Barnet, Enfield and Haringey Mental Health NHS Trust

Child and adolescent mental health wards

Trust Headquarters, Block B2
St Ann's Hospital, St Ann's Road
London
N15 3TH
Tel: 02084426000
www.beh-mht.nhs.uk

Date of inspection visit: 07 October to 19 October 2020
Date of publication: 04/12/2020

Ratings

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

Summary of findings

Child and adolescent mental health wards

Requires improvement

Summary of this service

This was an unannounced, focused inspection of the Beacon Centre.

The Beacon Centre is provided by Barnet, Enfield and Haringey Mental Health NHS Trust. The service is a 16-bed mixed gender inpatient child and adolescent mental health unit for young people aged between 13 -18 years old. It is the only child and adolescent mental health ward provided by the trust. At the time of this inspection, 14 young people were using the service. The Beacon Centre aims to provide care for young people at risk when their mental health needs cannot be safely met in the community. The service provides a range of treatments including psychological therapies and treatment with medicines. Young people admitted to the service are diagnosed with a range of mental disorders, including depression, psychoses, severe anxiety disorders and emerging personality disorder.

We last inspected the trust's child and adolescent mental health wards in September 2017, when it was rated as good overall and for all five key questions.

During the inspection we focused on staffing levels and competencies, how staff managed patient risk and restrictive interventions, how the service learned from lessons and how the service was managed.

We undertook this inspection due to information of concern the trust had previously shared with us. The trust undertook a review of the service in June 2020 and identified several areas of concern for which they developed an implementation plan. During this inspection we followed up on high risk concerns identified during this review to check whether improvements had been made. We also identified some additional concerns.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent on the ward to prevent cross infection. Two inspectors and a CQC specialist advisor visited the unit on 7 October 2020 to complete essential checks. Whilst on site we wore the appropriate PPE and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included staff interviews over the telephone and analysis of evidence and documents. Our final telephone staff interview was completed on the 22 October 2020

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the environment and observed how staff were caring for young people
- spoke with seven young people who were using the service
- spoke with three parents of young people using the service
- spoke with the ward manager and service managers
- spoke with 12 other staff members across the multidisciplinary team
- spoke with the patient advocate
- looked at six care and treatment records of clients
- looked at twelve medication records of clients

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service

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

- We changed our rating as Safe to inadequate and Effective and Well-led to requires improvement due to the concerns that we identified during this inspection. We did not re-rate Caring as we did not collect enough evidence for us to be able to do this. We did not inspect any aspects of Responsive during this inspection.
- Leaders had identified concerns with the service earlier in the year, and they had developed an implementation plan to address the concerns, but there had been limited progress in putting in place agreed actions to ensure young people were safe and received good care.
- The service did not have enough registered and non-registered nursing staff working on each shift who knew the young people and had received appropriate training and supervision to keep the young people safe from avoidable harm.
- Risk management arrangements were not adequate. Staff had not consistently assessed and managed risks to young people. Staff had not always undertaken risk assessments in advance of young people taking leave. This meant staff might permit a patient to leave the ward without fully considering the young persons assessed risks to themselves or others. Handovers were ineffective. They were not documented and staff described them as chaotic, which meant staff could be unaware of the risk status of patients on the ward.
- Staff had not consistently followed trust policies on ensuring young people were kept safe after the administration of rapid tranquilisation medication.
- Staff use of de-escalation to prevent incidents escalating on the ward was not consistent. Staff and young people told us that temporary staff were sometimes too quick to restrain, and other times they did not restrain them when needed. We shared our concerns with the trust, who responded promptly. The trust placed a member of staff on the ward who specialised in the prevention and management of violence and aggression, to provide additional support and training for staff. The trust also arranged meetings with the young people to speak about their concerns.
- Lessons learned from incidents were not always shared with the whole staff team.
- Safeguarding alerts were not always passed on to the local authority.
- Staff had not received regular clinical supervision. There was limited training available specific to supporting young people with mental health needs. Staff completion of the additional training provided was low.
- Some agency staff did not always treat young people with compassion and kindness.

However,

- Young people spoke highly of permanent members of staff across the multi-disciplinary team. Permanent staff had completed most of their mandatory training.
- A range of activities were provided for young people, including attending school, therapies as well as craft making and cooking activities.
- Staff understood how to protect young people from abuse and in most instances the service worked well with other agencies to do so.

Is the service safe?

Inadequate 

Summary of findings

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

- The service did not have enough registered and non-registered nursing staff working on each shift who knew the young people and had received appropriate training to keep young people safe from avoidable harm.
- Risk management arrangements were not adequate. Staff had not consistently assessed and managed risks to young people. Staff had not always undertaken risk assessments in advance of young people taking leave. This meant staff might permit a patient to leave the ward without fully considering the young persons assessed risks to themselves or others. Handovers were ineffective. They were not documented and staff described them as chaotic, which meant staff could be unaware of the risk status of patients on the ward.
- Staff had not always followed the organisation's policy for ensuring relevant physical health checks were performed following rapid tranquilisation being administered or that young people received a full debrief following each incident of restraint. This meant that if a young person deteriorated rapidly this may go unnoticed by staff and that they were not given the opportunity to reflect on the restraint or provide feedback.
- Staff use of de-escalation to prevent incidents escalating on the ward was not consistent. Staff and young people told us that temporary staff were sometimes too quick to restrain, and other times they did not restrain them when this was needed. We shared our concerns with the trust, who responded promptly. The trust placed a member of staff on the ward who specialised in the prevention and management of violence and aggression, to provide additional support and training for staff. The trust also arranged meetings with the young people to speak about their concerns.
- Staff had not consistently submitted safeguarding alerts to the local authority in line with trust guidance.
- Staff had not consistently followed trust policy when documenting details of a young person's refusal to take medication. Staff had not consistently recorded the date liquid medications had been opened.
- The wards did not have a good track record on safety. Managers investigated incidents although did not share lessons learned with the whole team or the wider service.

However,

- The permanent nursing and medical staff had completed most of their mandatory training.
- Staff understood how to protect young people from abuse and in most instances the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and most staff had completed this to at least a basic level.
- Managers provided support to staff following serious incidents.

Is the service effective?

Requires improvement 

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

- Young people did not always have access to psychological therapies. Some therapy sessions had been disrupted due to lockdown, the clinical psychologist role had been vacant for some time but had since been filled.
- Staff were not receiving regular clinical supervision.

However:

- The service provided a range of activities and therapeutic interventions.

Summary of findings

Is the service caring?

As this was a focused inspection, we did not inspect most aspects of caring, so we have not changed our rating. When we inspected the service in September 2017, we rated it as good for caring.

- Young people using the service gave us mixed feedback regarding how staff treated them. They told us that some agency staff did not always treat them with compassion and kindness. However, they were complimentary regarding permanent and therapy staff and how they felt supported by them.

Is the service responsive?

This was a focussed inspection and we did not cover this key question as part of our review.

Is the service well-led?

Requires improvement 

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

- Leaders had carried out a review at the Beacon Centre and were aware of most of the concerns we identified prior to the inspection. However, they had failed to address areas where improvements were needed in a timely manner. Following the inspection the trust recognised that improvements were still needed to keep the young people safe and implemented appropriate measures promptly.
- Staff morale was low. Staff did not feel supported or valued.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively as the failure to implement the changes needed to improve safety on the ward had not been identified and addressed.
- Staff engaged actively in local audits but, the findings were not reflective of the issues we identified during inspection.
- The service listened to concerns raised by young people, although there was no record that staff provided feedback in respect of action taken.

However:

- The manager had access to a broad range of performance information to support them in managing the service.

Detailed findings from this inspection

Is the service safe?

Safe staffing

Nursing staff

The service did not always have enough nursing staff, who knew the young people to keep young people safe from avoidable harm.

Managers had calculated a set number of nurses and non-registered nurses required to work each shift, with additional staff to provide enhanced observations. The nursing team worked a three-shift pattern, with three registered nurses planned to work early and late shifts, two at night. Three non-registered nurses were planned to work every shift, with additional support for enhanced observations. However, a review of rotas over a five-day period in September indicated staffing cover was not always provided in accordance with the required establishment.

On some shifts, there were insufficient members of staff deployed on the unit. We reviewed 15 whole shifts and found that nine shifts were short by one registered nurse, including two night shifts, which meant that the ward had cover from only one registered nurse. Five of the shifts that were short of registered nurses had additional non-registered nurses working, but four shifts did not. One shift was short of three non-registered nurses and had one additional registered nurse. There was a high use of temporary staffing across all shifts reviewed.

Most of the staff and young people we spoke with reported that there were insufficient staff deployed to keep young people safe. Some members of staff described the ward as 'chaotic' and informed us that therapy staff and the ward manager had to help out on the ward due to lack of staffing. Patient records did not always contain the necessary information, and there was a high number of incidents. Young people informed us that staff did not always have enough time for them. Some staff and young people also informed us that, on occasion, some staff fell asleep whilst providing enhanced observations. We raised our concerns with the trust who took prompt action by increasing the number of core staff by one unregistered nurse per shift on a temporary basis. The trust also redeployed two registered nurses from another service to support the ward, which helped reduce reliance on temporary staffing. The trust increased managerial and monitoring roles to provide the ward with additional support to ensure the safety of young people on the ward.

When necessary, managers sought agency staff to maintain safe staffing levels, although adequate cover was not always provided. When agency staff were used, they were staff who came to the wards regularly and were familiar with young people and ward routines wherever possible. There had been a high reliance on agency staff due to vacancies as well as the number of young people on enhanced levels of observation. During the month of September 2020, the bank and agency fill rate was 68.7% with 22.4% of shifts which remained unfilled.

This core service reported an overall vacancy rate of 19.5% on 7 October 2020, with two new band five nurses appointed, who were awaiting necessary employment checks, further reducing the vacancy rate to 14%. The trust continued with their recruitment programme to appoint registered nurses.

The service reported no vacancies for non-registered nurses.

The service used a high and increasing rate of bank and agency registered and unregistered nurses due to vacancies, sickness and enhanced observations. The number of unfilled shifts fluctuated each month, but overall had increased from 9.5% in April 2020 to 22.4% in September 2020. Sickness had been very high during April and May at the height of the pandemic and gradually reduced and in August. In September it was low and well within the trust target of 3.5% at 1.6% and 2.6% respectively. During the same period the number of unfilled shifts fluctuated each month with the lowest percentage seen in July at 7.3% and the highest in September at 22.4% of shifts unfilled.

Detailed findings from this inspection

Month	Percentage of staff sickness	Bank and Agency fill rate	Unfilled shifts per month
April	**16.9%**	**40.9%**	**9.5%**
May	**14.5%**	**59.4%**	**8%**
June	**7.7%**	**58.6%**	**14.8%**
July	**6.2%**	**64.4%**	**7.3%**
August	**1.6%**	**63.9%**	**9.3%**
September	**2.6%**	**68.7%**	**22.4%**

We were informed that the main reason for bank and agency usage on the ward was due to the number of vacancies as well as a high acuity of young people who required enhanced observation.

The ward manager could adjust staffing levels according to the needs of the Young people. Although shifts were not always filled and the staff and young people, we spoke with told us there were still not enough staff.

Mandatory training

Permanent staff had received and were up to date with most of their mandatory training.

Overall, staff in this service had undertaken 81% of the various elements of training that the service had set as mandatory. Although staff attendance was below 75% in three of the 15 mandatory training sessions: intermediate life support (69%), safeguarding level 3 adults (71%) and safeguarding level 3 children (60%). However, there was a high percentage of agency staff used on the ward.

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection, we reviewed the risk assessments of four young people.

Staff had not updated the risk assessment and management plan for three young people each time an incident had occurred, for example, when a young person had self-harmed. This meant that staff caring for the young people may not be unaware that their risk status had changed, and that young people's care may not be safely managed in accordance with their needs. We shared our concerns with the trust who acted promptly to update each young person's record. They also assured us that a member of staff would be allocated responsibility each shift to review young people's risk assessments and ensure that they were updated following an incident.

Staff had not assessed the risk for two young people on four separate occasions prior to them going on section 17 leave. This meant that the young people may not be well enough to take their permitted leave and could be a risk to themselves and/or others. We shared our concerns with the trust who responded promptly and assured us that an additional member of staff was placed on the ward who would be responsible for ensuring all risk assessments are completed prior to young people taking leave.

Detailed findings from this inspection

The ward undertook monthly audits on the completion of risk assessments. The audits included a review of whether young people's risk assessments were current and whether they had been updated following a risk incident. The ward achieved scores of 96-100% between the period July to September. The September audit achieving a score of 100%, but this was not reflective of our inspection findings which demonstrated risk assessments were not consistently updated in accordance with policy.

Management of patient risk

Staff did not always provide key information to keep young people safe when handing over their care to others. Staff did not complete specific handover documents. Some of the staff we spoke with told us that handovers were chaotic and lacked structure. One member of staff was of the view that young people were not safe as a result and that this may have led to some incidents. This meant there was a risk staff did not have a clear overview of the young people on the ward and the risks they presented at that point in time.

Use of restrictive interventions

There were 214 reported incidents of restraint in the twelve months prior to the inspection.

Month	**Number of restraints**
October 2019	**4**
November 2019	**1**
December 2019	**5**
January 2020	**12**
March 2020	**14**
April 2020	**23**
May 2020	**41**
June 2020	**27**
July 2020	**17**
August 2020	**24**
September 2020	**24**

We were informed by the manager and through review of records that the majority of restraints related to a small number of young people. Staff told us that restraints had increased during the pandemic, and this was likely due to the admission of young people of higher acuity during this time. Restraint records contained all the required level of detail in terms of who held the young people, what position they were restrained in and where.

Staff use of de-escalation to prevent incidents escalating on the ward was not consistent. There were not always enough staff to restrain young people safely. Most of the young people we spoke with and two staff members reported that de-

escalation was inconsistent and that sometimes staff restrained young people too quickly and other times they did not restrain when it was appropriate to do so. Another member of staff informed us that there were not always enough staff to restrain young people safely. The meeting minutes of the young people's forum held in August noted that young people had commented that agency staff used too much force when restraining them.

Staff had been trained in physical interventions as part of their mandatory training, although young people informed us restraint was not always carried out safely. This meant that staff were supported to develop their skills to de-escalate young people who became aggressive and minimise the use of restrictive interventions. Some young people informed us that agency staff restrained inappropriately. We also noted that in the young people's forum held in August, young people raised concerns that agency staff used too much force and questioned whether they had been specifically trained in restraining young people. The manager informed young people that this would be investigated. Feedback was not provided to young people at subsequent meetings.

Staff did not debrief young people after restraint. We reviewed the records of three young people for eight incidents of restraint. We found no evidence recorded that young people had been involved in a debrief for any of the restraints. This was also supported by the views of young people as well as some staff who informed us that debriefs rarely happened. This meant that young people were not provided with the opportunity to reflect on the restraint or provide feedback, which may help inform their treatment and prevent future episodes of restraint.

The service did not conduct checks on young people's vital signs following intra-muscular administration of rapid tranquilisation in accordance with their own policy. The trust's policy required staff to check a young person's observations every 15 minutes for the first hour after the administration of rapid tranquilisation and then every hour until there were no further concerns. After one hour the doctor should make a decision as to whether continued monitoring is required. We reviewed the files of two young people including six incidents of restraint where rapid tranquilisation was used. We found that on four occasions post rapid tranquilisation physical health checks were not undertaken. For two of the incidents, post rapid tranquilisation physical health checks were performed immediately following the rapid tranquilisation. However, the young person's observations were out of range and this was not escalated or rechecked. This meant there was a risk that the physical health of young people may deteriorate without staff being aware or escalating concerns.

We shared our concerns with the trust who responded promptly. The trust informed us that they had placed a dedicated Prevention, Management of Violence and Aggression (PMVA) instructor with experience in working with young people on the ward for a period of two months. The trust informed us that the PMVA instructor would support staff, ensuring they followed the correct techniques and performed restraints in accordance with national guidance as well as trust policy. The trust informed us that daily monitoring would take place and that they would review all incidences of restraint where rapid tranquilisation had been used in the last six months. The trust spoke with young people about restraints following the inspection and arranged to review care plans with them.

The service was required to undertake monthly audits on the use of restraint. We found that these had been completed bi-monthly and that the ward reported 100% compliance in July and September, achieving 90% compliance in May. The audit assessed several criteria, including whether care plans for young people had been updated and whether they had been debriefed following each episode of restraint. The findings from the audit were significantly different to what we found during inspection.

Safeguarding

Most staff had received training in safeguarding adults and children and knew how to recognise a safeguarding concern and refer to the local safeguarding team although this did not always happen.

Ninety-four percent of staff were trained in safeguarding children level 1&2 and 88% were trained in safeguarding adults 1&2. Training completion for level 3 safeguarding adults and children was lower at 71% and 60% respectively.

Detailed findings from this inspection

Most staff could give examples of safeguarding alerts they had made. Staff completed records of safeguarding referrals and submitted them to the local authority safeguarding team. Staff put protection plans in place to keep young people safe.

Staff had not always shared information with the local authority in accordance with section 85 of the Children Act 1989. This section of the Act requires staff to inform the local authority when a young person has been on the unit for more than three months. We shared this information with the trust who assured us they would inform the local authority of all young people who had been on the unit for three months or more.

Staff did not always make notifications to external bodies as needed. We found that in most instances the service reported safeguarding concerns to the local authority safeguarding team as well as the police if applicable, although a referral was not made for one young person in accordance with guidance. We found that an alert had been raised by a member of the team with the social worker for the unit, but a formal notification was not made to the local authority until we raised this as a concern with the trust.

Medicines management

Staff had not consistently followed good practice in medicines management. Staff stored, prescribed and administered medicines safely, although we found that a small number of liquid medicines did not have the date the bottle had been opened recorded on them. We brought this to the attention of staff who addressed this without delay.

We reviewed the medicine administration records for twelve young people. Records were not always completed appropriately. Staff signed when they administered medicines or recorded the young person's refusal to take them. However, we found that six young people had refused medication on more than one occasion and their patient record had not been updated with details. This meant that staff caring for young people who were not involved in the administration of medication may be unaware they have not taken their medication as prescribed and how this may affect their mental state and behaviour. Staff noted allergies and potential adverse reactions on patients' records. The prescriber gave staff clear directions about when staff should administer 'as required' medicines.

Audits of medicines administration records were completed by nursing staff although these were not completed consistently each month. The service reported an overall score of below the trust target of 90% on two of the four monthly audits provided.

Track record on safety

The service had reported one serious incident during the 12 months prior to inspection. This had occurred shortly prior to the inspection and was subject to a thorough investigation.

Reporting incidents and learning from when things go wrong

Staff knew which incidents to report and how to report them. Staff reported all incidents they should report in accordance with the requirements of the provider.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when things went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with young people about their care and treatment. This includes a duty to be honest with young people when something goes wrong.

Staff held team meetings where the number of incidents which had occurred were noted rather than discussed, not all staff were in attendance and lessons learned were not shared. Some of the staff we spoke with informed us that there was no feedback from incidents at all. . Others reported that it happened on occasions although they could not tell us about any learning from them. We were informed that incidents were discussed at team meetings. Team meetings minutes showed that the meetings were attended by managers, medical and therapy staff. Registered and non-

registered nurses did not attend. Incidents were included as an agenda item and discussion was focussed on the number of incidents as opposed to discussing individual incidents or learning from them. Staff did not tell us about learning from a recent serious incident, although an investigation was underway. If lessons are not learned and shared there is an increased risk, similar incidents will continue to occur.

Staff received support after serious incidents. The manager and staff told us that staff and young people were well supported following serious incidents. There had been one serious incident in the last 12 months. The trust provided evidence that a meeting with staff had taken place, facilitated by a member of the therapy team and that staff were able to access additional support if they felt they needed it.

Is the service effective?

Best practice in treatment and care

Staff provided a range of treatment and care for young people based on national guidance and best practice, although psychological support had been limited due to a vacancy.

The staff team provided a weekly therapy and activity programme for young people, although this had been disrupted during early lockdown, with many of the therapists providing therapy via video-link. There had been a vacant post for a clinical psychologist since January, which had now been filled and the new psychologist commenced in October 2020. An assistant psychologist provided support to young people face-to-face. Young people told us that when therapy was provided remotely this was not always effective in reducing their distress, but this had improved now that staff were based back on site. Young people also told us that the assistant psychologist had worked incredibly hard to support them, but there was a high demand for their time. During the school term young people attended school throughout the week. Group sessions included art therapy, music therapy, family therapy, cookery, craft making. Discussion groups included coping skills and sessions to help young people understand and manage their behaviours in stressful situations. Young people told us that they were a range of activities offered on the ward, and that they enjoyed them. Young people told us that occupational therapy was ‘amazing’, ‘really good’ and that ‘the therapists went out of their way to help them’.

Staff participated in clinical audits. There were checks on the use of rapid tranquilisation, restraint, medication practices and risk assessments. However, audit scores were not consistent with the inspection findings.

Skilled staff to deliver care

The ward team included but did not always have access to the full range of specialists required to meet the needs of young people on the ward. Managers did not always make sure they had staff with the range of skills needed to provide good quality care. They did not always support staff with appraisals, supervision and opportunities to update and further develop their skills.

The service did not always have access to a full range of specialists to meet the needs of the young people on the ward. The multidisciplinary team included consultant psychiatrists, registered nurses, occupational therapists, an art therapist, a family therapist, a social worker, a recently appointed clinical psychologist and an assistant psychologist. Young people and staff told us that access to psychological support had been limited and reliance had been placed on the assistant psychologist to provide psychological support. We were assured this would improve now that the clinical psychologist position had been filled.

Detailed findings from this inspection

Managers did not always make sure staff received specialist training for their role. Staff told us that they needed more training to support young people with self-harm as well as training in autism, ADHD and eating disorders. However, the CAMHS specialist training did not cover any of these topics. Most staff (75%) had completed Dialectical Behaviour Therapy (a talking therapy) training, the average completion rate for Mental Health specific training which included wound care, ligature training and CAMHS clinical presentations, was 30%.

Managers and leads did not consistently provide staff with supervision. Staff said they did not always receive supervision regularly but when they did, they found it helpful. We requested supervision records for three members of staff. Records showed that only one member of staff had received supervision in the past three months. Supervision records for this member of staff covered both managerial and clinical supervision and were constructive. The provider was aware of the need to increase the rate of supervision and that delays had been due to staffing shortages as well as differing shift patterns.

Managers and supervisors provided some staff with appraisals to discuss their work performance. We requested appraisal records for three members of staff, two had been completed, one had not, an explanation was not provided why this was not available. Detailed appraisal records were completed for each staff file we reviewed.

Team meetings took place each month but meeting minutes lacked detail and were not attended by all staff. Meetings were attended by managers, medical and therapy staff, but not by nurses or non-registered nurses. Limited discussion was recorded around the agenda items listed. For example, clinical governance and performance reports were regularly presented, discussion focussed on numbers rather than content.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

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

Staff did not always treat young people well or behave kindly. Young people told us that some agency staff could be rude and unkind, but that the permanent staff were all kind and supportive and went out of their way to help them when they could. Young people told us there were not many permanent staff on each shift. Three of the young people and two carers told us that staff (mainly agency) could be unkind. Two young people told us that some staff laughed at them during restraint. One young person told us that some night staff left their rubbish in young people's bedrooms. Five members of staff told us that young people have spoken with them about how other staff have shouted at and mocked them.

Is the service well-led?

Leadership

Leaders had the experience and knowledge to manage the service, although suitable measures were not always in place to manage care safely. Patient acuity was high, and the shifts did not always have adequate staff cover. This meant that the ward manager often had to support staff on the ward. The ward manager commenced in the role in January 2020 and came to the ward with previous experience in mental health, mainly in forensics.

Leaders did not always take action promptly when concerns were identified. Senior management had undertaken a review of the service in June 2020, an implementation plan was developed in response to the concerns identified. However, prompt action was not taken at the time. We found similar concerns were present during our inspection. Since our inspection, the trust has taken the concerns very seriously and put measures in place to improve the service.

Detailed findings from this inspection

Culture

Staff reported that morale was low and that the multi-disciplinary team did not work well together. Five members of staff reported that the ward was hierarchical and medically driven or that communication was poor and that nursing staff were not involved in decision making and this is also evident from their lack of involvement in team meetings. Staff acknowledged that the communication between the nursing team and wider multi-disciplinary team could be improved.

Staff reported they had a positive relationship with the ward manager, but seven members of told us that senior management listened but did not act on concerns shared with them.

The sickness rate for the service had been high during the pandemic but was now well below the trust target.

Governance

Managers had undertaken a review of the service. An implementation plan was developed but managers had not acted on the concerns identified.

Managers undertook a review of the service in June 2020 following a series of concerns. A range of issues were identified, and an implementation plan was in place. The majority of agreed actions remained rated as red or amber, with only a small number rated green. Action taken at the time of the in-house review was not sufficient to ensure improvements were made and that care provided was safe. Following the Care Quality Commission onsite inspection, the trust responded promptly to our concerns. The trust temporarily increased staffing levels and included more experienced staff on the rota. Patient numbers were restricted and there was additional managerial oversight of how the ward operates.

Staff participated in local audits. Examples of audits included risk assessment audits, medication audits and restraint audits. It was unclear how many young people's records had been reviewed as part of the audit exercise. The audit findings for restraint and risk assessment were not consistent with our inspection findings which meant that senior management did not have a clear and accurate view of areas the ward needed to improve on.

Team meetings were not attended by all staff groups and recorded discussion lacked detail. Team meetings were held each month and attended only by managers, medical and therapy staff. Registered nurses and non-registered nurses did not attend the meetings. There were standing agenda items including dashboard and team performance, incidents and feedback from young people's forum, although discussion lacked content. We noted that some areas of relevance did not feature as agenda items such as audit findings and safeguarding issues. Important learning points such as lessons from incidents did not form part of the meetings. This meant that the staff group were not well informed on how the service functioned and performed.

Information management

The manager had access to information to support them with their management role. This included information on the performance of the service, staffing and care of young people. For example, the manager could access data on the number and type of incidents which had occurred during a given period. The manager also kept a record on the number staff who had attended mandatory training and the rate of staff sickness. Performance information about young people's length of stay and discharge rate was also available.

Staff had not always made notifications to external bodies as needed. For example, informing the local authority when a young person had been on the ward for three months, we also found that one safeguarding incident which had been shared with the safeguarding lead had not been notified to the local authority.

Engagement

Detailed findings from this inspection

Young people were not always updated on action taken in relation to feedback provided. Young people had opportunities to give feedback on the service at ward round as well as the young people's forum. The forum was scheduled to take place each week, although this did not always take place as planned. We noted that young people shared their concerns, but feedback was not always provided. For example, at the August meeting, young people spoke about how staff restrained them, stating that some staff used unnecessary force. They were informed this was being investigated, but there was no subsequent feedback provided at meetings held in September.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that there are sufficient staff on duty at all times who know the service and young people to ensure there is consistency of care. Regulation 18(1)

The provider must ensure that staff review risk assessments following incidents and that the current risks young people are presenting is shared with staff clearly, for example in handover meetings. Regulation 12 (1)(2)(a)(b)

The provider must ensure that staff complete the required physical health observations on young people following administration of rapid tranquilisation or record reasons why this was not been done in accordance with best practice and the service guidelines. Regulation 12 (1)(2)(a)(b)

The provider must ensure that the restraint of young people is undertaken in accordance with national and service guidelines including engaging them in a debrief following the restraint. Regulation 12 (1)(2)(a)(b)

The provider must ensure that safeguarding alerts and notifications are raised and sent to the local authority in accordance with guidance. Regulation 13 (1)(2)

The provider must ensure learning takes place following incidents and that that lessons learned are shared with all staff. Regulation 17(1)(2)(b)

The provider must ensure staff have access to appropriate supervision. Regulation 18 (1)(2)(a)

The provider must ensure that there is strong leadership in place on the unit and that governance processes operate effectively to ensure improvements are identified and implemented as needed. Regulation 17(1)

Action the provider SHOULD take to improve

The provider should ensure that the liquid medication is dated when opened.

The provider should ensure that staff record details of young people refusing medication in their patient record.

The trust should ensure that staff have access to specialist training to support young people with varying mental health needs.

The provider should ensure all staff are polite, respectful and approachable when engaging with young people.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and one specialist advisor who was a registered mental health nurse with a background in child and adolescent mental health services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing