

Inadequate 

North East London NHS Foundation Trust

# Child and adolescent mental health wards

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RATRK	Brookside Unit	Brookside Unit – Reeds and Willows ward	IG3 8XQ

This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Inadequate



Are services safe?

Inadequate



Are services effective?

Inadequate



Are services caring?

Inadequate



Are services responsive?

Requires improvement



Are services well-led?

Inadequate



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

### **We rated child and adolescent mental health wards as inadequate because:**

- The ward environments were not safe, clean or suited to the care of children and young people. The environment on the Willows ward was stark and unappealing. There were a number of historic maintenance issues on the ward which had not been remedied, for example we found broken dining room chairs which posed the risk of harm to young people. The overall cleanliness of both wards on the unit was poor and we found potential infection control risks. Cleaning records were not all up to date. The layout on both wards did not allow for good observation of young people. There were blind spots throughout the wards with no aids to assist with observations, for example convex mirrors. The wards completed a yearly ligature audit. The audit identified ligature risks around the unit and documented action to mitigate the risks. Actions included replacing ligature points with anti-ligature alternatives. Most ligature risks had been addressed through a recent programme of maintenance works at the unit. However, we found ligature points in the disabled toilet on Willows ward which had not been identified in the audit. There were no curtains or blinds on the bedroom windows on the Willows ward. This impacted on the privacy and dignity of young people. The family visiting room did not provide privacy when young people had visitors at the unit.
- The wards were not adequately staffed. The unit had a vacancy rate of 58% and had a high reliance on bank and agency staff. Not all shifts were covered by sufficient numbers of staff to meet the needs of young people. During our inspection we observed two shifts without the minimum staffing levels. Access to doctors out of hours was not sufficient. It could take several hours for a doctor to attend the unit. Doctors who attended the ward out of hours did not always have a background in child and adolescent mental health. Staff members were not routinely receiving clinical supervision sessions.
- There was a high usage of restraint and rapid tranquilisation at the unit. Staff restrained young people in the prone position and some restraints culminated in the administration of rapid tranquilisation.
- The unit had blanket restrictions in place and restrictive practices. All doors were locked within the unit and young people had to rely on staff members to move throughout the unit. We observed young people unable to summon staff members to assist them moving between different areas of the unit and being left behind locked doors.
- The level of incidents reported on Datix did not correspond with incidents recorded in young people care notes. Incidents were under reported.
- Staff searched young people routinely following leave but the search policy was not in date. One young person had been asked to remove clothing during a search.
- The wards were not effectively developing care plans or risk assessments. Care plans we reviewed were not recovery orientated and focused on behaviours. Care plans were not holistic and did not have young people's views and goals. Risk assessments were sparse. The assessments contained little background and historical information about young people.
- We could not find evidence in the case notes that staff had assessed whether the children and young people had the capacity to consent to admission and treatment.
- The unit did not formally seclude young people. The unit did not have a seclusion room. However, during our review of care records the care plans showed evidence that young people may be secluded without proper safeguards in place.
- Staff were not always responsive to the needs of young people at the unit. During our inspection we observed young people asking for staff assistance to get a drink or go to the toilet. Staff responded by saying they were too busy.
- Young people reported the food was poor quality.

# Summary of findings

However:

- The physical health needs of young people were assessed and monitored appropriately.
- Staff were aware of safeguarding processes and had received training. The CAMHS service had a named safeguarding nurse lead who communicated with the local authority about issues on the wards.
- We were told by staff that following incidents there was a de-brief for both the staff and young people. Incidents were discussed at daily risk meetings. The unit had also introduced daily safety huddles that were held in the morning and afternoon.
- Feedback about incidents was done through daily risk meetings, weekly multi-disciplinary team meetings and in the weekly Brookside Quality and Performance meeting.

- There was an advocacy service available to formal and informal young people at the unit.

Due to the severity of the concerns found during the inspection we issued the trust a warning notice under section 29A of the Health and Social Care Act 2008. The warning notice was issued as the CQC's view of the quality of the health care provided required significant improvements. These improvements were as a result of risks to the health, safety and welfare of young people using the service were not always completed or mitigated. Care and treatment was not always provided in a safe way for young people. The warning notice also required improvements in relation to the unit not having effective systems or processes in place to ensure that the care and treatment provided to young people was in a safe environment.

# Summary of findings

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

### Are services safe?

We rated safe as **inadequate** because:

- The environment and furniture in the Willows ward dining area was damaged five months ago. It had still not been repaired and posed a risk of injury to young people and an infection control concern.
- There was poor observation of patient areas.
- The overall cleanliness of the unit was poor.
- The clinic room was dusty and posed an infection control risk.
- The unit completed a yearly ligature audit. The audit identified ligature risks around the unit and the action taken to mitigate such risks. However, we found ligature points in the disabled toilet on Willows ward which had not been identified in the yearly audit.
- Staff's personal safety alarms did not work in all areas of the unit.
- There were less than the agreed number of staff on duty during two shifts during our inspection.
- The unit had a high level of vacancies - 58%. As a result, the unit relied heavily on agency and bank staff. Agency staff were not always familiar with the unit or the young people.
- Risk assessments were sparse. The assessments contained little background and historical information about young people.
- Out of hours access to doctors was variable. It could take several hours for a doctor to attend the unit when requested.
- The unit had very high use of restraint, prone restraint and the use of rapid tranquilisation.
- Blanket restrictions and restrictive practices were in place in the unit. All doors in the unit were locked and patient movement was restricted.
- Staff searched young people with an electronic wand device. There was no policy in place to support staff who were conducting searches on young people.
- Incidents were being under reported on the units electronic recording system

However:

**Inadequate**



# Summary of findings

- A ligature risk assessment had been completed and improvement work was on going.
- There were regular pharmacy audits
- The unit had identified that a high number of incidents were in the early evening between the hours of 18:00 – 21:00. In response to this the unit had developed an evening schedule of activities. This had reduced the number of incidents during the evening in the months prior to our inspection.
- The unit had introduced daily safety huddles.

## Are services effective?

We rated effective as **inadequate** because:

- The ethos of the unit was containment rather than therapy. The wards did not always have enough permanent staff members on the wards to deal with a therapeutic environment and we saw young people locked behind doors and unable to access other areas without staff assistance.
- Care plans reviewed were not recovery orientated and more behaviour orientated. Some care plans were out of date.
- Only regular staff could access information on the electronic system. Due to low numbers of regular staff on duty there was additional pressure on regular staff to make all entries into the system
- Staff were not receiving regular supervision
- We could not find evidence in the case notes that staff had assessed whether the children and young people had the capacity to consent to admission and treatment.

However:

- There was a multidisciplinary team with professionals from a range of disciplines including a consultant psychiatrist, nurses, occupational therapy and psychologists.
- The multidisciplinary team met daily to review young people in risk meetings. Meetings were well attended, detailed and holistic discussions took place. We observed a patient-centred and respectful approach.

**Inadequate**



## Are services caring?

We rated caring as **inadequate** because:

**Inadequate**



# Summary of findings

- During the inspection we saw staff refuse to facilitate the requests of young people.
- Young people and their families were not always treated with dignity and respect.
- There was little evidence of patient involvement in care or discharge planning.
- Some young people said they felt unsafe at the unit.

However:

- Young people were generally positive about regular staff members.
- The unit had created a video to be viewed by new young people about the ward
- There was an advocacy service available to formal and informal young people at the unit.

## Are services responsive to people's needs?

We rated responsive as **requires improvement** because:

- The family visiting room provided little privacy when young people met with their families.
- Young people stated the food was of poor quality and cultural and religious foods were not available.
- Willows ward was a stark and unappealing environment. Patient bedrooms did not have curtains or blinds to maintain young people's privacy and dignity.

However:

- Young people had access to education five days a week.

**Requires improvement**



## Are services well-led?

We rated well-led as **inadequate** because:

- There were substantial failures in the governance at the unit in relation to staffing. Managers had failed to ensure adequate staffing levels consistently and shifts were not always covered by staff with the right level of experience. Regular staff members were under increased pressure to undertake administrative duties as agency staff members could not make entries onto electronic records systems.

**Inadequate**





# Summary of findings

- There were failures in relation to mandatory training of staff members and supervision for staff members.

However:

- Staff were aware of the Trust's vision and values.
- Staff reported that since the new ward managers and modern matron had taken up post the unit was beginning to improve.
- Regular staff members demonstrated motivation and dedication to the patient group.

# Summary of findings

## Information about the service

The Brookside Unit is an 18-bedded inpatient mental health unit for young people in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. The Brookside unit is divided into three services onsite. There are two inpatient wards, Willows and Reeds wards, and a day patient service. It is the only inpatient child and adolescent facility within the trust. The unit is mixed sex and admits children and young people between the ages of 12 and 18. The unit provides

24 hour specialist psychiatric care for young people who are experiencing an acute mental health crisis, whose presentations are complex and requiring inpatient treatment.

The unit has an on-site school. The school is registered with the office for standards in education, children's services and skills (Ofsted). The school has not yet been inspected by Ofsted.

## Our inspection team

The team that inspected the child and adolescent mental health ward on 5, 6 and 7 April 2016 comprised six people: a CQC inspection manager, two specialist advisors with experience in child and adolescent mental health services, an expert by experience, a Mental Health Act Reviewer and a pharmacist inspector.

An evening visit was undertaken on 14 April 2016. This team comprised three people: a head of hospital inspections, an inspection manager and a national professional advisor who specialises in inpatient child and adolescent services.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information and sought feedback from young people at focus groups.

During the inspection visit, the inspection team:

- Visited the unit and looked at the quality of the ward environments and observed how staff were caring for young people.
- Spoke with seven young people who were using the service.
- Spoke with the modern matron and two ward managers.
- Spoke with 14 other staff members; including psychiatrists, nurses, health care assistants, psychologist and occupational therapist.
- Looked at 12 case notes looking at areas including risk assessments and care planning.
- Looked at other relevant records such as checks of resuscitation equipment, medicine records, staff rotas and trust policies.

# Summary of findings

- Observed a governance meeting, observed CPA meetings, a shift handover, community meeting and safety huddle.
- Carried out a Mental Health Act review.

## What people who use the provider's services say

Young people we spoke with gave mixed views on the unit. We were told regular staff members were nice and respectful. However, we were told that not all agency staff introduced themselves to the young people and were sometimes rude.

Young people told us they did not like the food and there was not enough variety.

Young people reported they were happy with the range of therapies available.

Young people knew how to make a complaint, however, we were told by some there was no point raising a complaint as they were not dealt with sufficiently.

Young people we spoke to said that staff searched them when they returned to the ward. Young people also told us that they had access to drinks and snacks during the day. However, as the kitchen door and all other doors were locked, young people had to rely on staff to open the door to get snacks and drinks at the time of our visit.

Young people had a named worker who they saw for regular sessions. However, we were told these sessions did not always happen due to staffing issues.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure there are sufficient numbers of, and suitably skilled, staff deployed at the unit.
- The trust must review the restrictive practices and blanket restrictions in operation throughout Brookside unit.
- The trust must review the capacity and consent to treatment of all young people at Brookside unit. No record of parental consent to admission to hospital was recorded for any patient records we reviewed or whether the young people were competent (if under 16 years of age) or consent (if over 16 years of age) to their own hospital admission. We found no evidence of assessment of capacity to consent to treatment in patient notes and no evidence of the use of Gillick competence (for those under 16 years of age).
- The trust must review patient care plans and ensure they are holistic and recovery orientated.
- The trust must review the policy to support staff when searching young people.
- The trust must undertake maintenance works on Willows ward in the dining area.
- The trust must review the cleanliness of the Brookside unit.
- The trust must ensure that staff include all risks that they identify, when making a risk assessment of a patient, in the patient's care plan.
- The trust must ensure food choices are available to meet the needs of cultural and religious beliefs.
- The trust must ensure all incidents and safeguarding are recorded on Datix.
- The trust must ensure staff receive regular supervision.
- The trust must ensure staff receive regular appraisals.

# Summary of findings

## Action the provider **SHOULD** take to improve

- The trust should ensure that all staff understand Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents' consent.
- The trust should ensure that young people understand their rights. We found evidence young

people were given their rights on admission. However, there was no evidence regarding a patient's level of understanding or that rights were represented at regular intervals.

- The trust should ensure each patient is able to access patient protected time on a regular basis.

## North East London NHS Foundation Trust

# Child and adolescent mental health wards

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Brookside Unit	North East London Foundation NHS Trust

#### Mental Health Act responsibilities

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

- At the time of our inspection there were five young people detained under the MHA and 10 informal young people at Brookside unit.
- In the records scrutinised, there was evidence that young people were informed of their rights under section 132 on admission. However, the records provided no further explanation as to whether young people had understood their rights or had them given to them at intervals thereafter.
- Some documents relating to detention were available on the ward. However, these were difficult to find and

only two of the five patient records were found. We were told that records were uploaded to 'Windip', but staff could not access this during our visit. We were concerned that it would not be possible to transfer a young person to another hospital outside working hours without copies of the detention documentation being available.

- The nurse in charge of the ward provided receipt and scrutiny of documentation on admission to the ward and uploaded to Windip; however, we could find no checklist for staff to complete this task. Documents were then sent to the mental health administration department for scrutiny and uploading to the 'Windip' system.

#### Mental Capacity Act and Deprivation of Liberty Safeguards

- We could not find evidence in the case notes that staff had assessed whether the children and young people

had the capacity to consent to admission and treatment. This was important because not all of the

# Detailed findings

young people were detained under the Mental Health Act and some were of an age where they were likely to be able (or be competent) to agree to admission and treatment.

- We did not see that staff recorded if children and young people on the ward had been assessed for Gillick competency.
- No young people were detained under the Mental Capacity Act or Deprivation of Liberty Safeguards at the

time of the inspection. The trust were compliant with the Mental Health Act in that no young people were detained under the Mental Capacity Act and since the Deprivation of Liberty Safeguards within the Mental Capacity Act apply only to individuals aged 18 years and over. We were told any application to deprive someone of their liberty between the ages of 16-17 years would be made directly to the Court of Protection

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- Both wards were situated inside a purpose built unit on the ground floor. Access to the hospital was through an airlock door system. Access to both the wards, Reeds and Willow high dependency unit (HDU), was through magnetically locked doors. Staff were required to open the magnetically locked doors with key fobs. Reeds ward had one bedroom corridor with individual bedrooms; the lower half of the corridor was a female area and had a small female lounge. The upper area of the corridor could be used for young people of either gender. There was a small lounge with television. Reeds ward also had a large games room with pool table, table football and sofas. Reeds ward had a large dining room which was also used by day young people. Willows (HDU) ward had four bedrooms with en-suite bathrooms. There was a small lounge and dining room. There was also a small outside space. The family room was located off the ward and was used by young people from both wards. The layout of both Reeds and the Willows ward meant observations of young people could be difficult. The staff office on Reeds ward had windows on either side of the room to observe the games room and patient bedroom corridor. However, the ward windows were small and there were areas of the games room and corridor that could not be observed from the staff office windows. There were no convex mirrors to assist with monitoring blind spots in ward areas.
- The unit completed a yearly ligature audit. It was last undertaken in August 2015. The audit identified ligature risks around the unit and the action taken to mitigate such risks. Such action included replacing ligature points with anti-ligature alternatives, for example, door handles. The audit also included staff actions to mitigate ligature risks such as supervising ward areas at all times. We reviewed the wards for ligature points during a tour of the environment. Most of the ligature risks identified had been addressed through a recent programme of maintenance works at the unit, the majority were on Reeds ward. However, we found ligature points in the disabled toilet on Willows ward which had not been identified in the yearly audit, for example there were swing taps that could be used to tie a ligature to for the purpose of self-harm.
- We found the wards to be compliant with Department of Health guidance on same sex accommodation. Young people on the Willows ward were provided with a bedroom and en-suite bathroom. Young people on Reeds wards had specific areas and also gender specific toilet and bathroom areas.
- The clinic room was situated in the middle of both wards and was accessible from both. Staff kept stocks of medication prescribed for physical and mental health. Controlled drugs were stored securely in a locked cupboard. The use of controlled drugs was recorded in a special register. The trust pharmacist audited the clinic room on a weekly basis. The clinic room was dusty with both high and low dust. This was an infection control risk. There was only one emergency grab bag available. This was locked in the clinic room and behind multiple locked doors making quick access in the event of an emergency situation difficult. We raised this as a concern during our inspection and two new emergency grab bags were provided to the unit. Staff were responsible for cleaning the clinic room. A daily checklist was in place, however, it was not signed by staff using their full names. This made it difficult to identify who had carried out the checks. Consistency of recording was variable. For example, for the week commencing 21 March 2016 only one day on the checklist had been completed by staff. Fridge temperatures were monitored daily and all entries in the checklist had been completed. All equipment in the clinic room had been tested and were within date.
- The unit was undergoing redecoration at the time of our visit. The reception area had been redecorated and was bright. Reeds ward had undergone recent redecoration and was bright. The environment on Willows ward was stark, unappealing and non-therapeutic. The ward was dark and had low ceilings. We found furniture in the Willows ward dining area to be damaged following an incident five months ago. The left cushion on the fixed chair was ripped and hard wood and metal fixings were

# Are services safe?

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exposed. The right cushion was ripped with foam exposed. This posed a risk of injury to young people and an infection control concern. Furthermore, drawers on the sink unit had been removed due to damage and had not been replaced. The walls in the Willows ward dining area were damaged. The garden furniture in the outside area of Willows ward was damaged and potentially dangerous. This was identified as a risk in August 2015 but had still not been remedied. We were told by staff that these issues had been raised with the trust and they were awaiting maintenance to rectify the problems.

- Commissioners had raised concerns about the maintenance of the environment previously when they noted during a visit that the fence in the garden had fallen down. This led to a gap in the fence leading to a residential property which no one in the unit was aware of until it was raised. The trust responded to commissioners that it was not a fence they were responsible for as it was the residential properties. Commissioners had also raised previously a dignity concern that there were no curtains in some young people's bedrooms whilst ongoing building work was occurring. There appeared a lack of urgency in the response which said that they were ordering new curtains that would meet the requirements of the ligature audit and that safety came first.
- The patient-led assessment of the care environment (PLACE) score for cleanliness at the Brookside unit was 98.75%. It was last undertaken in 2015. However, at the time of our inspection the overall cleanliness of both wards was poor. We observed a domestic staff member cleaning the toilet on Willows ward without an apron, this posed infection control risks. Carpets and floors throughout the unit were stained, dirty and had loose debris on them. The walls on both wards were scuffed and marked. The cleanliness of the unit overall posed an infection control risk to young people, especially those who may engage in self-harming behaviour which may lead to wounds being exposed. There was a cleaning schedule held by domestic staff, however, it contained minimal information about each area to be cleaned. Young people using the service stated that the wards were often dirty.

- We were told there is a daily safety walk round by staff on both wards. The purpose of the walk round was to identify any safety concerns within the unit. We requested to view the records of the daily safety walk round but none were available.
- Alarms were in place throughout the unit. Staff were issued with keys, key fobs, personal alarms and radios. We were told by staff and young people that an incident had happened during the evening prior to our inspection visit. The alarm system does not activate in the education area of the unit and a young person had been required to find staff members to assist with the incident. We escalated this at the time of our inspection.

## Safe staffing

- Minimum staffing levels for Reeds ward were set at three registered mental health nurses and five health care assistants in the day. By night the minimum staffing levels for Reeds ward were set at two registered mental health nurses and four health care assistants. Minimum staffing levels for Willows ward were set at one registered mental health nurse and two health care assistants in the day and night. Staff absorbed the first increase in observations. For example if a young person's level of observation increased from intermittent to requiring a staff member with them at all times. Extra staff would then be requested in the event of further increases in observations. The ward managers on both Reeds and Willows ward were supernumerary to the staffing complement.
- There were less than the agreed numbers of qualified staff on duty during two days of our inspection visit. Review of staffing records for the four months prior to the inspection confirmed there were other occasions when the agreed numbers of qualified and unqualified staff were not met. It appeared that it was difficult to find staff (bank or agency) to sufficiently staff the unit. In the afternoon during one of our inspection visits the unit was three staff members under the staffing complement. This was impacting on the safe operation of the ward, especially in the event of increased patient observations, incidents or restraints (during each of our visits we were aware of a number of restraints taking place). Increased pressure was placed on the regular qualified staff during incidents without other regular staff to support them.



# Are services safe?

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- There were a number of vacancies across the Brookside unit for nurses and a vacancy rate of 58%. This was impacting on the safe operation of the ward, especially in the event of increased patient observations, incidents or restraints (during each of our visits we were aware of a number of restraints taking place). Increased pressure was placed on the regular qualified staff during incidents without other regular staff to support them. The staffing levels were also impacting on the care received by young people. We observed situations where young people asked staff members to access drinks or toilet areas and staff informed young people they were too busy to assist.
- The unit had a high reliance on bank and agency staff due to recruitment issues for substantive staff. The unit block booked bank staff to fill shifts. The aim of this was so that there were staff on shift that knew the running of the wards and the risks of the young people. We were told by staff and young people that the unit was at times required to bring agency staff in on a shift by shift basis. The young people we spoke with did not always know who these staff were and felt this disrupted the service as they were not familiar with the unit or the young people themselves.
- During the day, there was good access to doctors. However, out of hours cover was variable. We were told by staff out of hours on-call cover is provided by King Georges Hospital. The doctor on-call covers the Accident and Emergency department and we were told about instances where it could take several hours for the doctor to attend when requested. We were also told the doctor on-call rarely had a background in child and adolescent mental health.
- Staff received mandatory training which was provided by the trust in face to face and computer based forms. The average mandatory training rate for staff was 79% across 15 mandatory training areas. Training rates in life support (73%), Prevent 1 (62%), Prevent 2 (42%), prevention of management of violence and aggression (75%) and safeguarding adults enhanced (73%) were 75% or below.
- Between 1 April 2015 and 29 February 2016 there had been 459 episodes of restraint at Brookside unit, 108 of which had been prone restraints and 86 had resulted in the use of rapid tranquilisation.
- Staff received training in the prevention of management of violence and aggression. The training taught verbal de-escalation skills, break-away and restraint. The compliance rate for this training at the unit was 75%. The majority of staff we spoke with felt confident in managing challenging behaviour on the ward. However, regular staff members told us agency staff were not always trained in the prevention of management of violence and aggression and were unable to participate in restraints. Training of agency staff in the prevention of management of violence and aggression was variable. Agency staff we spoke to confirmed they could only participate in restraints with permanent staff members if they had received training.
- The unit did not formally seclude young people. The unit did not have a seclusion room. However, during our examination of care records the care plans showed evidence that young people may be secluded without proper safeguards in place. For example, one patient care plan indicated that they agreed to being restricted to their bedroom for brief periods if they were finding it difficult to manage their behaviour in ward areas. It went on to state staff do not have to remain in the bedroom but will stand directly outside the door and prevent the young person from leaving the room until they are ready to be escorted to another ward area. We were concerned this amounted to seclusion but was not being treated as such. Chapter 26 of the Mental Health Act (1983) Code of Practice states:
 

26.103 Seclusion refers to the supervised confinement and isolation of a patient, away from other young people, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

26.104 If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as ‘therapeutic

## Assessing and managing risk to young people and staff

# Are services safe?

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isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code.

26.105 Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward."

- We reviewed 12 care records during our visit. Risk assessments were sparse and did not carry over into care plans in any of the records we reviewed. The assessments contained little background and historical information about young people. We were concerned with the high use of bank and agency staff that risks, and how to address them, were not being adequately documented and conveyed to staff.
- Blanket restrictions and restrictive practices were in place throughout the unit. All internal doors were magnetically locked. Young people were required to ask permission to move from one area of the unit to another at all times and needed to be escorted by staff who could open doors with key fobs. The locked doors meant patient movement was excessively restricted and affected their dignity. For example young people were required to ask for drinks which were locked in the kitchen, to gain access to the kitchen, young people needed to be escorted through four locked doors from the TV lounge. Water machines were available, however, these were in reception or the dining room which again were behind locked doors and would require a staff member to assist with access. We observed young people asking permission to go to the toilet. This involved passing through several locked doors, unlocking of the toilet door where a staff member would then stand outside compromising patient privacy and dignity. We observed a young person attempt to access a locked toilet, there were no staff available to unlock the door. The young person then returned to their bedroom. Other blanket restrictions in place included a ban on shoe laces. Young people were given the option of wearing their shoes without the laces or handing them into staff.
- The wards had locked doors so young people were not able to leave at will. However, there was a sign visibly informing informal young people of their right to leave. There were 10 informal young people across the two wards.
- We observed young people being left locked behind doors with no way of summoning staff members. One young person was left in a lounge area with no way of summoning staff. We consider this could pose a risk to the safety of young people in the event of a fire or the need to evacuate the unit. It was also restrictive in terms of patient movement throughout the unit.
- Staff searched young people on returning to the ward after leave. This was to minimise the risk of contraband items such as sharps used for self-harm being brought into the unit. Young people were searched with a wand device to detect any concealed items prohibited in the unit. We asked to review the search policy staff operated within and we were told this was still in development. We were made aware of an incident where a female patient had been asked to remove their clothes and shake out their underwear during a search in March 2016. The search had been carried out by an agency staff member. During a governance team meeting observed during our visit the incident was discussed. At the time of this meeting the incident had not been reported as a safeguarding alert and the member of staff who undertook the search had not been identified. This was escalated during our inspection and a safeguarding referral was made relating to the incident.
- Staff were aware of safeguarding processes and had received training. The CAMHS service had a named safeguarding nurse lead who communicated with the local authority about issues on the wards.
- We were told bank and agency staff do not always have formal training on safeguarding. This was a potential risk.
- We found that the pharmacy team provided a clinical service to ensure people were safe from harm from medicines. The ward manager told us that the pharmacist was seen as part of the ward team.

# Are services safe?

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

- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This included medicines to take home on leave. This meant that young people had access to medicines when they needed them.
- We saw that pharmacy staff had made comprehensive records on the prescription charts to guide staff in the safe prescribing and administration of medicines. For example, reminding the prescriber when prescriptions should be reviewed, noting when blood tests were due and checking that the maximum dose was not exceeded, when a medicine was prescribed, both regularly and when needed.
- We looked at the prescription and medicine administration records for 13 young people. Young people's allergies were recorded and medicines were administered as prescribed. We noted that the child's height and weight were not routinely recorded on the charts but the pharmacist told us they were taken into account and doses were calculated in accordance with the British National Formulary for Children.
- On one occasion when an agency nurse was on duty, one young person gave someone else's name and was given the medicine prescribed for that person. We were told that where possible a member of staff who knows the young people would be involved in administering medicines, and that other measures, such as having a description of the person or including a photograph on the prescription chart were being considered. The ward pharmacist said she was involved in reviewing medicine related errors and helping the staff develop action plans. The review of medicine related errors were discussed in the weekly governance meeting at Brookside and staff were identified who may require additional training.

## Track record on safety

- There had been no serious incidents reported in the 12 months prior to our inspection.
- The unit had identified that a high number of incidents were in the early evening between the hours of 18:00 –

21:00. In response to this the unit had developed an evening schedule of activities. This had reduced the number of incidents during the evening in the months prior to our inspection.

## Reporting incidents and learning from when things go wrong

- Staff were knowledgeable about the incidents that should be reported and how to report them on an electronic record system, DATIX. However, we found a number of incidents in the care records of young people that should have been reported on the DATIX system. We cross referenced these incidents with information held on DATIX and they had not been reported. We were concerned that, despite staff knowledge of reporting incidents, there was under reporting of incidents. A review of the Brookside Quality and Performance meeting minutes, confirmed variable staff knowledge of what to log on DATIX had been raised as an issue on the agenda.
- We were told by staff that following incidents there was a de-brief for both the staff and young people. Staff told us they reflected on incidents. Incidents were discussed at daily risk meetings. The unit had also introduced daily safety huddles that were held in the morning and afternoon. The purpose of the safety huddle was to review each patient and discuss any emerging risks so all staff were aware. Staff told us this had assisted in the day to day monitoring of young people's risk.
- Feedback of incidents was done through daily risk meetings, weekly multi-disciplinary team meetings and in the weekly Brookside Quality and Performance meeting. There had been a recent incident where two young people had given an agency member of staff each other's details in order to be given each other's medication. The incorrect medication had not been administered but it acknowledged this was a potential issue. In response to this pictures of each young person were to be put on their medication charts. In the interim young people were to wear wrist bands to ensure correct identification.

# Are services effective?

Inadequate 

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

## Our findings

### Assessment of needs and planning of care

- Young people admitted to the unit were assessed within 14 days of admission. There was an admission protocol available at the unit.
- Physical health was monitored weekly or as necessary dependent on the needs of the young people. We saw evidence of the early warning score being completed at least weekly in patient records. Access to physical healthcare was through the ward doctors and then by escorting young people to the local hospital.
- Care plans that we scrutinised were not recovery orientated and in most cases did not reflect the young person's personal preferences, goals or views. Care plans we reviewed contained brief statements that were not holistic or recovery focused. They were more behaviour focused. One care plan we reviewed stated "I will be restrained". Care plans were basic and had minimal information regarding minimum restrictions on young peoples' liberty. There was little evidence of patient involvement in care or discharge planning.
- Staff stored care plans on an electronic system, RIO. Daily progress notes were completed within RIO. Only regular staff members had access to the RIO system. Due to the low numbers of regular staff on duty there was additional pressure on regular qualified staff to make entries in the care notes appropriately. During a night visit there was only one regular member of staff on Reeds ward and one on Willows ward. This meant that they were the only staff who could access the electronic care records. Staff told us that agency nurses would write up their notes on word documents and the regular staff member would then copy and paste into the relevant electronic records. We observed a staff member during our evening visit log into the system at 22:00 to complete their notes for the day. We were told they expected this to take one hour. The shift of that staff member was scheduled to finish at 21:00. Staff told us this was not an unusual occurrence.

### Best practice in treatment and care

- We found that staff on both wards followed NICE guidance when prescribing medication. However, the use of rapid tranquilisation did not follow best practice.

For repeated use the wards would be required to request a second opinion appointed doctor authorise its use on a T3 consent to treatment form. Young people are unable to give advanced consent and they would not have the capacity to consent to rapid tranquilisation in a crisis situation.

- There were not always enough permanent staff members on the ward to deal with a therapeutic environment. The ward ethos was containment rather than therapy. For example all doors within the unit were locked and young people had to ask staff remembers to move through the wards.
- Young people on both wards had input from psychology and offered therapies recommended by NICE, for example mentalised based therapy. Young people were able to access 1:1 time with psychologists.
- Physical health was monitored for young people on both wards on a weekly basis or as required. The wards used the early warning score. These were present in the records of young people. Access to physical health care was provided by the ward doctors.
- Clinical staff participated in clinical audits on both wards. For example there had been audits on missed doses, depression in young people, care planning and physical monitoring on discharge.

### Skilled staff to deliver care

- The multi-disciplinary team for both wards had a range of mental health professionals including nurses, psychologists, consultants and occupational therapists. A trust pharmacist visited the unit monthly to audit medicine stock.
- Staff we spoke with said they were scheduled to receive individual supervision approximately every four weeks. However, staff told us this was not always happening as regularly as every four weeks due to time pressures on staff. Between 1 September 2015 and 29 February 2016 an average of 55% of supervisions were completed. Staff knew who their supervision supervisor was. Staff told us they valued supervision and felt it was supportive when they received it. Staff we spoke told us they could speak with managers and their supervisor informally if required.

# Are services effective?

Inadequate 

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

- We were told by staff that some agency and bank members of staff at times were unskilled and bank staff have been put on prevention and management of violence and aggression training.
- Figures provided by the unit showed that 43% of staff on Reeds ward and 40% of staff on Willows ward had received an annual appraisal.
- There were regular team meetings. Staff we spoke with said they felt supported by the local management structure and colleagues. Ward managers were highly visible and available on the wards. Staff told us morale was generally good but at times it dipped due to the pressures of the unit and staff vacancy rates at times impacted on morale.
- As part of the Quality Improvement project at the unit a video had been made to be viewed by bank and agency staff. The video outlines the service and is intended to orientate new staff to the ward.
- Staff performance issues were monitored using the trust policy. There were no staff performance issues reported at the time of the inspection.

## Multi-disciplinary and inter-agency team work

- The multidisciplinary team met daily to review young people in risk meetings. There were also multi-disciplinary team meetings weekly. We observed a multi-disciplinary team meeting. It was well attended; detailed and holistic discussions took place. We observed a patient-centred and respectful approach. Risk and safeguarding concerns were discussed. All team members present were given the opportunity to contribute to the meetings and their views were listened to and valued by all in attendance.
- There were shift to shift handovers which contained a summary of the young people's presentation and risks. However, we observed a night shift handover where minimal information was provided and discussed. The handover was delivered by the qualified nurse who was the only regular member of staff. The handover was interrupted for a prolonged period of time by a restraint that culminated in intramuscular (IM) medication being administered. The majority of staff in the handover assisted with the restraint. The handover was also

interrupted by agency staff members who requested their time sheets to be signed off. The agency staff then left the unit as the handover continued past the shift finish time.

- Staff told us they involved young people's social workers in care programme approach (CPA) meetings. Staff also told us family members were also involved in CPA meetings.

## Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- At the time of our inspection there were five young people detained under the MHA and 10 informal young people at Brookside unit.
- In the records scrutinised there was evidence that young people were informed of their rights under section 132 on admission. However, the records provided no further explanation as to whether young people had understood their rights or had them given to them at intervals thereafter.
- Some documents relating to detention were available on the ward. However these were difficult to find and only two of the five patient records were found. We were told that records were uploaded to 'Windip', but staff could not access this during our visit. We were concerned that it would not be possible to transfer a young person to another hospital outside working hours without copies of the detention documentation being available.
- The nurse in charge of the ward provided receipt and scrutiny of documentation on admission to the ward; however, we could find no checklist for staff to complete this task. Documents were then sent to the mental health administration department for scrutiny and uploading to the 'Windip' system.
- Appropriate information about young people's rights under the Mental Health Act was not visible on the ward noticeboards. For example on the high dependency unit the noticeboard advertised a hospital manager's visit for 25 November 2011.
- A parent whose child was informal said that they wanted to discharge their child after a prolonged stay but they and their child felt the clinical team threatened them with the Mental Health Act if they tried to discharge.



# Are services effective?

Inadequate 

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

## Good practice in applying the Mental Capacity Act.

- No young people at the unit were detained under the Mental Capacity Act 2005 at the time of the inspection. The trust were compliant with the Mental Health Act in that no young people were detained under the Mental Capacity Act and since the Deprivation of Liberty Safeguards within the Mental Capacity Act apply only to individuals aged 18 years and over. We were told any application to deprive someone of their liberty between the ages of 16-17 years would be made directly to the Court of Protection
- Staff we spoke with did not have an understanding of Gillick competence. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. For children under the age of 16, the young person's

decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

- We did not see that staff recorded if children on the ward had been assessed for Gillick competency. There was also no evidence that staff considered any other authority for admitting the children and young people.
- We could not find evidence in the case notes that staff had assessed whether the children and young people had the capacity to consent to admission and treatment. This was important because not all of the young people were detained under the Mental Health Act and some were of an age where they were likely to be able (or be competent) to agree to admission and treatment.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- Young people we spoke with were generally positive about regular staff. However, some young people reported the high use of agency staff could disrupt the ward and often they were not introduced to agency staff members and did not know their names. Some young people told us that agency staff members were rude to them. We observed a mixture of interactions between staff members and young people. During our day visits staff were friendly and respectful to young people. At times we observed young people making requests to staff that could not be facilitated due to pressures on staffing.
- Young people and their families were not always treated with dignity, respect and supported. During an evening visit we observed a family in the reception area whose child was involved in an incident on the ward. The family were left in the reception area for a prolonged period of time. The family were not supported or provided with an update by staff. From the reception area the family could hear their child in a state of distress during the incident.
- Staff were not always responsive to young people. During visits in the day and the evening we saw staff failing to respond to young people attempting to gain access to the unit. For example, during our evening visit we observed a young person on the CCTV trying to regain access to the unit through the outside locked gate. A buzzer sounds in the nursing office when a person is trying to gain access through the front gate. A bank member of staff walked into the office, heard the buzzer and saw the young person trying to gain access and walked out of the office without allowing access to the unit. The nurse in charge, the only regular staff member on duty, eventually responded and opened the gate.
- We observed a young person leave their bedroom and attempt to use the toilet which was locked. The young person made no attempt to summon staff and returned to their bedroom. This was indicative of their view on the responsiveness of staff. The bedroom areas had two locked doors between them and the staff office. Our inspector waited and summonsed staff to alert them that the young person required access to the toilet. Staff were surprised the young person was in their room and thought they were elsewhere on the unit. The staff member did then facilitate the young person to access the toilet albeit with a lengthy delay.
- Staff focus appeared to be more concerned with controlling the environment to manage the levels of distress rather than addressing the individual needs of young people. We observed six young people in a bedroom corridor that was locked at either end. There were no staff observing the young people. Not all of the young people in the corridor had bedrooms in that area. One young person was in a distressed state being comforted by another young person. The member of staff escorting the inspector asked if the young person was ok, however they then focussed on the rules and asked the other young person to leave the distressed young person's bedroom. Our inspector asked to return to the office so that the member of staff could stay with the young person, however the staff member insisted on continuing to escort the inspector. Not wanting to cause any further distress to the young people our inspector waited until they were away from them before again asked for the staff member to go back and spend time with the distressed young person. We also saw young people sitting on the floor while they waited to gain access to the games room on Reeds ward.
- We observed situations where young people asked staff members to access drinks or toilet areas and staff informed young people they were too busy to assist. We observed a young person asking for a drink during our ward tour. The young person was on medication that would affect their thirst. The member of staff told the young person to ask someone else as they were busy. The young person stated they had asked other staff members who had all indicated they were too busy. The inspector asked to change the schedule of the tour to view the kitchen, so the young person could get a drink. The young person expressed surprise that the inspector would facilitate that request.
- Young people told us at times they felt unsafe at the unit. This was because of staffing issues and the acuity of other young people at the unit. Young people told us

# Are services caring?

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

they did not always receive patient protected time with their nurse due to time constraints. Staff told us patient protected time could be difficult as staff rotate between Reeds ward and Willows ward.

## The involvement of people in the care they receive

- A parent whose child was informal said that they wanted to discharge their child after a prolonged stay but they and their child felt the clinical team threatened them with the Mental Health Act if they tried to discharge.
- Young people we spoke to said they knew the names of the regular staff who looked after them. We were told by some young people they did not always know the names of agency staff members and were not introduced to them. Agency staff members did not wear name badges.
- A parent told us that they would not recommend the care to any other parent. There was very limited communication or feedback on how their child was progressing.
- The unit had developed a video to give new young people an overview and orientation when they arrived at the ward. New admissions could visit the unit before being admitted where possible. This helped new admissions to be shown the unit by staff members and answer any questions they had.
- Young people told us they had some involvement and participation in care planning and risk assessment. Young people attended CPA meetings. However, the care plans and risk assessments we reviewed were not holistic and goal orientated.
- There was an advocacy service available to formal and informal young people at the unit. The service attended the unit once a week for a period of two hours and offered a drop in service for young people. The unit also held an advocacy forum once per month. Staff and young people we spoke to knew how to access the advocacy service. Families of young people could also access the advocacy service.
- The unit held a weekly community meeting where young people helped to make decisions about the unit.
- We were told that patient representatives, who have used child and adolescent mental health services, were involved in the recruitment of new staff members. The representative took part in the interview panel.
- Young people were able to give staff feedback and there was a “you said, we did” board. This board identified suggestions that had been made by young people and the action the unit had taken to address the suggestions.
- Family therapy was offered within the care pathway. Family members were invited to CPA meetings and could visit the ward flexibly.



# Are services responsive to people's needs?

Requires improvement 

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

## Our findings

### Access and discharge

- Bed occupancy levels for the unit were 70%. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by young people.
- Commissioners were not always aware of the acuity of the patient group. Brookside mainly admitted young people locally from community child and adolescent mental health services within the trust. Commissioners were meant to be notified about an admission and the level of assessed need. However this was not happening regularly and the trust had been requested to address this process.
- The service was not always responsive to young people identified externally as needing their service. For example, a young person in a low secure service had been identified as requiring a move closer to home in a step down to a generic unit as part of their discharge pathway. Despite Brookside being identified as the closest unit to home, the clinical team did not respond to communication from the low secure unit or community teams. After five weeks it took the intervention of the CAMHS case manager to instruct the service to take the young person within one week.
- Staff we spoke to told us that young people were able to return to their bedrooms after coming back to the ward from leave. This meant that the ward did not admit new young people to beds that belonged to young people who were on leave.
- Young people were discharged during the week and not during the weekend. However, there was little evidence in the care records of the plans being put in place to effect discharge.

### The facilities promote recovery, comfort, dignity and confidentiality

- Young people had access to a range of treatment and activity rooms, including a gymnasium, both on and off the wards. All activity and treatment rooms were located within the unit.
- The Willows ward was a stark and unappealing environment. Bedroom windows in the Willows ward

did not have curtains or blinds and this impacted on the privacy and dignity of young people. All doors were locked within the unit and young people had to rely on staff members to move throughout the unit. We observed young people unable to summon staff members to assist them moving between different areas of the unit and being left behind locked doors.

- There was a visitor room located off the wards. The room was in an old converted reception room and had glass walls surrounding it. The room did not offer much privacy or sound proofing when young people had visitors. We spoke with a parent of a young person who felt the visitor room was quite disruptive to visits due to its location and sound proofing.
- Young people did not have access to mobile phones. There was a public phone on the ward. Young people could use the office phone if they needed to make a phone call. Young people carried the office phone to a private area when they made personal calls.
- There was a secure garden for young people to access when accompanied by staff members. Young people were risk assessed before using the garden area.
- Young people told us the food was of poor quality and the menu choice available was not varied enough. Cultural and religious foods, including halal, were not available at the unit. Hot and cold drinks were not available at all times as facilities to make drinks were behind a number of locked doors. We observed a young person asking for a drink who was told by a staff member they were too busy to assist with the request.
- Reeds ward had a quiet room, however this was locked off. The TV lounge was small for the number of young people using it and although the games area was a large space we only saw limited use during our evening visit.
- Young people had access to education five days per week in the education unit located next to the ward. The head master attended weekly multi-disciplinary team meetings and daily risk review meetings.
- Young people told us they were generally happy with the range of activities available. An evening programme of activities had been introduced following the unit identifying a high number of incidents occurred during evening hours. This had helped to reduce the number of incidents during the evening.

# Are services responsive to people's needs?

Requires improvement 

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

- Patient bedrooms on Willows ward were bare and not personalised. Staff told us that young people were allowed to personalise their bedrooms but rooms on Willows ward were not.
- The unit was on the ground floor with wheelchair access and had disabled bathrooms.

## Meeting the needs of all people who use the service

- Staff received training in equality and diversity as part of their mandatory training. We reviewed training records and found that 89% of staff had completed the training within the last year. However, only 71% of staff on the Willows ward had received the training compared with 93% of staff on Reeds ward who had received the training.
- All young people on both wards spoke English as their first language. Staff told us that interpreters were available on request should they be required. The hospital utilised an interpreter for British Sign Language to assist with a young person who was deaf.
- Leaflets were not available in a range of languages on the ward. However, we were told versions in different languages were available on request.

- Choices of meals were available. However, young people reported they were often childish options and had suggested alternative meals in community meetings.

## Listening to and learning from concerns and complaints

- Information about how a young person could complain was clearly displayed on the ward noticeboards. Young people we spoke with felt confident that they could raise a complaint, however, some young people reported there was little point as complaints were not addressed sufficiently. Staff were aware of the complaints management process for and told us that they would initially try to remedy complaints locally. If the staff were not able to remedy a complaint they stated it would be escalated to the ward manager.
- Between 1 September 2015 and 29 February 2016 there had been six complaints received by the Brookside unit. One complaint was upheld.

# Are services well-led?

Inadequate 

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

## Our findings

### Vision and values

- Staff we spoke with were aware of and agreed with the Trust's visions and values. There were posters throughout the unit about the Trusts values.
- Staff we spoke with were aware who the senior managers in the Trust were. Staff were not aware of any recent visits of senior management to the unit.

### Good governance

- The unit held a weekly Quality and Performance meeting. The agenda items included discussion of complaints, risks, audits and assurance, safeguarding, staffing and incidents.
- Staff were not up to date with all of their mandatory training. We found 79 % of staff had completed all mandatory training. However, five of the 15 mandatory training areas had training rates of below 75%.
- Staff were not receiving regular supervision or appraisal.
- We found shifts were not always covered by a sufficient number of staff with the right level of experience.
- Regular staff members were under pressure due to staffing levels and we were told that young people were not always able to receive patient protected time. We also observed that regular staff members were required to enter information into the care records on behalf of agency staff who could not access the RiO system.

### Leadership, morale and staff engagement

- Staff told us that working at the unit had been very challenging over the past 18 months. Staff told us the wards were generally unsettled and there were high levels of restraint and IM medication use. Staff questioned whether some of the young people were appropriately placed and felt this was related to difficulties at the unit. Staff also told us the high vacancy rate had impacted the unit. Staff told us that since new ward managers and a modern matron had come into post at the end of 2015 things were beginning to improve.
- At the time of our visit there were no ongoing grievance procedures, allegations of bullying or harassment at the unit.
- Staff reported they were aware of the whistle blowing process and how to use it if required.
- Staff told us they were able to raise any concerns they had about the unit without fear of victimisation.
- Staff demonstrated that they were motivated and dedicated to the patient group. However, staff we spoke to felt the high vacancy rate could impact on the care they were able to deliver. Staff morale was generally satisfactory, however, it was reported morale could be effected by staffing concerns. Staff felt pressure at times due to staffing concerns.

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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Diagnostic and screening procedures	<b>Patient bedrooms on Willows ward did not have curtains or blinds on the windows</b>
Treatment of disease, disorder or injury	Young people's bedrooms were bare and not personalised.
	The family visiting room provided little privacy for young people and their visitors
	This is a breach of Regulation 10 (1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Diagnostic and screening procedures	<b>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</b>
Treatment of disease, disorder or injury	Regulation 13: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	Safeguarding service users from abuse and improper treatment
	Bank and agency staff did not always have formal training on safeguarding.

This section is primarily information for the provider

## Requirement notices

Blanket restrictions and restrictive practices were in place throughout the unit. All internal doors were magnetically locked. Young people were required to ask permission to move from one area of the unit to another at all times and needed to be escorted by staff who could open doors with key fobs. The locked doors meant patient movement was excessively restricted and affected their dignity.

This is a breach of Regulation 13 (2) (4) (a) (b)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

**Young people told us food was of poor quality and the menu choice available was not varied enough. Cultural and religious foods, including halal, were not available at the unit.**

This is a breach of Regulation 14 (4) (a) (c)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing  
**Brookside unit had 58% staff vacancies.**

During our unannounced visit to the unit on the evening of 14 April 2016 there was only one regular member of staff on duty, the nurse in charge, with one agency nurse and four healthcare assistants who were a mixture of bank and agency. The qualified nurse in charge was clearly under pressure and had to make all decisions regarding the safe running of the unit. On the high dependency unit it was a similar picture of one qualified

This section is primarily information for the provider

## Requirement notices

nurse who was the only regular member of staff and five health care assistants who were also a mix of bank and agency. This was one member of staff less than their numbers.

During the afternoon of April 7th 2016 the unit was down by three staff members.

Review of staff rotas showed numerous occasions when shifts were not filled sufficiently.

Staff supervision was not being regularly undertaken.

Only 43% of staff on Reeds ward and 40% of staff on Willows ward had received an annual appraisal.

This is a breach of Regulation 18(1)(2)(a)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Under reporting of incidents. Incidents found in progress notes on RiO which had not been reported on DATIX. Inspectors found information in progress notes that would meet the threshold for being reported as an incident. When compared against data in the DATIX system such incidents had not been reported

Staff use a wand device to search young people. The search policy is not in date. Incident reported during inspection visit of a young person being asked to remove clothes and then shake out underwear.

This is breach of Regulation 17 (2)(a)(b)

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

**Regulation 11 HSCA (RA) Regulations 2014**

**Need for Consent**

Regulation 11: Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

**Need for Consent**

Capacity and Consent to treatment. There were high levels of restraint and IM medication being used. We were told parental consent was sought for young people. We found limited evidence of this within the young people notes or no evidence of the use of Gillick competence. In patient care plans we found statements such as "I may be restrained".

This is breach of Regulation 11

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Care plans were not recovery orientated and in most cases did not reflect the young people's personal preferences, goals or views. Care plans we reviewed contained brief statements that were not holistic or recovery focused. We reviewed 13 care records.

Risk assessments were sparse and not personalised. They did not contain historical information about young people.

This is a breach of Regulation 9(1)(a)(c), 9(3)(a)(b)(d)(f).

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Section 29A HSCA Warning notice: quality of health care
Diagnostic and screening procedures	Furnishings were damaged and the décor was dated and in poor quality. The ward was dirty and no evidence of regular cleaning. In particular the dining area and visiting area in the high dependency unit. The visiting area had a stained carpet that had not been hoovered in some time. Cupboards in the room were broken and not fixed with a staff fridge in the corner and electrical plant equipment on the wall that was not boxed in.
Treatment of disease, disorder or injury	Ward layouts do not allow good observation of young people. Blind spots throughout the ward and no convex mirrors. Ligature points in disabled toilet on Willows (HDU)
	Poor cleanliness throughout Reeds ward and the Willows (HDU). Ripped chairs in dining area of Willows ward, with exposed foam, posing infection control risks.