across the unit. Children and young people could not make their own hot drinks and snacks on Mermaid and Pixie wards which meant they were dependent on staff. We also found young people were not given keys to their bedrooms which meant they could not access them without a member of staff. We were told that this was due to risk management factors. • The provider had not addressed breaches in regulations, around blanket restrictions, from previous inspections. At our previous inspections we also found that there were blanket restrictions in place concerning access to bedrooms. However: • All staff were given a complete induction before they started working with young people. In

Summary of findings

cases where new starters had not worked in healthcare or with young people before, they were given formal independent training with an external education provider.

- The service provided a range of care and treatment options. There were regular multi-disciplinary team meetings and review meetings to ensure that care and treatment plans fully met the needs of the young person.
- We observed that staff were caring, discreet and respectful. We saw high levels of positive staff interaction with young people. Young people were supported to understand and have input into their own care. People were encouraged to give feedback on their carer and the service in general. Carers and young people we interviewed were complimentary of the service and spoke highly of staff and management.
- Staff and young people we spoke with were complimentary of senior managers and stated that they were visible and approachable. They also stated that they felt that they were listened to by managers.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Joyce Parker Hospital

Cygnet Joyce Parker hospital is provided by Cygnet Healthcare Ltd. The hospital provides care and treatment for children and adolescents between the ages of 12 and 18. It provides the following regulated activities:

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

Children and young people between the age of 12 and 18 could access the service and there was an Ofsted registered school onsite. The school opened in January 2021. Before this date there had been an offer of online education.

Mermaid ward is a child and adolescent psychiatric intensive care unit, this ward has 10 beds and opened on 3 November 2020.

Pixie ward is a general Adolescent unit, this ward has 12 beds and opened on 15 February 2021.

Dragon ward is a low secure ward with 12 beds.

We most recently rated this service at an inspection that was undertaken on the 15 March 2021. At the time of this inspection it was rated as requires improvement overall.

During our previous inspection we found that, in order to improve, the service must ensure:

- staff were suitably skilled and confident to keep the patients safe and should be trained and competent in the assessment of competence and capacity.
- the hospital notified the Care Quality Commission of notifiable incidents without delay.
- there was suitable signage to indicate where the designated female lounges were located, and local protocol identifies this as a need in line with the national guidance on mixed gender accommodation.
- staff were clear about how frequently they should complete patients' physical health observations and that they completed these accurately and fully.
- Mermaid ward was robust and safe so that patients were unable to damage the environment to cause harm to themselves or others.
- keys and staff alarms were always secure.
- the ward environments were suitable to meet the needs of all patients. There was a lack of relevant information for patients and on Mermaid ward there was not an appropriate place for patients' faith needs.
- restrictions were individually risk assessed and suitable for each patient.

What people who use the service say

All 12 young people we interviewed were complimentary of the service. They all stated that they felt that they were treated with dignity and respect by staff and felt that the care they received was suitable to their needs. They all felt that the environment was good, and they were safe from harm. All five carers we spoke to were all complimentary of the service and stated that they felt that their loved ones were safe and receiving appropriate care. We were also informed that family members and carers had been included in the risk assessment process.

Summary of this inspection

How we carried out this inspection

During our inspection we:

- Undertook a tour of all three wards, the hospital reception area and other areas such as corridors and stairways and the area directly outside the hospital building. We also undertook an inspection of all three clinic rooms where we looked at all clinical equipment, including emergency equipment.
- We interviewed the service manager, two out of the three ward managers, a consultant, two doctors, a psychologist, an assistant psychologist, a specialist speech and language therapist, an occupational therapist, six nurses and three healthcare assistants.
- We spoke with 12 patients and five carers
- We reviewed 13 care records, 12 medication charts, a selection of paperwork relating to the application of the Mental Health Act, eight incident reports, a range of policies, cleaning records for the three months prior to our visit, staff rotas and training records for staff.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that restrictions are individually risk assessed and suitable for each patient. HSCA Regulation 13 (4) b Safeguarding Service users from abuse and improper treatment.
- The service must ensure breaches of regulation are assessed, monitored and improvements are made to the quality and safety of the services provided in the carrying on of the regulated activity HSCA Regulation 17 Good governance (2) a

Action the service SHOULD take to improve:

- The service should ensure that there are effective systems of audit in place to ensure that any recording issues with medication are identified quickly.
- The service should ensure that maintenance and repairs are carried out to ensure that areas that are out of use due to damage are able to be made safe put back into use as quickly as possible.
- The service should ensure that all care plans contained input from the young person if possible and should be created in collaboration with the individual and represent the voice of the young person.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Child and adolescent mental health wards

Safe	Good
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Are Child and adolescent mental health wards safe?

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We saw that ligature risks that could not be removed had been mitigated with working practices and robust assessment of risk. Young people who had been identified as having risks of ligating had care plans that reflected this with management plans that were regularly reviewed.

Staff could observe children and young people in all parts of the wards. The wards were laid out in such a way that observation of most of the daily living space was possible from the central areas of the ward. Where there were blind spots of corridors that could not be observed, we saw that staff were situated in places where they could observe these spaces when patients used them.

The wards complied with guidance on same sex accommodation. The bedrooms all had en-suite shower and toilet facilities which meant that patients did not have to pass other people's bedrooms to wash. At the start of the inspection, Dragon ward did not have a female only lounge because they had only admitted one patient who was female. During our inspection the maintenance department converted one of the rooms to become a female only lounge due to the impending admission of a male patient. This meant that by the end of our inspection, all three wards had a lounge that was set aside for females to use.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Personal alarms were issued to staff and visitors by reception staff upon entering the building. These were tested regularly, and it was the responsibility of reception staff to ensure that they were charged and well maintained.

Requires Improvement

Child and adolescent mental health wards

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. We spoke with cleaning staff and saw cleaning logs showed us that regular planned cleaning was done, and a system of regularly deep cleaning specific parts of the ward was in place. In addition to this, non-patient areas of the building were maintained and cleaned regularly to ensure that the building was clean and well presented.

Staff followed infection control policy, including handwashing. There was hand sanitiser available in reception and policy stated that all people entering the building washed their hands before approaching reception. Each ward had ready access to hand sanitiser. The organisation had an infection control policy that was in line with national guidance.

Seclusion room

Two of the three seclusion rooms, on Dragon and Pixie wards, were out of use due to damage. Maintenance staff informed us that the materials that were needed to repair these areas was on order and that they would be repaired as soon as they arrived. Pixie and Mermaid ward had areas that were designated for long term segregation. These were areas that could be used if someone required extra support or enhanced observation in a safe area away from other patients. We were informed shortly after our inspection that the seclusion rooms had been repaired and were able to be used.

The seclusion room which was in use at the time of our inspection allowed clear observation and two-way communication. They had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We looked at all clinic rooms and emergency bags, including resuscitation equipment, during out visit and found that they were all clean, fit for purpose and regularly checked. All equipment was in date with visible dated stickers. Sharps bins and out of date medication disposal bins were collected and appropriately disposed of.

We saw cleaning records that showed that the clinics were cleaned regularly and included on the scheduled deep clean plan.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. We reviewed staff rotas and found that all shifts were covered with the correct number and grades of staff.

The service had reducing vacancy rates. The organisation had an ongoing process of recruitment to ensure that vacancy rates were reducing. The hospital had opened Dragon ward the week prior to our inspection and was actively recruiting for staff for that area in preparation for when patient numbers increased. At the time of our inspection the hospital reported turnover rates of 14% in the three months prior to our visit.

The service had rates of bank and agency nurses at around 28% at the time of our inspection. This was due in part to increased sickness levels due to the COVID-19 pandemic. Another impact factor to agency and bank usage was increased levels of observations. Overall, there was reducing rates of bank and agency nursing assistants as their vacancy rates reduced.

Managers limited the use of bank and agency staff and requested staff familiar with the service. The hospital had a system where they would prioritise the use of agency staff who had worked with the organisation before wherever possible. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. We saw a number of examples where the organisation was supporting staff who were off on long term sick leave. Engagement levels with these staff were appropriate and support had been arranged for them.

Levels of sickness were 5% in the three months prior to our inspections and this included staff that had to self-isolate as a result or COVID-19.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants for each shift.

The ward managers could adjust staffing levels according to the needs of the children and young people.

Children and young people had regular one to one sessions with their named nurse and key support workers. The system of allocation of named nurses and key workers meant that every patient had an allocated individual on both shift patterns during the day.

Children and young people rarely had their escorted leave, or activities cancelled.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Junior doctors had an on-call rota to ensure that the unit always had access to a doctor out of hours. In line with the provider's policy, on call doctors were expected to be within a twenty-minute drive from the hospital. If this was not possible there was a doctor's on call suite on site for allocated doctors to use during their period of cover.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Training compliance rates

with mandatory subjects were above 75% the time of our inspection. However, due to the way in which the organisation collected and presented its training data it was not clear what the compliance levels were for individual subjects. In cases where staff had not received the training or their training required refreshing, there was a clear action plan in place and the organisation was able to provide us with dates evidencing when those members of staff would receive their training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Specialist training had been sourced from external provider where required. The hospital had implemented a system of training and

development to ensure that staff who were new to healthcare or had not worked with children and young people before were given the knowledge they needed to undertake their role. This included providing all staff with learning via an external education provider at induction. All new members of staff completed the first three modules of "working with children and young people in mental health" course. This course was provided and monitored externally by an independent education provider. This meant that new staff were provided with formal and externally moderated learning prior to going on the wards. There was also a buddy system in place to ensure that new starters had the support they needed from an experienced member of staff during their probationary period.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

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

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission using a recognised tool. Risk assessments were reviewed regularly, including after all incidents. The organisation had robust systems in place to ensure that risk assessments were undertaken and updated regularly. All 13 care records we reviewed had completed risk assessments that included physical health risk assessments. In cases where a physical health condition had been identified, risk assessments contained detail about the condition and any ongoing treatment requirements. There was evidence that family members and carers had been included in the risk assessment process.

Staff used a recognised risk assessment tool. The organisation used established internal risk assessment tools that were in line with best practice guidelines. They also used the short-term assessment of risk and treatability assessment tool. The organisation was also using nationally recognised tools such as health of the nation outcome scales and the model of human occupation screening tool.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff we spoke with were able to talk to us in detail about individual risks and management plans for the people they were caring for.

Staff identified and responded to any changes in risks to, or posed by, children and young people. We observed several handovers and team meetings where changes to risk and people's presentation was discussed. Staff asked relevant questions and were able to offer suggestions for improvements or adjustments of individuals care to manage changes.

Staff could observe children and young people in all areas of the wards or staff followed procedures to minimise risks where they could not easily observe children and young people.

Staff followed provider policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Staff we spoke with knew the provider's search policy and were able to talk us through the processes they would use if searching was required. Search training was part of the mandatory training calendar and the induction process.

Use of restrictive interventions.

Requires Improvement

Child and adolescent mental health wards

We looked at data that showed that incidents of restrictive interventions had been reducing. This data also showed that the majority of physical interventions were lower level in line with provider policies and procedures, and the use of supine or prone restraint was rare. Each incident of physical intervention was reviewed by a suitably qualified individual to assess that each use of restraint was justified and that the minimum intervention possible was used. We also saw examples of where this system of review had resulted in staff being subject to the organisation's disciplinary procedure if it had been evidenced that these principles had not been followed. We did not find any examples of patients experiencing physical harm when looking at the organisation's response to disciplinary issues.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff attended the restrictive interventions training course as part of their induction and undertook refresher training annually.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Every young person had a positive behaviour support care plan in place that contained information on de-escalation strategies to attempt and guidance around support pre, during and post use of physical interventions. These plans had been created in collaboration with the individual.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff undertook training in the Mental Capacity Act. Staff we spoke to understood the definition of restraint.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Compliance rate for safeguarding training was at 92% and every member of staff was booked on to training.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw examples in clinical notes where consideration had been given to a number of areas including protected characteristics in order to maintain the safety of the individual.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. The hospital had a child visiting policy that had been risk assessed and was in line with national guidance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke to could identify their safeguarding lead.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The organisation used an electronic recording system that required staff to fill in all sections of the document.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We found a singular error in recording where the quantity of medication had been adjusted but no name had been recorded next to the adjustment. If looking at this document in isolation it appeared that this medication was unaccounted for. If examined alongside medication cards it was clear that the medication had been appropriately administered. This was an isolated incident and the organisation changed this system of recording.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. Medication was reviewed at every ward round by the multi-disciplinary team. We also observed that staff spoke about medication regularly at hand over and other team meetings so that any issues or adjustments could be raised with prescribing doctors quickly.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. The hospital had a contract with a local pharmacy that monitored storage and administration of medication.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. The organisation had identified staff to lead in the monitoring and distribution of information relating to medication. All staff members had an email address linked to the electronic system which meant that the organisation could update staff quickly of any changes to guidance.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Requires Improvement

Child and adolescent mental health wards

Track record on safety

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. We looked at the incident recording system and found that staff regularly reported incidents. This included any low risk incidents. Staff that reviewed these incident recording forms followed the same system of review for all incidents regardless of the severity and fed their findings back to senior staff regularly.

Staff raised concerns and reported incidents and near misses in line with providers policy.

Staff reported serious incidents clearly and in line with the providers policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. We saw examples of where the organisation had provided honest and frank feedback to young people, families and carers in the event that something had gone wrong.

Managers debriefed and supported staff after any serious incident. Psychologists and assistant psychologists were also involved in debrief to offer staff and service users support should they require it.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. We selected five different incidents and looked at how the organisation had investigated them. We found they had involved people with specialist knowledge from the hospital and wider organisation in order that they could thoroughly investigate incidents and formulate management plans to ensure that they did not reoccur.

Staff received feedback from investigation of incidents, both internal and external to the service. All staff received feedback in a number of ways including electronically, via email and information shared in person.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. We saw changes to working practice that had been implemented as a result of investigations.

Managers shared learning with their staff about never events that happened elsewhere.

Requires Improvement

Child and adolescent mental health wards

Are Child and adolescent mental health wards effective?

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. The organisation used a range of tools to undertake a full range of assessments upon admission. These included a capacity assessment undertaken by a qualified professional.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. In the records we reviewed we saw examples of ongoing assessment and care of physical health conditions.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. We reviewed 13 care records and found they were comprehensive and contained individualised and recovery focussed care plans. Although the care plans did not always contain input from the young person, all care plans we looked at contained a positive behavioural support care plan that had been developed in partnership with the young person. We found these plans contained the young person’s voice and gave staff direction about what the individual expected from their care. They also set out achievable targets for the young person linked to their recovery. Where care plans did not contain input from the young person, refusals or an inability to engage in the process was recorded.

Staff regularly reviewed and updated care plans when children and young people's needs changed. We noted all care plans we reviewed had been regularly reviewed and updated. Each record had a date that it should be reviewed and there was also evidence they had been reviewed when circumstances had changed.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service. There were a variety of treatments available to young people on the wards. These were in line with national guidance and had input from a wide range of qualified staff. The hospital employed dieticians, speech and language therapists, psychologists, social workers and occupational therapists to support consultants and doctors in developing individualised treatment options for children and young people.

Staff delivered care in line with best practice and national guidance.

Staff identified children and young people's physical health needs and recorded them in their care plans. In all care records we reviewed, physical health had been assessed. Where required we saw children and young people had physical health care plans in place. Staff made sure children and young people had access to physical health care, including specialists as required.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. There was support available from a dietician where required.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. We saw staff engaging with young people on the ward to encourage them to be involved in sessions that were being delivered. We also saw that, where possible, young people all went off the wards to undertake education sessions with suitably qualified staff.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. The hospital used several tools to monitor the severity of people's conditions including the health of the nation outcome scales.

Staff used technology such as IT systems to support children and young people.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements. We saw examples of changes to working processes as a result of audits and quality improvement initiatives.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward. These included doctors, psychologists, social workers, occupational therapists, dieticians, specialist speech and language therapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. The organisation had a high proportion of staff that had either not worked in healthcare before or had not worked with children. The management had developed strategies to ensure that they were given the skills and knowledge that they would need. This included regular review during their probation, formal education and support from mentors and experienced staff.

Managers gave each new member of staff a full induction to the service before they started work. The induction process took two weeks and all staff had to attend all sessions before they could work on the wards.

Managers supported staff through regular, constructive appraisals of their work. Appraisals were undertaken at the end of new starters probation period and annually thereafter. We found that appraisal rates were 100% at the time of our inspection.

Requires Improvement

Child and adolescent mental health wards

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. We found that appraisal rates for non-medical members of staff were 100% at the time of our inspection.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. We found that appraisal rates for permanent medical staff were 100% at the time of our inspection.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Nursing staff all had clinical supervision every six weeks.

Managers supported medical staff through regular, constructive clinical supervision of their work. Medical staff all received supervision in line with guidance from their professional bodies. Supervision rates for medical staff were 100% at the time of our inspection.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings occurred monthly.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these. We reviewed a number of cases where the organisation had managed poor performance from staff. We found that each case had been considered individually and managers had followed their own human resources guidance in terms of developing an appropriate response or action plan.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Multi-disciplinary team meetings occurred weekly on all three wards. These were in addition to a morning meeting to review any changing needs. Multi-disciplinary team members attended these meetings at the start of their working day.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We observed number of handover meetings and found that they were detailed and included a review of each person on the ward.

Ward teams had effective working relationships with other teams in the organisation. Staff were able to move between teams effectively and there were processes and meetings in place to ensure working practices across all three wards were in line.

Ward teams had effective working relationships with external teams and organisations. This included local community child and adolescent mental health teams.

Requires Improvement

Child and adolescent mental health wards

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of our inspection 92% of staff had completed the training and were in date.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff we spoke to knew how to access this support and also knew which staff were responsible for providing it.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. All organisational policies were available electronically, wards had also printed out regularly used policies which staff could access in nursing offices. There were also information leaflets and documents relating to the Mental Health Act on notice boards in all three nursing offices.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. On admission every young person was given a welcome pack that contained information about the service. This included information about how to access advocacy services.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Requires Improvement

Child and adolescent mental health wards

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection 92% of staff had completed the training and were in date.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. There were also information sheets posted in the nursing offices that gave a breakdown of Gillick competence and the Frasier guidelines.

Are Child and adolescent mental health wards caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Requires Improvement

Child and adolescent mental health wards

Staff were discreet, respectful, and responsive when caring for children and young people. We saw very high levels of engagement on the wards. Staff were able to interact with young people in a respectful way about subjects that engaged them.

Staff gave children and young people help, emotional support and advice when they needed it. We saw staff supporting young people in a number of ways. In all cases they were caring and respectful.

Staff supported children and young people to understand and manage their own care treatment or condition. All patients had a positive behaviour support care plan in place that had been created with input from the young person.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Children and young people said staff treated them well and behaved kindly. All 12 of the young people we spoke with were complimentary of the service and staff.

Staff understood and respected the individual needs of each child or young person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. The process of orientation to the ward included showing new admissions around the unit and introducing them to other service users.

Staff involved children and young people and gave them access to their care planning and risk assessments. We were told, by all the young people we spoke with, that they had spoken to their named nurse about their care plans. They also stated that they had been offered a copy of their care plans.

Staff made sure children and young people understood their care and treatment and found ways to communicate with children and young people who had communication difficulties. All information on the wards was available in easy read versions and could also be provided in different languages if required. We also saw that the organisation can organise interpreters including British sign language as and when required.

Staff involved children and young people in decisions about the service, when appropriate.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The wards had regular patients' meetings and some of the young people were a part of a patients' council to communicate and share information with other service users from across all of Cygnets hospitals.

Requires Improvement

Child and adolescent mental health wards

Staff supported children and young people to make decisions on their care.

Staff made sure children and young people could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. All of the carers we spoke with were complimentary of the service that their family members were receiving. They stated that they felt involved in the care provision. They also stated that there was good contact with the service and that they were confident that the organisation would let them know immediately about any changes in their family members condition.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Are Child and adolescent mental health wards responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff planned and managed the discharge process of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. The length of stay was regularly reviewed at multi-disciplinary team meetings.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned. Since the beds at this unit were not commissioned in the same way as NHS beds, commissioners paid for the bed until the young person was discharged from this service. This meant that the bed would remain empty during periods of leave.

Children and young people were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interest. We saw that children and young people were moved between Mermaid and Pixie wards as the risk they presented reduced. In time Dragon ward was expected to be the next step for people from Pixie ward.

Staff did not move or discharge children and young people at night or very early in the morning.

Discharge and transfers of care

Children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. During our inspection there were a number of young people who were out of the service visiting new placements that they would be moving to. We saw from their records that these visits had been planned with contingencies to return the person to the unit early if required.

Staff supported children and young people when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality.

Each or young person had their own bedroom, which they could personalise. Young people were encouraged by staff to personalise their rooms in order that they felt more at home. However, we found that patients were not given keys to their bedrooms which meant they could not access them without a member of staff. However, young people we spoke with told us there were no issues with having access and staff always facilitated opening the doors quickly.

Children and young people had a secure place to store personal possessions. All wards we visited had secure lockers for personal items that were allocated to each patient.

Staff used a full range of rooms and equipment to support treatment and care. The wards we visited all had an occupational therapy room that could also be used for education sessions if it was not possible for someone to visit the education suite. There were quiet rooms available as well as space for young people to undertake joint activities. All wards had a room set aside as a lounge area that could only be used by female patients as per mixed gender guidelines.

The service had quiet areas and a room where children and young people could meet with visitors in private. These rooms were situated close to the entrance for the wards so that young people could visit with people in privacy.

Children and young people could make phone calls in private. All patients had unrestricted access to their own mobile phones. If a young person did not have their own phone, there was a telephone that they could use on request.

The service had an outside space that children and young people could access easily.

Children and young people could not make their own hot drinks and snacks on Mermaid and Pixie wards which meant that they were dependent on staff. We were told this was due to risk management factors. However young people we spoke with told us there were no issues with having access and staff always facilitated making facilities available quickly. There was access to water and cold drinks at all times.

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff helped children and young people to stay in contact with families and carers.

Staff encouraged children and young people to develop and maintain appropriate relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by children, young people and the local community.

Managers made sure staff, children and young people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people.

Children and young people had access to spiritual, religious and cultural support. We found this was being used by a number of young people. All three wards had small multi-faith rooms for people to use. There was also an area off the wards in the education suite that people could use if they wished to worship in a group of in the presence of a religious leader.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. The young people and carers we spoke with all told us they would know how to make a complaint if they needed to and felt confident that they would be supported by staff to do so.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Requires Improvement

Child and adolescent mental health wards

Are Child and adolescent mental health wards well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

Ward managers we spoke to had undertaken leadership training and were supported to undertake any training that was required to allow them to develop in their role. We spoke to all three ward managers and were told that they had been supported to develop into their roles and were able to source training and development opportunities if required.

Senior managers had been recruited with the skills, experience and knowledge to develop the service.

We observed interactions between mangers and staff that demonstrated that they were well known to staff and had developed strong relationships with staff on the wards. We were told that all managers, including senior managers, regularly visited the wards and were available quickly if staff needed to speak with them.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

All staff we spoke with understood the organisations visions and values both locally and nationally and could explain them to us.

Senior managers actively promoted the visions and values of the hospital to staff and encouraged them to have direct input into the development of the hospital strategies. We found that senior managers had implemented processes whereby staff could engage with them directly to present ideas for improvement and tell them about the service they worked in. This included senior managers making themselves available in person at staff meetings or one to one sessions.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff we spoke with stated that they felt respected and valued. We were told by staff that they view the management team positively and felt that they were part of a happy staff team. Staff felt that diversity and inclusion was high on the agenda in this organisation.

All staff we spoke to stated that they felt proud to work at the hospital. They felt that they had been involved in improving the service directly.

All staff told us that they felt they could raise concerns without fear of retribution. Staff we spoke with all knew how to use the whistle blowing process and stated that they were confident they would be supported if they needed to.

Staff appraisals included a conversation about career development, and we spoke with staff who had developed and improved into roles with more responsibility.

Though the hospital had seen elevated rates of staff sickness and absence throughout the pandemic, in the three months prior to our inspection they had returned to pre-pandemic levels.

Staff had access to support for their own emotional and physical wellbeing through an occupational health service.

The provider recognised staff success through a staff awards scheme.

Governance

Our findings from the other key questions demonstrated that governance processes generally operated effectively at team level and that performance and risk were generally managed well. However, we found failings from the previous inspection had not fully been addressed.

Documentation we looked at linked to governance processes was well thought out, clear and captured relevant information. Staff understood governance processes and knew how to complete documentation. However, not all audit systems were effective. We found that training data was not well recorded.

There was a clear framework of what should be discussed at ward, team or directorate level in meetings to ensure that essential information, such as learning from incidents and complaints, were shared and discussed.

Staff had implemented recommendations from reviews and investigations. This included changes or improvements to working practice.

The organisation had not implemented improvements recommended at the last inspection linked to blanket restrictions. We found that a number of blanket restrictions identified in our last inspection, round room keys and access to hot drinks, had not been reviewed or audited and were still in place.

Staff understood the requirements for working with other teams from within the organisation and externally to meet the needs of the patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

All staff had access to the electronic systems. This meant that they could access all the documents that the required to provide safe and effective care.

All staff had access to the risk register either at team or directorate level and could escalate concerns when required. Ward staff told us that they would be supported by their managers to do this if required.

The hospital had plans in place for emergencies, for example inclement weather, and had developed contingency plans that were clear.

Requires Improvement

Child and adolescent mental health wards

Information management

Staff engaged actively in local and national quality improvement activities.

Staff were engaged in audit and quality improvement at a local level. They also participated in quality improvement projects which included other hospitals in the organisation nationally.

Staff had access to equipment and information technology that allowed them to undertake their roles. The infrastructure in place worked well to help support the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them in their role. This included a manager's dashboard that included information about staff training and performance.

Staff made notifications to external bodies such as the local authority or the care quality commission as and when required.

Engagement

Managers engaged actively other local health and social care organisations and commissioning bodies.
Managers from the service participated actively in the work of the local transforming care partnership.

Managers were involved with other providers and hospitals within their own organisation to develop and ensure integrated health and social care systems. Senior managers met regularly with commissioners they worked with to understand the needs of commissioning groups and develop a service that met their needs.

The provider used its website, intranet and bulletins posted around the hospital to update staff, children and young people and carers about improvements and developments within the service.

Children and young people and their carers had the opportunity to give feedback about the service.

Managers had access to feedback from carers and children and young people and considered these when improving and developing the service.

Children and young people and staff had access to senior managers from the organisation at listening events and could offer feedback to them.

Learning, continuous improvement and innovation

Staff induction included formal study with a formal education provider, the Open University, to ensure that they had the skills required to work on the wards. We also spoke to a number of staff who had completed college or university courses to help them develop into new roles.

Staff were given time and support to consider innovation and quality improvement. This had led to changes in areas such as recruitment and service delivery. We saw that the organisation had developed systems whereby staff that were new to working in children's services could be developed and supported.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure breaches of regulation are assessed, monitored and improvements are made to the quality and safety of the services provided in the carrying on of the regulated activity (Regulation 17(2, 1))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service had not ensured that restrictions were individually risk assessed and suitable for each patient. (Regulation 13 HSCA)