Partnerships in Care Limited

Kent House 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?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Kent House Hospital is a low secure independent hospital in the London borough of Bromley. It provides care and treatment to female children and adolescents with severe mental illness and additional complex behaviour.

We rated each key question as follows: safe as inadequate, effective as requires improvement, caring as good, responsive as requires improvement and well led as requires improvement.

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

- The service did not have enough staff who knew the young people. There were 10 vacancies for registered nurses and 12 vacancies for non-registered nurses. The ward manager often stepped in to cover shifts when they were short staffed. The service used a high number of bank and agency staff. Some incidents that involved violence and aggression identified use of bank and agency staff as a factor. Young people felt there was no consistency with frequently changing staff in how rules were consistently applied.
- Ongoing vacancies for a clinical psychologist, social worker, occupational therapist and hospital director meant that some of the required specialists needed to meet the needs of young people were locums and changed frequently, which impacted upon consistency of care.
- Staff did not keep up to date with basic training to keep people safe from avoidable harm. Overall, mandatory training compliance for registered nurses fell below the provider's 85% target. For example, Infection control, fire safety and the Mental Health Act. Managers did not ensure staff received specialist training for their role. Nursing staff had not received training in working in child and adolescent mental health services.
- Staff did not consistently record physical health checks. Some staff were not familiar with the Paediatric Early Warning System (PEWS) used by the provider to monitor physical health. There was a risk that staff could not safely identify when a young persons' physical health was deteriorating.
- The ward environment required improvement. The service's physical examination room was not clean. Staff did not consistently record the temperatures of the fridge in the clinic room. Some environmental risk assessments were not up to date and some bedrooms were not fitted with alarms.
- Improvements were needed in the reviewing of medicines incidents and devising treatment plans in relation to some medicines.
- Managers did not share lessons learnt with the whole team. Staff did not meet to discuss feedback and look at improvements to young people's care. Staff could not provide examples of where they had learnt lessons after an incident.
- Improvements were needed to ensure that appropriate reviews took place for one young person being nursed in long term segregation. The service did not meet the needs of all young people – including those with a protected characteristic. Staff needed to improve how they supported young people with their gender identity.
- Staff were not responsive to young people's feedback. Young people complained that they were often bored at weekends and during the evenings. This had been raised in the community meetings and to us during the inspection. Whilst there were plans for additional staffing to address this need, they were not yet in place.
- Staff did not always feel respected, supported and valued. The provider did not promote equality and diversity in daily work or provide opportunities for development and career progression. Staff did not always feel they could raise any concerns without fear.
- Our findings from the other key questions demonstrated that governance processes needed strengthening and that performance and risk management needed further embedding across the hospital. Staff did not keep an up-to-date risk register and action plan to reflect all the risks of the service. Staff did not complete audits of good quality and address the improvements needed.

Summary of findings

However:

- Whilst the inspection identified concerns about the safety and quality of care of young people, senior managers within the hospital were aware of these. Senior managers were working with local stakeholders to develop and implement action plans to improve the service and keep children and young people safe.
- The service had limited the number of young people they were caring for to ensure the service was safe whilst improvements were made.
- Care plans were personalised, holistic and recovery orientated. Staff used the positive behavioural support (PBS) model to understand young people behaviours which challenge. The multidisciplinary team and young people contributed to their PBS plans.
- Staff had made improvements to outside space for young people. The courtyard had a gym, basketball court and gardening area with plants and flowers.
- Most staff treated young people with dignity and respect. Young people said staff treated them well and behaved kindly. Young people specifically praised the support of the occupational therapist. Staff supported patients to understand and manage their own care treatment or condition. We observed staff interacting with patients in a thoughtful way.
- Staff made sure young people had access to high quality education throughout their time on the ward. The on-site school was registered with Ofsted and rated as 'Outstanding' at their last inspection in June 2021. Staff encouraged young people to attend school, and this was part of their recovery journey. The teaching staff were involved with young people's care and treatment at the hospital.
- Staff helped patients to stay in contact with families and carers. The service had a purpose-built bungalow for parents and carers to use when visiting. The young person could also stay with their family in the bungalow if it was suitable for them to do so.
- Whilst there had been changes in the leadership of the service, staff and parents reported that improvements had been made since the interim hospital director had been in post. These improvements included communication and a reduction in incidents of violence and aggression from young people.

Following the inspection we issued the provider with a warning notice due to the serious nature of the concerns we found on inspection. We asked the provider to take immediate action. We issued the provider with a warning notice because we were concerned the service did not have enough staff who were adequately trained to keep young people safe. The service needs to address this by 11 May 2022.

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 	

Summary of findings

Contents

Summary of this inspection

Background to Kent House Hospital

Kent House Hospital is in Orpington in Kent and is one of the hospitals of Partnerships in Care Limited. The hospital is registered to provide the following regulated activities:

• Assessment of medical treatment for persons detained under the Mental Health Act 1983.

• Treatment of disease, disorder or injury.

The service provides low secure services to female children and young people aged 12 to 18 with mental health issues. The unit admits young people who frequently have complex needs and exhibit a high level of self-harming behaviour. The unit has 17 beds split across two wings. Previously, one wing was a rehabilitation wing, and the other was an acute care wing. However, at the time of our inspection both wings were providing acute care.

At the time of our inspection, the hospital had voluntarily paused admissions due to concerns around some quality issues, identified by themselves and commissioners. These were due to the gaps in reporting safeguarding concerns in a timely way, staffing and lack of leadership.

The hospital had developed an action plan to address these issues. From April 2022, the hospital planned to start increasing the number of admissions gradually, to full capacity by October 2022.

We previously inspected this service during June 2019. We rated the service as good overall.

On the day of our inspection, there were 10 young people receiving care at the hospital across the two wings – Pacific and Atlantic. At the time of our inspection, eight young people were being cared for on Atlantic ward and two young people were being cared for on Pacific. On Pacific one young person was being nursed in long-term segregation and the other young person was in isolation after testing positive for COVID-19. All young people were detained under a section of the Mental Health Act 1983.

At the time of the inspection, there was no registered manager in place. The service had appointed an experienced interim hospital director who was applying to become the registered manager of the service.

What people who use the service say

We spoke with five young people and their families. We received mixed feedback from young people about the quality of care they received. Young people said staff treated them well and behaved kindly. Young people specifically praised the support of the occupational therapist.

Most of the negative feedback we received was about the issues with staffing and the night staff always changing, which could be unsettling. Young people felt there was no consistency with frequently changing staff in how rules were consistently applied.

Four young people said they were given a copy of their care plans. One young person said that they needed to ask staff for a copy of their care plan, it was not offered to you.

Summary of this inspection

Young people liked the quality of the food.

After the inspection, we asked the provider to supply us with the young peoples' most recent satisfaction survey results. However, they could not provide these results for us to analyse.

How we carried out this inspection

The team that inspected this service consisted of two CQC inspectors, one Mental Health Act reviewer, a CQC pharmacist specialist and a specialist advisor who had experience working in children and adolescent low secure mental health services.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interactions.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for patients
- spoke with five young people who were using the service
- spoke with four family members of those using the service
- spoke with 14 members of staff including, the interim hospital director, interim director of clinical services, team leads, nurses, healthcare assistants, a mental health act administrator, a clinical psychologist, a consultant psychiatrist, a specialty doctor and an independent advocate
- attended a handover meeting and one young person's ward round discussion
- reviewed four patient care and treatment records.
- checked how medication was managed and stored, including reviewing nine prescription charts
- reviewed five staff records
- reviewed information and documents relating to the operation and management of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

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 they always deploy enough suitably skilled, qualified, competent and experienced staff. **Regulation 18(1)**

The service must ensure that staff complete mandatory training to safely support young people. The service must ensure that staff receive specialist training to help them effectively support young people. **Regulation 18(2)(a)**

The provider must ensure the systems in place to assess, monitor and improve the quality of service are effective and embedded into the service. **Regulation 17 (1)(2)(a)(b)**

The provider must ensure they effectively support staff to help increase morale. The service must ensure they monitor and reduce the risks relating to the welfare and safety of staff. **Regulation 17 (2)(b)**

The service must ensure that information about patients' physical health care is recorded accurately so that it can be followed up quickly when concerns are identified. **Regulation 12 (1)(a)(b)**

The service must ensure that young people can access a working call system from their bedrooms to enable them to alert staff to their need for support. **Regulation 12 (1)(a)(b)**

The service must ensure they have robust systems in place to ensure staff learn lessons from safety incidents. **Regulation 12 (1)(a)(b)**

The service must ensure that staff effectively review young people subject to long-term segregation and update this in their care plans. **Regulation 9 (1)**

The service must ensure they provide young people with activities at weekends and evenings. **Regulation 9 (1)**

The service must ensure they meet the needs of young people in relation to their protected characteristics. The service must ensure that young peoples' protected characteristics are considered in their care planning, for example, use of language when referring to young people's gender identity. **Regulation 9(1)**

Action the service SHOULD take to improve:

The service should review individual treatment plans to ensure that staff have enough guidance to assist them in deciding which formulation of PRN medication to administer.

The service should review how medicines incidents are managed.

The service should ensure all environmental risk assessments are up to date.

Summary of this inspection

The service should ensure they keep the physical health examination room clean.

The service should ensure the seclusion room complies with the Mental Health Act Code of Practice to maintain privacy and dignity.

The service should ensure staff record they have checked and maintained the fridge temperatures in the clinic room.

The service should ensure they have a robust process in place for managing the high usage of bank and agency staff.

The service should ensure that nursing staff receive effective supervision, and this is appropriately monitored.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Improvements were needed to the environment. The service was not always clean, well equipped and well maintained. Some environmental risk assessments were not up to date and some bedrooms were not fitted with alarms.

Safety of the ward layout

The layout of both wards did not always allow for clear lines of sight in every area. Staff could not observe patients in all parts of the wards. Staff managed the risk of blind spots through regular safety checks, convex mirrors, observations and engagement with patients. There was closed circuit television (CCTV) monitoring in communal areas, corridors and young people's bedrooms but not in their ensuite bathrooms. This was monitored remotely by nurses who immediately contacted the unit to inform them if a young person was at risk of harm. Young people and parents confirmed that they were given written and verbal information about the CCTV.

Staff carried out risk assessments of the care environment including an up-to-date ligature risk assessment to manage and reduce the risk of ligature points. The ligature risk assessment clearly outlined the ligature risk and how staff should mitigate these risks.

However, not all environmental risk assessments were up to date. The wheelchair risk assessment was due to be reviewed in October 2021, but this had not been done. Staff had completed a COVID-19 risk assessment, but this had no date on it. This meant that staff may not be able to manage the environmental risks to young people.

Staff had easy access to alarms, but not all young persons' bedrooms had working nurse call systems. Staff used radios to raise the alarm in the emergency. However, if a young person wanted to seek assistance in an emergency when in their bedroom, the nurse call bell might not work. The ward manager said that staff managed this through one-to-one observations so staff were with young people should they need to raise the alarm.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The provider had taken steps to reduce the number of ligature points on both wards, by fitting bedrooms and bathrooms with anti-ligature fittings such as collapsible curtain rails and anti-ligature door handles. Staff were aware of the ligature cutters and where to access them.

Maintenance, cleanliness and infection control

Staff did not always ensure the premises were clean. The physical examination room was unclean. For example, equipment was covered in dust, staff had not used clean stickers to show that it was clean, and the dustbin was overflowing. Staff used this room to carry out physical health checks and investigations on young people such as administering nasogastric feeding. Staff did not keep cleaning records to ensure that this room was cleaned regularly. We raised this with the provider immediately who said they would clean it straight away.

Staff followed infection control and COVID-19 policies. Staff always wore face masks and were required to complete COVID-19 lateral flow tests daily. The service ensured all staff had negative tests before they entered the ward to minimise the spread of infection.

Seclusion room

The service had two seclusion rooms on each ward. The seclusion rooms did not fully comply with the Mental Health Act Code of Practice. Whilst both rooms allowed clear observation, the seclusion room on Pacific Ward did not allow for two-way communication. On Atlantic Ward, the seclusion room bathroom did not allow for a young person's privacy and dignity. The mirror in the bathroom was placed directly opposite the observation panel. This meant that staff could see if a young person was sat on the toilet. Both rooms had a toilet and a clock. The interim hospital director said they had plans to refurbish the wards and improve the seclusion rooms facilities.

Clinic room and equipment

Staff did not always check and maintain clinic room equipment. Staff did not always check the temperature of the fridge in the clinic room to ensure medicines were stored at the right temperature. We checked the fridge temperature for the months of October 2021 - January 2022 and found gaps in staff recording of the fridge temperatures. For example, in the month of December staff did not record that they checked the temperature for over a week. This meant that staff did not ensure that medicines were stored at a safe temperature.

The clinic rooms had emergency equipment including oxygen masks and tubing. This was contained in an emergency response bag, which staff kept sealed to prevent interference between checks. Staff regularly checked the resuscitation equipment and emergency drugs.

The clinic room was clean, spacious and included handwashing facilities.

Safe staffing

The service did not have enough nursing and medical staff who knew the patients. Staff did not keep up to date with basic training to keep people safe from avoidable harm.

Nursing staff

Requires Improvement

Child and adolescent mental health wards

The service did not have enough nursing and support staff to keep patients safe. The service had a high number of vacancy rates. The ward had an establishment of 14 whole time equivalent registered nurses and 52 non-registered nurses working. There were 10 vacancies for registered nurses and 12 vacancies for non-registered nurses at the time of the inspection. These vacancies had been covered by locum, bank and agency staff.

Staff and young people said staffing was the biggest problem and a considerable number of vacancies remained unfilled. The ward manager often stepped in to cover shifts when they were short staffed. This took the manager away from carrying out their role and responsibilities to run the ward safely. Young people reported there being no consistency with staff – particularly the night staff changing so often.

We reviewed the incident reporting system to check the number of incidents reported relating to short staffing. From the period 1 November – 19 January 2022 staff had reported 16 incidences where the location was short staffed. One incident report stated that a young person had assaulted staff because there was not enough staff on shift.

Four staff expressed concerns about the levels of staffing. These concerns included the shifts sometimes being short staffed and that retention of permanent and agency staff was poor. We reviewed the clinical governance meeting minutes for the month of December 2021. A staff member expressed concerns around staffing and commented that 'there are not enough nurses and there is a lot of pressure on nurses and deputies.'

The service had a high usage of bank and agency nurses and nursing assistants to cover staff vacancies. We reviewed the 'staffing establishment vacancies' for the months October and November 2021. This showed that in October, 75% of the staff used by the provider was bank and agency. In November, 60% of the staff used by the provider was bank and agency. There was not a robust system in place to regularly monitor the use of temporary staff and to manage the risks associated with high numbers of bank and agency staff working with young people.

We checked the nursing staff rotas for the period 3 January – 21 January 2022. We reviewed these rotas, particularly looking at the night shift. On 4 January all nursing staff on the night shift were either bank or agency. On 5 January three out of 12 staff on the night shift were permanent staff. On 6 January two out of the 12 staff on the night shift were permanent staff, with one of these being off sick. On 7 January one out of 10 staff on the night shift was permanent. This was a risk to young people as it did not ensure continuity of care.

Managers did not always support staff who needed time off for ill health. Staff reported incidents of young people assaulting them. This sometimes led to staff leaving work early to seek medical treatment and taking time off for ill health. The provider had not paid for sickness absence before December 21. Subsequently, the interim hospital director ensured staff were paid when they were off sick. This had improved staff wellbeing.

Levels of sickness were high but had recently started reducing. For the months of November and December staff sickness was high due to COVID-19 and assaults on staff from young people. By January this had improved with the levels of assaults on staff reducing.

The ward manager requested staff familiar with the service and made sure all bank and agency staff had a full induction to understand the service before starting their shift. New staff read and completed an induction booklet containing policies and important information about the service. Staff signed to confirm they had completed it with the nurse in charge.

Requires Improvement

Child and adolescent mental health wards

At the time of our inspection there were 16 nursing and support staff allocated to the day shift to support with the four young people who were on close observations. The manager used the provider's 'staffing ladder' to calculate the number of staff needed for each shift.

Patients had regular one to one sessions with their named nurse. Young people rarely had their escorted leave even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients 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. The hospital had one locum consultant psychiatrist and two specialty doctors working during the daytime. For night-time cover, the specialty doctors shared the on-call duty rota with a doctor working at another hospital site. The on-call doctors were available over the telephone. Managers said the telephone on-call system worked for the hospital and provided enough assistance in an emergency.

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 not completed and kept up to date with their mandatory training. Overall, registered nursing staff had completed 63% of their mandatory training and non-registered had completed 77% of their mandatory training. This was below the provider's target of 85% compliance.

Courses that registered nurses had low compliance rates in, included Infection control (33%), fire safety (50%) and the Mental Health Act (33%). This was a risk to young people because staff did not complete basic training to keep them safe.

Mandatory training included safeguarding children, reducing restrictive intervention breakaway, basic life support and health and safety.

Managers monitored mandatory training and alerted staff when they needed to update their training, however there was not always protected time for staff to attend their training courses.

Assessing and managing risk to patients and staff

Improvements were needed in the monitoring and recording of young people's physical health.

However, staff 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. Staff assessed and managed risks to young people and themselves.

Requires Improvement

Child and adolescent mental health wards

Assessment of patient risk

We reviewed four young people's risk assessments. Staff completed risk assessments for young people on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a recognised risk assessment tool. Risk assessments included a patient's physical, mental and social risk history.

Management of patient risk

Improvements were needed in how staff monitored and recorded young people's physical health. Three young people's physical health records showed gaps in the recording of their vital signs and scoring. For one young person they were only completed on sporadic days. In addition, for one young person who needed weekly weighing, staff did not always record they had weighed the young person

Staff did not use a recognised early warning scoring system to help identify a deterioration in a young person's physical health. We raised this with the provider who said that staff should be using the paediatric early warning score (PEWS) to ensure prompt escalation of potential physical health problems.

However, staff knew about risks to each patient and acted to prevent or reduce risks. Staff, including the multidisciplinary staff, attended daily handover meetings where each young persons' risk level was discussed. Staff formulated risk management plans with young people to help reduce their level of risk. Due to the nature of the self-harming incidents on the wards staff developed positive behavioural support plans with the young people to include their early warning signs, triggers and what staff should do if the situation escalates.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff updated young people's risk assessments each week at the MDT meeting and after an incident had occurred. Education staff held daily risk management meetings to ensure that young people felt safe enough to attend education classes or whether they needed one-to-one support.

The interim hospital director told us about plans they had in place to introduce a new risk management tool to help minimise the risks of young people self-harming. This tool included what events and/or feelings happened before and after the risk behaviour. This tool would help support staff and young people to reduce risk incidents but implementation hadn't started at the time of the inspection

Staff monitored patients who received food and hydration through a nasogastric tube. Staff completed a litmus test, which checked whether the feeding tube had been inserted correctly, before nasogastric feeding. If the tube is inserted incorrectly this could be fatal. We checked the previous months record for a young person who was receiving nasogastric feeding. On each occasion, staff had recorded the results of the litmus testing. This ensured the safety of the nasogastric tube.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff followed the provider's policy and procedures when carrying out observations. The multidisciplinary team assessed the level of observation patients required. All young people were observed every 15 minutes or subject to random checks four times every hour. Four young people were subject to one-to-one observations as they had a high level of risk. This was to reduce the risk of harm to themselves or to others.

Staff followed the providers' procedure to search young people or their bedrooms to keep them safe from harm. Young people were searched when they returned from leave. This took place in a private room at reception.

Requires Improvement

Child and adolescent mental health wards

Use of restrictive interventions

Staff worked hard to reduce the levels of restrictive interventions used. The interim hospital director had implemented a new strategy to managing violence and aggression, including more robust de-escalation techniques. This had started to reduce the number of incidents of violence and aggression.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff received training in reducing restrictive intervention breakaway to prepare them for physical restraint. For the month of December 2021 there had been 59 incidents involving physical restraint. These restraints were low-level holds and mostly attributed to two young people. Staff did not restrain young people in the supine or prone position. Staff used safety pods to support with de-escalation.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff met quarterly to review restrictive interventions. However, staff had not met in October due to their being no senior management available.

There had been no use of rapid tranquilisation in the last 12 months.

When a patient was nursed in seclusion, staff kept clear records and followed best practice guidelines. Staff did not seclude young people for more than a few hours. We checked the seclusion records for 2021, no young person had been secluded for more than eight hours. Most records for episodes of seclusion clearly documented the rationale, date and time of commencement and termination. However, one seclusion record for a young person did not clearly document the rationale of why they were in seclusion.

Safeguarding

Staff understood how to protect patients from abuse and the service had made improvements on working 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. All registered nurses had completed training in how to recognise abuse in children and 89% of un-registered staff had completed it. Staff also received training in how to recognise abuse in vulnerable adults.

The service had made improvements in their reporting of safeguarding concerns since October 2021.

The service had a safeguarding lead to support staff in protecting young people from abuse. The lead was the social worker. As this post was vacant at the time of our inspection, it was being covered by the ward manager. A log of all safeguarding concerns raised within the hospital was maintained by the lead.

Most staff knew how to recognise children at risk of or suffering harm and worked with other agencies to protect them. For example, staff had reported an incident of abuse where a young person had suffered harm. Another example was where staff had reported a safeguarding alert after an inappropriate restraint on a young person.

Staff followed safe procedures for children and adults visiting the wards. The visitor's room was located off the reception area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Between the months of March – December 2021 there had been 39 reported incidents of alleged abuse. These included incidents where young people had swallowed objects and attended accident and emergency.

Managers took part in serious case reviews and made changes based on the outcomes. For example, managers attended strategy meetings at the local authority for serious allegations of abuse.

Staff access to essential information

Staff did not always have easy access to clinical information, so it was difficult for them to maintain high quality clinical records – whether paper-based or electronic.

Young people's notes were not always comprehensive and could not always be easily accessed. The service used a combination of electronic and paper records, which were not always up-to-date and complete. For example, the rationale for prescribing clozapine had not been updated in a young person's care plan. When we asked for staff to find this information for us it was difficult and lengthy.

Electronic care notes were kept in two different electronic systems. This meant that staff had to search on two different systems to check young people's records were complete. When we asked for certain parts of a young person's care records staff could not always find it promptly. For instance, when we asked to see a young person's long-term segregation care plan and review this could not be found.

The manager supported bank and agency staff to access the electronic system.

Records were stored securely.

Medicines management

Improvements were needed in the reviewing of medicines incidents and devising treatment plans in relation to some medicines.

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

Staff did not always review each patient's medicines regularly and provide advice to patients and carers about their medicines. We reviewed four young peoples' care plans for medicines. In one young person's care plan we found that staff had not recorded the rationale for prescribing intramuscular rapid tranquilisation in line with the provider's policy. In another care plan, we could not see the rationale for prescribing clozapine to a young person.

Staff did not learn from safety alerts and incidents to improve practice. The pharmacist conducted medicines audits to log medicines incidents. However, there was no record of action taken and shared learning amongst the staff to prevent medicines incidents reoccurring.

We looked at nine prescription charts. These were screened by an external pharmacist on a weekly basis. Staff recorded progress notes on an electronic system. Staff ordered medicines from the external pharmacy, who dispensed them and delivered them to the hospital by the next working day. If medicines were required out of hours, staff could send prescriptions to a local community pharmacy. Staff appropriately restricted access to the medicine's storage areas.

Staff completed medicines records accurately and kept them up to date. Staff had pictures of consenting young people with the drug charts to assist in identifying them. Staff initialed the prescription charts to show that medicines were administered as prescribed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Information relating to medicines were sent prior to young people being admitted to the hospital. Doctors used this information to prescribe medicines and write the drug chart. Nurses checked this information for discrepancies prior to giving medicines. When the pharmacist attended the ward, they also conducted medicines reconciliation.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us that giving medicines for managing aggression and agitation was a last resort. There were positive behaviour plans in place. If medicines were given, oral medicines were offered first before intramuscular medicine.

Staff reviewed the effects of each patient's medicines on their physical health according to best practice guidance. Doctors took bloods and accessed blood results to assist with the monitoring of clozapine. When patients were admitted, an attempt was made to take baseline blood and electrocardiogram (ECG) readings. Monitoring was attempted periodically in line with best practice.

Track record on safety

Reporting incidents and learning from when things go wrong

Managers did not share lessons learnt with the whole team. Staff did not meet to discuss the feedback and look at improvements to young people's care.

However, staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave young people honest information and suitable support.

We spoke to seven nursing staff. Staff could not give examples of where they had learned lessons from incidents. In addition, we reviewed the minutes for the staff meetings for the months August – December 2021. These did not show any learning from incidents reported. Staff discussed shared learning in the December clinical governance meeting, however nursing staff did not attend this. Learning had not been cascaded into the staff meeting.

Managers did not always investigate incidents thoroughly. The ward manager investigated less serious incidents on the provider's electronic system. However, the manager still had several outstanding reports to investigate. This meant incidents were not always investigated in a timely way to improve young people's safety.

The serious incidents were investigated by senior management. For example, an incident regarding inappropriate physical restraint on a young person.

Staff knew what incidents should be reported and where to report them. Staff reported incidents on the hospital's electronic reporting system. Incidents included self-harm, physical restraint and violence and aggression. For the period June – December 2021, staff had reported 1,211 incidents. Most of these incidents reported were related to short

Requires Improvement

Child and adolescent mental health wards

staffing, self-harm, violence and aggression and infection control. A number of incidents were attributed to two complex young people. The hospital director said incidents were high because staff reported all incidents that they should be reporting. The hospital director said small improvements had been made to incidents of violence and aggression and they were starting to reduce.

Staff reported serious incidents clearly and in line with provider policy. For the month of December 2021 staff had reported three serious incidents. All of these were in relation to self-harm with one being in relation to a swallowing incident. Investigation reports included situation, background, action and review (SBAR) to support staff to complete investigation reports.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if things went wrong.

Managers debriefed and supported staff after any serious incident. Staff reported that they debriefed after incidents. The interim hospital director had introduced the antecedent, behaviour, consequence checklist for incidents. This tool supports staff to comprehensively debrief after an incident to provide meaningful interventions with a young person to help reduce incidents. Staff had not yet implemented this tool.

Are Child and adolescent mental health wards effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff did not always complete care plans that reflected all young peoples' assessed needs. Improvements were needed to ensure that appropriate reviews took place for one young person being nursed in long term segregation.

Staff assessed the physical and mental health of all patients on admission. Staff completed personalised and holistic positive behavioural support plans.

Staff did not regularly review and update care plans when patients' needs changed. We reviewed four young people's care plans. Young peoples' care plans were meant to be updated on a regularly basis, including at the weekly multi-disciplinary team meetings. However, we found two care plans that had not been appropriately updated. One young person recently had their care plan for 'keeping well' updated. However, it did not contain detail for their nutritional needs or input from the dietitian's assessment of their needs. The same young person's care plan identified that they needed their physical health monitoring because of their clozapine medication. The care plan did not contain details of what actions the staff would take to monitor this and escalate if necessary.

Another young person did not have their care plan regularly reviewed to record the outcome of all reviews and the reasons for their continued long-term segregation (LTS). The Mental Health Act Code of Practice recommends that

anyone placed in LTS should have it regularly reviewed. The young person's LTS started in November 2021 and a plan was put in place. However, staff had not recorded where they had regularly reviewed this LTS and communicated with the young person what had to happen for their LTS to end. This did not meet the young person's needs or follow best practice.

Staff completed a comprehensive mental health assessment and physical health assessment of each young people either on admission or soon after.

Staff used the positive behavioural support (PBS) model to understand young people behaviours which challenge. The multidisciplinary team and young people contributed to their PBS plans. For example, PBS plans included the young persons' early warning signs and what staff can do if the situation escalates.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients 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.

However, staff did not participate in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Young people had access to therapies provided by the psychologist and family therapist such as cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT) and family therapy.

Staff delivered care in line with best practice and national guidance. Psychologists based treatment pathways on best practice guideline, including psychological therapies. Medical staff used best practice to inform their treatment pathways for managing young people with severe trauma, self-harm, anxiety, and depression.

Staff made sure patients had access to physical health care, including specialists as required. Staff often supported young people to attend the local acute hospital for medical assistance after incidents of self-harm or physical health deterioration. Staff said the relationship with the local acute hospital has improved over the year, but more work was still needed to strengthen it. Staff said that they could easily ask for advice and could arrange for patients to transfer to the acute hospital if this was necessary. In addition, the service had a general practitioner who visited each week to support young people with their physical health.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, a qualified dietitian assessed the nutritional status of a young person needing support with their nutrition. The dietitian completed an assessment with the young person to meet their nutritional needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff offered nicotine replacement therapy for those young people that wanted to quit smoking. The service had an outdoor gymnasium that young people could use to exercise, supported by staff.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA)

Staff used technology to support patients. Young people had access to tablet devices to support them with education.

Requires Improvement

Child and adolescent mental health wards

Staff did not always take part in clinical audits, benchmarking and quality improvement initiatives. Medical staff were not completing any clinical audits at the time of the inspection. This meant that young people and their families would not know where the service is clinically performing well and in line with national standards. The ward manager completed care plan and environmental audits.

Managers did not use results from audits to make improvements. For example, the ward manager completed audits on care plans. There was no record of the results from the audits or the action taken. The service's audits and the actions identified was not a standard agenda item at clinical governance meetings. The clinical governance meeting minutes for December showed no follow up for an 'audit report' or how this would be shared with all staff.

Skilled staff to deliver care

Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Ongoing vacancies for a clinical psychologist, social worker, occupational therapist and hospital director meant that some of the required specialists needed to meet the needs of young people were locums and changed frequently, which impacted upon consistency of care.

The team included, doctors, nurses, psychologists, social workers, family therapists and occupational therapists. At the time of the inspection, locum staff were covering the vacant positions of the social worker, occupational therapist and clinical psychologist. The consultant psychiatrist was covering the position whilst the psychiatrist was on parental leave. Three parents commented that the high turnover of the consultant psychiatrist role, three people in the last year, was frustrating. The previous hospital director had been on long term sick leave which impacted on the leadership of the hospital.

Managers did not always support nursing staff through regular, constructive clinical supervision of their work. The kept a supervision tracker to monitor which staff had received clinical supervision. Since October 2021 supervision rates were decreasing. For the month of November 73% of nursing staff had received supervision. For December only 21% of nursing staff had received supervision. The ward manager stated that this was due to formal supervision not being able to take place in December due to staff sickness and the ward manager having to cover nursing duties on the ward. Senior managers attributed the low figures to staff not recording completed supervision appropriately.

Staff reported that they received regular clinical supervision. However, these were not always effective. We looked at two staff supervision records. Where actions had been identified, it was not clear how these had been followed through.

The service offered nursing staff weekly reflective practice facilitated by a clinical psychologist. During these sessions staff reflected on incidents that had happened on the ward. However, staff did not always have the time to attend this. During the inspection no staff attended the reflective practice session. Staff commented that these sessions should be facilitated by an external psychologist who can provide objective support to staff.

Managers did not ensure staff received specialist training for their role. Nursing staff had not received training in working in children and adolescent mental health. The interim management team had developed an action plan to address this. However, this training had not commenced yet. Some young people required support in relation to their autism, but staff had not been trained to develop the skills and knowledge to care for young people with autism. This meant that staff did not have the skills and experience to effectively support young people.

Requires Improvement

Child and adolescent mental health wards

The ward manager and two deputy ward managers had not received any leadership training to effectively carry out their roles.

Managers gave each new member of staff a full induction to the service before they started work. All staff, including agency staff, had a comprehensive induction to the service, which covered key aspects of caring for the young people on the ward.

The provider was not able to share with us data to show whether staff had received a recent appraisal.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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

However, staff needed to strengthen and further embed monthly team meetings.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The consultant psychiatrist held a weekly ward round, which consisted of nursing staff, ward doctors, therapists and education staff. These meetings reviewed the young peoples' care and treatment including risk, recovery goals, capacity and medicines. Staff invited patients to these meetings and parents were given the opportunity to provide feedback. However, two parents said they did not regularly get invited to these meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. At the start of each shift, nursing staff handed over pertinent information regarding the patients' wellbeing, risks and observation levels. In addition to handovers, members of the MDT and the senior management team met every morning to hand over risk information about the ward. We observed this morning meeting which was focused on risk and well attended.

Staff on the ward met every month to discuss business continuity and complex cases. However, the minutes showed that staff did not discuss pertinent issues such as clinical governance, shared learning and case management.

Senior leaders started facilitating monthly clinical governance meetings since December 2021. Before that staff did not regularly meet to discuss clinical governance or other matters.

Ward teams had effective working relationships with other teams in the organisation. For example, the interim hospital director liaised with the provider's medical director in the North.

The service was commissioned by the South London Partnership (SLP). The SLP had recently carried out their own contract monitoring visit to the service. The service met monthly with the SLP and stakeholders.

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

Requires Improvement

Child and adolescent mental health wards

Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. There was still more work to do to increase staff understanding of long-term segregation. Managers made sure that staff could explain patients' rights to them.

The provider categorised training in the Mental Health Act 1983 (MHA) as mandatory. This training had one of the lowest compliance rates with registered nursing staff at 33%. This meant staff would not be kept up to date with the MHA and Mental Health Act Code of Practice.

At the time of the inspection, all 10 young people were detained under the MHA. Staff generally understood their roles and responsibilities under the MHA and the Mental Health Act Code of Practice and discharged these well. However, staff still had more work to do to increase their knowledge of long-term segregation. For example, reviews for a young person nursed in long-term segregation did not regularly take place.

Staff authorised and administered medicines for detained patients in line with the requirements of the Mental Health Act and its regulations. For example, staff completed consent to treatment forms (T3) accurately. This meant they were detained and treated lawfully.

Young people had easy access to information about independent mental health advocacy and young people who lacked capacity were automatically referred to the service. As young people were under 18, they all had access to the local Independent Mental Health Advocacy service.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Good practice in applying the Mental Capacity Act

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

Staff had a good understanding of the Mental Capacity Act (MCA), and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care. The MCA applies to people over the age of 16. Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005.

Staff understood how to support young people wishing to make their own decisions using Gillick competency. For consent and capacity in children and adolescents, staff should refer to guidance on Gillick competence. This is a test in

medical law to decide whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they give informed consent and do not need parental permission. We checked two young people's records. We found that for those young people under 16 years old where staff had assessed their consent to treatment – staff followed the guidance of Gillick competence.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Where staff did appropriately assess patient's capacity, they ensured assessments were time and decision specific.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff completed capacity assessments for patients that might have impaired capacity. These were time and decision specific.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff knew how to apply the Mental Capacity Act to patients 16 to 18 and where to get information and support on this.

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 patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

However, young people did provide negative feedback in relation to staffing.

We spoke with five young people and their families. We received mixed feedback from young people about the quality of care they received. Young people said staff treated them well and behaved kindly. Young people specifically praised the support of the occupational therapist.

Most of the negative feedback we received was about the issues with staffing and the night staff always changing, which could be unsettling. Young people felt there was no consistency with staff as the rules can change frequently between staff when they ask for things.

Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. We observed staff interacting with patients in a thoughtful way. Staff provided emotional support to patients to minimise their distress. We observed a young persons' ward round and saw that staff knew the young person well. Staff offered the young person a chance to feedback on their care and listened to their responses.

Staff directed patients to other services and supported them to access those services if they needed help. Staff worked closely with the education centre onsite to ensure young people were adequately supported to help them prepare for mainstream school.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Staff did not display any of the young person's personal information in communal areas.

Involvement in care

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

Involvement of patients

Staff introduced young people to the ward and the services as part of their admission. Young people and their families were given a welcome pack when they first arrived.

Staff involved patients and gave them access to their care planning and risk assessments. Four young people said they were given a copy of their care plans. One young person said that you needed to ask staff for a copy of your care plan, it was not offered to you. Staff completed positive behavioural support plans with the young person. The four risk assessments we looked at showed that young people were involved in their formulation.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. The welcome booklet detailed important information about the ward such as visiting times and the role of the professionals on the ward.

Staff involved patients in decisions about the service, when appropriate. Young people had a say in the decoration of the ward and how the new courtyard would be refurbished.

Young people could give feedback on the service and their treatment and staff supported them to do this. Staff facilitated weekly community meetings with young people. We looked at the minutes of these for the month of November 2021. Young people fed back about occupational therapy and education trips, staff issues, maintenance and repairs, a lack of activities and getting involved with seasonal celebrations.

Staff made sure patients could access advocacy services. The advocate had only just started to visit the service after COVID-19 restrictions had reduced.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, improvements could be made to the levels of communication with family members.

Requires Improvement

Child and adolescent mental health wards

We spoke to four parents of the young people using the service. We received mixed feedback about the level of involvement families and carers thought they had in their child's care. Two parents told us that staff involved them in their child's care. One parent commented that staff focus on the whole picture with their child's needs.

However, parents said communication could be poor. For example, two parents said they had heard about an incident from the young person before staff told them. Staff told us that this would happen when the young people would contact their parents straight after an incident before staff had a chance to contact the parents to inform them.

Two parents told us that they did not always get a response from staff when they tried to arrange an appointment or call the service. For example, one parent said that staff had not involved them in their child's placement meeting. Another parent said they did not always get invited to their child's ward round meeting.

The service provided family therapy to young people and their family. In addition, families could stay on site at the service's bungalow to support young people and their family with home leave.

Staff helped families to give feedback on the service. The multidisciplinary team used feedback from families and carers to plan home leave and support. Families also complained to staff if they had concerns about their loved one's treatment and care.

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 went down. We rated it as requires improvement.

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and young people's discharge was rarely delayed for other than a clinical reason.

At the time of the inspection, the service had 10 young people admitted. The service had closed to new admissions whilst improvements in care and treatment were being carried out.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of the inspection, three young people had been at the service since 2020. The longest length of stay was 18 months.

Managers and staff worked to make sure they did not discharge patients before they were ready. Staff supported young people with their discharge by granting overnight leave to ensure that young people had a smooth transition when they left.

Requires Improvement

Child and adolescent mental health wards

The service took referrals from NHS England, which meant that young people could be admitted form all over the country. However, most young people were from the Kent and London area.

Staff always ensured patients' beds were available when they returned from leave. Patients did not move between wards during their admission unless it was justified on clinical grounds. Staff did not move or discharge patients at night or early in the morning.

Discharge and transfers of care

At the time of the inspection there were three young people at the service who had experienced a delay to their discharge; the manager was monitoring these. The reasons for these delays was that young people were waiting for suitable placements in the community or in medium secure units.

Staff planned young people's discharge and worked with care managers and coordinators to make sure this went well. Discharges were planned through the care programme approach (CPA) framework. The multidisciplinary team and the young person wrote a discharge plan as a goal to work towards and these included projected discharge dates for the young people. One young person needed extra support, so staff were seeking a placement to meet their needs. Staff worked with national forensic services to procure a suitable placement for the young person.

Staff supported young people when they were referred or transferred between services. For example, when patients required admission to an acute general hospital for their physical health needs staff supported them during their stay or outpatient appointment.

The service followed national standards for transfer. For example, when young people turned 18, they moved to an adult placement.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient 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 and patients could make hot drinks and snacks at any time.

However, staff did not provide young people with adequate activities at the weekends and during the evenings.

Each patient had their own bedroom, which they could personalise. Bedrooms included ensuite toilet facilities. Staff used a full range of rooms and equipment to support treatment and care. Each wing contained a nursing office, seclusion room and clinic rooms. In addition, young people accessed a gymnasium, dining room, lounge area, games room and outdoor space. Young people contributed to the decoration of the communal areas which contained murals and paintings.

Patients had a secure place to store personal possessions. Young people could access lockers and had to ask the staff for the key to their locker. Items such as toiletries were stored in their lockers.

The service had quiet areas and a room where patients could meet with visitors in private. Young people met with visitors in a private area off the ward. This ensured privacy for young people and their visitors.

Young people could make phone calls in private. Young people could access a cordless telephone or their own basic mobile phones to make personal phone calls.

The service had an outside space that young people could access easily. The hospital had recently refurbished their courtyard and turned it into a basketball court with gym equipment. Staff decorated the courtyard to make it age appropriate.

Young people could make their own hot drinks and snacks and were not dependent on staff. Young people could request drinks and snacks as they were not able to independently access these due to the level of risk on the unit.

The service offered a variety of good quality food. Young people had a choice of food to meet their dietary requirements. All young people fed back that the quality of food was very good. Young people praised the chef and could provide input into the menu. Catering staff catered to young people's cultural and religious needs in respect to the food. Young people had options available if they wanted halal or kosher foods.

Young people did not have enough activities at weekends and evenings to keep them engaged. Young people did have access to a weekly timetable of activities, including education, meal support groups, and art therapy. However, activities on the weekends and evenings were limited. All young people fed back that they were bored and did not get to do much outside of education and therapy. Young people praised the occupational therapist and enjoyed the activities led by them. At the last inspection in June 2019, young people fed back that they wanted more activities at weekends and in the evenings. Young people had also fed this back to staff in the November community meeting. The manager said this was because there was not enough staff at the weekends to facilitate activities and young people often went on leave at the weekends. Managers were trying to recruit extra staff for the weekends, but this had not happened yet. This did not provide a therapeutic environment to support young people with their recovery.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. The on-site school was registered with Ofsted. Ofsted rated the school as 'Outstanding' at their last inspection in June 2021. Staff encouraged young people to attend school, and this was part of their recovery journey. The teaching staff were involved with young people's care and treatment at the hospital. They attended the weekly ward rounds and input into their care planning where necessary. Young people spoke positively about their experience with the school and the teaching staff.

Staff helped patients to stay in contact with families and carers. The service had a purpose-built bungalow for parents and carers to use when visiting. The young person could also stay with their family in the bungalow if it was suitable for them to do so. This allowed families and carers to stay who had travelled some distance to see the young person.

Staff tried to encourage patients to develop and maintain relationships with people that mattered and with the wider community. The occupational therapist arranged for young people to volunteer at the local goat sanctuary. This gave young people the opportunity for therapeutic activities away from a hospital setting.

Meeting the needs of all people who use the service

Requires Improvement

Child and adolescent mental health wards

The service needed to improve how they supported some young people with protected characteristics, for example, gender identity.

Some parts of the premises were not wheelchair accessible. Staff's understanding for young people's needs in relation to their autism was limited.

Whilst staff considered young peoples' cultural, equality and diverse needs; more work could be done to ensure that patients holistic needs were met. For example, spiritual support was limited to the service providing the contact details of a priest. Staff did not provide patients with information on other religions. Young people's cultural needs were reduced to the type of food they wanted. Staff did not take a proactive approach to find out about other parts of a young person's culture and religion.

Staff were not actively aware of the needs of LGBT+ young people and did not consistently use their preferred pronouns when a young person identified as non-binary or a different gender to that allocated at birth. Staff had not taken steps to ensure the wards were clearly open and inclusive for LGBT+ young people. Staff did not receive specific training to make sure they met young peoples' diverse needs and consider engagement with specific community groups.

Staff made sure patients could access age-appropriate information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community. The medicines' leaflets had been translated into languages other than English. Staff displayed the community meeting minutes in easy-read format containing pictures. Managers made sure staff and patients could get help from interpreters or signers when needed.

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.

However, managers did not always share feedback from complaints with staff and ensure learning was used to improve the service.

Young people, relatives and carers knew how to complain or raise concerns. We spoke to four family members and five young people. Family members said they knew how to complain, with some stating they had complained previously. Three young people said they knew how to complain.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain was displayed on the ward noticeboard and included in young people' welcome packs.

Staff understood the policy on complaints and knew how to handle them. For the period January – December 2021, the service had received 14 formal complaints. These included complaints from families about poor communication, treatment plans and disrepair of the environment.

Staff knew how to acknowledge complaints and young people received feedback from managers after the investigation into their complaint. The senior managers kept a complaints log to monitor all formal complaints that they received.

Requires Improvement

Child and adolescent mental health wards

Staff formally acknowledged all complaints in writing within two working days and aimed to respond with an outcome within 20 working days. Parents fed back that they were able to sit down with senior managers and discuss their complaints. A parent explained that the senior management had responded to them in a timely way after they complained.

Managers investigated complaints and identified themes. Senior managers were assigned to investigate each formal complaint.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were included as a standard agenda item at the clinical governance meetings.

However, managers did not always share feedback from complaints with staff and learning was used to improve the service. Whilst the complaints log included areas for learning, these were not cascaded to the wider team. For example, the minutes for the clinical governance meetings showed that staff discussed recent complaints, however, no learning had been identified or shared.

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 understood the services they managed, and they were increasingly visible in the service and approachable for young people and staff.

Since the last inspection in June 2019, the service had gone through two senior leadership changes. For a few months prior to December 2021 staff did not have a senior manager to oversee the running of the hospital. In December 2021, the service appointed two interim managers to cover the hospital director and director of clinical services' vacancies. Both these senior managers oversaw the running of the hospital. Whilst the medical director was on parental leave a locum consultant psychiatrist was covering the post.

The interim leaders had the skills, knowledge and experience to perform their roles. The interim hospital director had a background of working in children and adolescent mental health services (CAMHS) and previously managing one of the provider's other hospital locations.

Staff, young people, and families all reported that senior leadership had improved recently. Staff reported that the interim hospital director was visible on the ward. The interim hospital director quickly became personable with the young people, which we observed during the inspection. One parent said that since December when the new leadership started, communication had started to improve.

Vision and strategy

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

Staff understood and knew how to apply the provider's values. The provider's values aimed to improve the quality and value of care for patients and young people. Staff tried to deliver care in accordance with these values. Staff emphasised optimism in young peoples' recovery and treated them with dignity and respect.

Culture

Due to the high number of incidents of violence and aggression towards staff, they did not always feel respected, supported and valued. The provider did not promote equality and diversity in daily work or provide opportunities for development and career progression. Staff did not always feel they could raise any concerns without fear.

All staff commented that morale amongst staff was low. Whilst most staff felt the culture and staff morale had improved, especially with their immediate colleagues. Staff felt there was still more improvements to be made. For example, the nursing staff did not feel empowered to input into decisions in young peoples' care and treatment. Staff attributed this to working with bank and agency staff that needed a high degree of support, the high number of violence and aggression towards them and lack of specialist training. Staff still had not had an away day to support with team building.

Staff felt that the senior leadership did not understand the impact that incidents of violence and aggression was having on them. Staff felt that violence and aggression was normalised. This further impacted on staff morale.

Since December managers had tried to improve team morale through appropriately facilitated clinical meetings and tackling the high number of incidents of violence and aggression against staff.

Staff could attend fortnightly reflective practice meetings that was facilitated by the psychologist. This meant staff could address the dynamics within the team and increase morale. However, staff did not always attend this meeting due to their busy clinical duties on the ward. Also, these meetings were facilitated by the internal psychologist rather than an external psychologist who could offer impartiality and no conflicts.

Staff felt the service did not always promote equality and diversity. Whilst the provider had a policy in place for supporting young people's cultural and religious needs; there was not a policy in place for staff. This meant that when staff were treated unfairly by patients and young people, some felt that systems were not in place to appropriately support them.

Staff did not feel the service provided opportunities for career development. For example, senior registered nurses had not received any leadership training to support them within their role. This was reflected in the high number of vacancies for registered nurses that meant nurses did not have the protected time to develop their skills and experience in leadership roles.

Although, staff could raise concerns through their quarterly staff forum, these were not very frequent or well attended. We looked at the minutes for the last forum in November, three members of staff had attended. The forum had not identified any actions to follow up from staff feedback. Staff meeting minutes did not include a standard agenda item for staff forums so that the feedback could be cascaded to the wider team for staff that could not attend.

Governance

Requires Improvement

Child and adolescent mental health wards

Our findings from the other key questions demonstrated that governance processes needed strengthening to operate effectively at ward level and that performance and risk management needed further embedding across the hospital.

Overall, the governance of this service needed strengthening and further embedding to ensure the quality and safety of the service. There was significant variation between the quality of care and treatment provided to young people since the last inspection in June 2019. For example, the service had a higher rate of vacancies for registered nurses. Bank and agency staff usage was also very high. Low compliance for mandatory training with registered nurses. No specialist training to support and equip staff with the skills to work with young people. Staff had not appropriately recorded young people's physical health observations in line with the correct policy. Staff did not learn lessons from the incidents that they reported. An effective audit programme was not being carried out.

The service had a clear framework for what must be discussed at senior management level but not at ward level. For example, monthly clinical governance meetings followed a structure where pertinent issues such as incidents, complaints, best practice and performance data were discussed. However, the monthly staff meetings did not always discuss pertinent issues or follow a standard structured agenda. These meetings needed to be more robust to ensure staff were aware of governance processes.

The managers could easily access information about the overall training and supervision for staff. The data was readily available on the dashboard showing training for each of the staff team. Managers also used a supervision tracker to see the supervision rates for the service. However, the supervision tracker for the year 2022 had not been created so that managers could start logging when they had completed staff supervision.

Management of risk, issues and performance

Staff teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

At the time of the inspection, the service had a recovery plan in relation to identified areas for improvement. The senior divisional management had identified several issues and areas of concerns to improve safety and quality of care. The plans objectives included senior management and multidisciplinary team stability, environment and increasing bed capacity. However, staff had yet to complete this recovery plan with its 11 identified actions. Some of the risks we identified during the inspection were not included in the action plan or risk register. For example, registered nursing staff recruitment and retention, lack of learning from incidents and inappropriate recording of physical health observations.

One action identified from our inspection in 2019 remained outstanding. This related to additional staffing to support activities out of hours and at weekends.

The service had a local risk register, to which the managers could add risks. At the time of the inspection the risk register had not been updated since September 2021. Some current risks were not included on the risk register. For example, the lack of leadership team at the hospital resulting in the recent embargo of new admissions to the hospital and limiting the number of admissions to 10. Low compliance rates for mandatory training amongst the registered nurses. Lack of specialist training to ensure staff can support young people's care and treatment.

The managers could analyse the use of physical restraint on the wards through collated data. This broke down the number of restraints, what position they were in, duration and the number of patients they attributed to. This meant the managers could identify any increases in the use restraint and themes and trends to help improve safety.

Information management

Staff collected and analysed data about outcomes and performance. However, these could be over-burdensome for staff.

The service collected reliable information and analysed it to understand performance, Managers collected data on incidents, physical restraints and safeguarding to identify themes and trends.

Minutes kept for the staff meetings were not appropriately recorded. This meant for those staff that could not attend would not be able to get important and up to date information about the running of the ward.

The service used systems to collect data from the teams, but frontline staff could find these systems over-burdensome.

The information systems were integrated and secure. Information governance systems included confidentiality of patient records. All patients' records were kept electronically in a password-controlled database that only staff could access.

Staff made notifications to external bodies as needed. The service submitted statutory notifications to CQC when required. However, the provider did not notify the CQC that they had a young person placed in long-term segregation. The service notified the local authority of the safeguarding concerns found on the ward.

Engagement

Due to the high number of nursing staff vacancies, staff did not always have time to engage with the service other than to do their clinical duties. Staff had not been able to contribute to ideas on how the service is run.

The provider published the results for the 2020 staff survey. However, the results for the 2021 staff survey had not been published yet to see a more up to date analysis on staff engagement.

Staff had access to the provider's intranet that contained up-to-date information on organisational news. Staff provided patients and carers with a welcome pack when they were admitted to the wards.

Young people had opportunities to give feedback about the service they received, and staff collected this in a way that reflected their individual needs. Staff collected informal feedback through weekly community meetings. Young people input into the design of the newly refurbished courtyard.

Staff collaborated with partner organisations to help improve services for patients within the trust. The service worked within the provider collaborative of the South London Partnership (SLP). The service was engaging with stakeholders to improve the quality of service provided.

Learning, continuous improvement and innovation

Requires Improvement

Child and adolescent mental health wards

At the time of the inspection, the service had recently undergone an audit completed by the Quality Network for Inpatient CAMHS (QNIC) in April 2021. The service had just received the report. The audit identified several areas for improvement, including staffing levels and training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not ensure staff effectively reviewed young people subject to long-term segregation and updated this in their care plans. The service did not ensure they provided young people with activities at weekends and evenings. The service did not ensure they met the needs of young people in relation to their protected characteristics. The service did not ensure that young peoples' protected characteristics were considered in their care planning, for example, use of language when referring to young people's gender identity.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not ensure they deployed enough suitably skilled, qualified, competent and experienced staff. The service did not ensure staff completed mandatory training to safely support young people. The service did not ensure that staff received specialist training to help them effectively support young people.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The provider did not ensure the systems in place to assess, monitor and improve the quality of service were effectively embedded into the service.

The provider did not ensure they effectively supported staff to help increase morale. The service did not monitor and reduce the risks relating to the welfare and safety of staff.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that information about patients' physical health care was recorded accurately so that it can be followed up quickly when concerns were identified. The service did not ensure that young people could access a working call system from their bedrooms to enable them to alert staff to their need for support. The service did not ensure they had robust systems in place to ensure staff learn lessons from safety incidents.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not deploy enough suitably skilled, qualified, competent and experienced staff.