Cygnet Hospital Godden Green

Quality Report

Godden Green
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

- On the 25 and 26 July 2017, we carried out an unannounced responsive inspection on Knole ward due to concerns raised with us including poor discharge planning, lack of communication between staff, relatives and carers and the safety of the ward environment.
- On the 4 August 2017 we undertook another unannounced, urgent responsive inspection to Knole ward due to further concerns raised with us about risk assessments, care planning, monitoring of physical health, medicines, use of and reporting of restraint and high levels and serious nature of incidents.
- On the 8 August 2017, a member of the medicines team from the Care Quality Commission carried out an announced, focused inspection on Knole ward to see if medicines were safely managed.
- Following these inspections, we took enforcement action and issued the provider with an urgent notice of decision under section 31 of the Health and Social Care Act, to impose conditions on their registration specifically on Knole ward, dated 8 August 2017. We told the provider they must not admit any young person to Knole ward without the prior agreement of the Care Quality Commission. This was because we believed a person could or would have been exposed to the risk of harm if we did not do so.

In the notice of decision, we told the service provider they needed to make the following improvements on Knole ward:

- Ensure there is an effective system in place for the development, review and ongoing monitoring for the assessment of risk for young people.
- Ensure there is an effective system in place to support the ongoing regular assessment, screening, follow up and intervention in respect of young peoples' physical health needs.
- Ensure there is an effective system in place to support and manage the use of restraint.
- Ensure they follow guidance as set out by the Department of Health, Positive and Proactive Care, NICE guideline NG10: Violence and aggression.

Summary of findings

- Ensure there is an effective system in place to monitor and review young people following the use of rapid tranquillisation.
- Ensure there is an effective system in place to make certain that prescribed medicines, including the use of PRN (as necessary) are absolutely required.
- On the 4 and 5 September 2017, we carried out an announced focused inspection, to find out if the service had made improvements to Knole ward. We specifically looked at the concerns identified in the urgent notice of decision.
- At that inspection, we found the service had made some significant improvements to the safety and quality of care and treatment given to young people. We were satisfied appropriate action had been taken to ensure that young people were no longer exposed to the risk of harm. On the 8 September 2017, we lifted all of the conditions set out in the urgent notice of decision and told the provider they could now admit young people to Knole ward. However, further improvements were required.

We found the following issues the service provider needs to improve:

- The service did not comply with the Department of Health guidance on same-sex accommodation on Knole ward. Although young people's bedrooms had en-suite toilet and shower facilities, the ward did not have separated sleeping arrangements in place for males and females and lacked a female only lounge provided.
- Young people's medicines were changed without an individual risk review carried out and decisions to change medicines from tablet form to liquid were not based on individual clinical need. We judged this to be restrictive practice, to suit the needs of the service.
- Medicines were not always available for young people at all times. Where specific medicines were not available, appropriate action was not taken by staff to prevent the risks associated with not taking the medicine prescribed.
- Learning from complaints and serious incidents was not always identified and there were some missed opportunities to improve the service.
- Staff did not operate within the service provider's policy and Mental Health Act Code of Practice to ensure young people were appropriately safeguarded when placed in seclusion or long-term segregation. The use of seclusion and segregation was used to control and contain young people in the absence of other behaviour-based approaches. We took enforcement action and issued a warning notice for regulation 13, safeguarding service users from abuse and improper treatment, on 16 August 2017. The warning notice served, notified the provider the Care Quality Commission had judged the quality of care and treatment being provided to young people as requiring significant improvement. We told the provider they must comply with the requirements of the regulation by 9 October 2017.

However, we also found the following areas of good practice:

- A proactive approach to anticipating and managing risks to young people was starting to be embedded and recognised by staff. Young people were actively involved in managing their own risks through the use of risk assessment tools and worked collaboratively with staff.
- Young people, where needed, had a positive behaviour support plan in place. Staff applied effective proactive strategies to de-escalate or prevent young people's challenging behaviour and applied reactive strategies when needed as per the young person's positive behavioural support plans. The service had a plan in place to reduce restrictive practices on the ward.
- All young people had a current, up to date, personalised care plan to support them through their care and treatment pathway. All young people had a comprehensive physical health assessment completed on admission. The service had implemented the use of 'The Lester Tool'. Physical healthcare needs were mostly incorporated into young people's care plans and were detailed.However, for one young person a physical health care plan was not in place despite a need for one.
- Staff completed physical healthcare checks on young people on Knole ward and these were mostly recorded clearly and consistently so that staff could quickly identify any changes or concerns and take the required

action. The service used a standardised system called Modified Early Warning System. However, further improvement was needed as staff did not always calculate and record scores on all charts.

- There were systems in place to monitor performance on Knole ward. This was measured against a range of indicators, which included safeguarding, incidents and types of incident.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Godden Green

Cygnet Hospital Godden Green has an integrated Tier 4 child and adolescent mental health service alongside a Department for Education, Ofsted -registered school, the Knole Development Centre. Their specialist pathway offers an open acute admissions service (Knole ward), and a pre-discharge ward (Littleoaks) to allow for a smooth transition for young people returning home to their families. The hospital also operates a low secure forensic service for men (Saltwood) that is run in joint working arrangement with Kent and Medway Partnership NHS Trust.

During the course of this inspection, we focussed on Knole ward, which comprised of 16 en-suite bedrooms, for males and females aged between 12-18 years of age.

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

The registered manager for the service is Danmore Padare.

We last inspected this service as part of our ongoing comprehensive inspection programme in April 2016. Following this inspection, we rated child and adolescent mental health wards as good. There were no outstanding requirement notices issued.

Our inspection team

Team leader: Hannah Cohen-Whittle

The team that inspected Knole ward comprised CQC inspection manager, two CQC inspectors', a Mental Health Act reviewer and a specialist nurse consultant with expertise in child and adolescent mental health inpatient services.

Why we carried out this inspection

We undertook a series of unannounced and announced, focused inspections, following concerns raised with us about the safe care and treatment of young people on Knole ward.

On the 25 and 26 July 2017, we carried out an unannounced, urgent responsive inspection on Knole ward due to concerns raised with us including poor discharge planning, lack of communication between staff, relatives and carers and the safety of the ward environment.

On the 4 August 2017, we undertook another unannounced, urgent responsive inspection on Knole ward due to further concerns raised with us about risk assessments, care planning, monitoring of physical health, medicines, use of and reporting of restraint and high levels and serious nature of incidents.

On the 8 August 2017, a member of the medicines team from the Care Quality Commission carried out an announced, focused inspection on Knole ward to see if medicines were safely managed.

On the 4 and 5 September 2017, we carried out an announced focused inspection, to find out if the service had made improvements to Knole ward. We specifically looked at the concerns identified in the urgent notice of decision.

As this was not a comprehensive inspection, we did not pursue all of our key lines of enquiry. We visited one ward within the core service at this location. Therefore, this report does not indicate an overall judgement or rating of the service. Our resources were focussed on inspecting the current areas of potential risk and this should be considered when reading this report.

Summary of this inspection

How we carried out this inspection

During this inspection we considered areas of the service to make a judgement on the following questions:

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

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations and professionals for information.

During the inspection visit, the inspection team:

- visited Knole ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for young people;
- spoke with nine young people who were using the service and seven relatives/carers;
- spoke with the registered manager, clinical service manager and general service manager for the hospital;
- spoke with the ward manager for Knole ward;
- spoke with 13 other staff members; including doctors, nurses, psychologist, social worker and healthcare assistants;
- received feedback about the service from eight care co-ordinators or commissioners;
- attended and observed one shift to shift, hand-over meeting and one multi-disciplinary team hand-over meeting;
- looked at 19 care and treatment records of young people including, prescription and administration charts;
- carried out a specific check of the medication management on Knole ward and observed medications being administered; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with nine young people; some described a positive experience of the service whilst others described a negative experience. Positives included access to home leave and community leave. Some young people were keen to tell us about specific members of staff they felt had provided a high level of care. Everyone we spoke with told us they had a named nurse. However, some young people felt a small number of staff were not always approachable or forthcoming with support. Most of the young people we spoke with did not feel their mental health diagnosis or medicines had been explained properly to them. Young people reported they did not always feel safe on the ward.

We spoke with seven relatives/carers during the course of the inspection and received mixed reviews on the service. Positives included, some carers felt involved in contributing to young peoples' care plans. They were invited to attend care programme approach meetings, and some were aware of plans and goals for discharge. Relatives knew how to raise concerns and complaints with the service, with some describing positive action taken by the service in respect to concerns they raised. However, some carers said that staff did not communicate well with them and they were not always kept informed of every aspect of their relatives care and treatment, including when incidents happened and changes to medicines. Some relatives felt their child was not safe on the ward, particularly during the night shift, due to the level of incidents and poor quality of staff.

We saw the service had received a number of compliments and positive feedback from young people, families and external stakeholders, praising the care and support provided by staff to young people.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues the service provider needs to improve:

- The service did not comply with the Department of Health guidance on same-sex accommodation on Knole ward. Although young people's bedrooms had en-suite toilet and shower facilities, the ward did not have separated sleeping arrangements in place for males and females and lacked a female only lounge.
- There was unwarranted restrictive practice on the ward. Young people's medicines were changed without an individual risk review carried out and decisions to change medicines from tablet form to liquid were not based on individual clinical need. We judged this to be restrictive practice, to suit the needs of the service.
- Medicines were not always available for young people at all times. Where specific medicines were not available, appropriate action was not taken by staff to prevent the risks associated with not taking the medicine prescribed.
- Staff did not operate within the service provider's policy and Mental Health Act Code of Practice to ensure young people were appropriately safeguarded when placed in seclusion or long-term segregation.The use of seclusion and segregation was used to control and contain young people in the absence of other behaviour-based approaches.

However, we also found the following areas of good practice:

- A proactive approach to anticipating and managing risks to to young people was starting to be embedded and recognised by staff. Young people were actively involved in managing their own risks through the use of risk assessment tools and worked collaboratively with staff.
- Risk assessments and risk management plans were completed and detailed. Risk management plans were developed with input from the multidisciplinary team. We found risk management plans summarised all risks identified, situations in which identified risks might occur and action to be taken by the young person and staff in response to any crisis.
- There was a noticeable reduction in the use of restraint and rapid tranquillisation. Staff now focused on preventative approaches. Staff proactively used de-escalation techniques and positive behaviour support.

Summary of this inspection

Are services effective?

We found the following issues the service provider needs to improve:

- Staff did not always calculate scores on the MEWS charts. This meant it might have been difficult to correctly identify concerns about young people's physical health so they could be followed up and appropriate action taken.
- The service did not notify the young person's care team, commissioners or local safeguarding team when incidents of seclusion or long-term segregation took place.
- Staff required further specialist training to ensure they were skilled and competent to meet all young people's needs.

However, we also found the following areas of good practice:

- All young people had a current, up to date, personalised care plan to support them through their care and treatment pathway. All young people had a comprehensive physical health assessment completed on admission. The service had implemented the use of 'The Lester Tool'. Physical healthcare needs were mostly incorporated into young people's care plans and were detailed. However, for one young person a physical health care plan was not in place despite a need for one.
- Ongoing monitoring of physical healthcare conditions was taking place, where needed. For example, the modified early warning system (MEWS), to monitor a young person's physical health care needs, was now fully implemented on the ward. However, staff did not always calculate and record scores on all charts.
- There was a reduction in the need to use of "when required" medicines administered. Records we reviewed showed staff clearly documented the clinical rationale as for the reason why PRN was given and its effect.
- There were effective working relationships with the local authority social services in respect of safeguarding concerns. Members of the young peoples' external care team were invited to attend meetings as part of young person's admission and discharge planning.

Are services caring?

We found the following issues the service provider needs to improve:

Summary of this inspection

- We received mixed reviews on the service from young people and their relatives. Young people reported they did not always feel safe on the ward and relatives expressed a concern for this too. Some relatives said staff did not communicate well with them well.
- Young people reported some staff could come across as unapproachable, due to appearing engaged in other activities. This meant they did not always ask for support when needed.
- Staff did not record if a young person was offered a copy of their care plan and accepted or refused.
- Young people were not invited to attend their weekly ward round meetings, despite some voicing an interest in doing so.

However, we also found the following areas of good practice:

- All interactions we observed between staff and young people were good. Staff interacted with young people in a positive, caring and compassionate manner.
- Young people were involved in the development of their care plans. Care plans were regularly reviewed with the multidisciplinary care team at ward rounds.
- Young people attended their care programme approach meetings.
- Relatives and carers told us they were invited to attend care programme approach meetings, and some were aware of plans and goals for discharge.

Are services responsive?

We found the following issues the service provider needs to improve:

- It was not clear how young people with a learning disability were being supported by staff on the ward or if any modifications had been made to ensure all their needs were met.

However, we also found the following areas of good practice:

- Proactive discharge planning took place from the point of admission. The service worked in conjunction with the young person, families and partner agencies to facilitate discharge as soon as was safely possible.
- Beds were available on a referral basis. The service accepted both urgent and planned admissions.
- Complaints were reviewed and responded to in a timely way.

Are services well-led?

We found the following issues the service provider needs to improve:

Summary of this inspection

- It was not always clear where performance did not meet the expected standard, what action was taken to ensure performance improved. For example, identifying themes and trends.
- The learning from complaints and serious incidents was not always identified and there were some missed opportunities to improve the service.

However, we also found the following areas of good practice:

- The service were committed to making improvements and developed an action plan to support them in doing so. We were unable to gauge the effectiveness of these initiatives as they had not been fully embedded into the service
- There were systems in place to monitor performance on Knole ward. This was measured against a range of indicators, which included safeguarding, incidents and types of incident.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- The ward's layout enabled staff to observe most parts of Knole ward. Mirrors had been appropriately placed in the corners of ceilings to increase visibility. There were some restricted lines of sight on the ward but these were adequately mitigated. Closed circuit television (CCTV) was in use in the communal areas and corridors. CCTV was not constantly monitored by staff. Staff told us that it was in place to safeguard young people and staff should an incident occur. We observed staff presence in communal areas of the ward and recording the young peoples' whereabouts.
- The service did not comply with the Department of Health guidance on same-sex accommodation on Knole ward. The ward admitted both males and females. Although young people's bedrooms had en-suite toilet and shower facilities, there were no designated zones to ensure that males and females had separate bedroom corridors. During each of the inspection visits, we found males and females in bedrooms located next to each other. There was no policy or process in place to explain how bedrooms and facilities were organised to ensure safety, privacy and dignity for young people on the ward. The Mental Health Act Code of Practice (paragraphs 8.25-6) states that: "All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients".
- During our inspections in July and August 2017, the ward did have a female only lounge however, this was uninviting, poorly furnished and used to store lockers and activity equipment. The television had been broken some months prior to the inspection and had not been replaced. During the inspection on the 4 and 5 September 2017, building work was taking place on the ward and the current female lounge was now used as the nursing station. There was no other designated space available at the time of this inspection, although staff we spoke with did tell us females could have access to a similar space if requested.
- During our inspection on the 8 August 2017, we found an appropriate range of emergency medicines was not available, and one medicine was out of date, which meant it might not work as intended. For example, only one Epipen (junior) was available as an emergency medicine to treat anaphylaxis. This was out of date, expired at the end of March 2017. The service did not have an Epipen (adult) which is suitable for patients above 25kg and would have been more appropriate for use.
- During our inspection on 4 September 2017, we found the service had taken action and improvement had been made. The appropriate emergency medicines were available and within their expiry dates, in line with the service provider's policy.
- Controlled drugs (medicines that are more liable to misuse and therefore need close monitoring) were stored securely and registers to record their handling were accurately completed by staff. Waste medicines

were disposed of correctly. The service reviewed and acted upon medicines safety alerts appropriately. There were processes in place for staff to order medicines for people to take away when on leave from the ward.

- During our inspection in July and August 2017, we found the environment on Knole ward to be in need of repair and maintenance works. Some of the decoration and furniture was worn. Several of the walls had graffiti markings on them and old paintwork was peeling off the walls. The clinic room door had recently been damaged because of an incident involving young people on the ward, as had the viewing panel on the door to the nursing office. There was a leak coming through the celling into the corridor because of a burst water pipe from the ward above. Concerns had been raised with us in respect of a room on the ward known as the "fishbowl". This room had floor to ceiling glass panels and was used as a therapy room or somewhere for young people to make private phone calls. Concerns raised included the level of incidents and damage to the fishbowl by young people on the ward and the glass structure of the room. We spoke with the hospital manager and general service manager (responsible for estates and housekeeping) who confirmed there had been three occasions in the last six months prior to the inspection that the fishbowl could not be used due to being damaged. To enable repair work to take place they estimated the room to be out of use for approximately two weeks each time an incident occurred. We further discussed the need for the glass structure and were informed the service was discussing plans to decommission the fishbowl and redesign that area of the ward.
- During our inspection in September 2017, we found the service had taken action and improvements had been made. Building work was taking place on the ward to include relocation of treatment rooms, new flooring and paintwork. Repairs to the leak in the celling had been carried out. The fishbowl had been removed and a new seating area was being built. To discourage young people graffiti on all the walls throughout the ward, staff painted black board walls in the young peoples' bedrooms so if they could graffiti in a designated area that could easily be maintained and cleaned.

Assessing and managing risk to patients and staff

- During our inspection in July and August 2017, we reviewed 11 young peoples' risk assessments. We found that 10 young people had a risk assessment documented at the time of admission, or just after. However, information contained in the risk assessment regarding current and historical risks did not correlate with information about risks documented in the young peoples' pre-admission records. Staff had not updated or reviewed risk assessments, particularly following any incidents that involved the young person. There was no evidence to show the decision-making process staff had followed when rating the risk identified. The risk management plans and crisis plans were vague and did not account for all the risks identified in the initial assessment. For one young person, we found no risk assessment, management or crisis plan documented, however there was a clear identified need for this.
- During our inspection in September 2017, we found the service had taken action and improvements had been made. We reviewed eight care records and found risk assessments and risk management plans were completed and detailed. Risk management plans were developed with input from the multidisciplinary team. We found risk management plans summarised all risks identified, situations in which identified risks might occur and action to be taken by the young person and staff in response to any crisis. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, observation levels of young people might increase or decrease following an incident of self-harm. Individual risk assessments took into account the young person's previous history, which correlated with the information about risks documented in their pre-admission record, as well as their current mental state. However, we found young people were completing a self-assessment of risk prior to leave from the ward. The reason for this was unclear and the information provided by the young person in their self-assessment had no bearing on their leave taking place or not. We spoke with the clinical team about this who agreed the self-assessment of risk lacked effectiveness and planned to stop using it.
- Risk assessments were reviewed and updated weekly by the multidisciplinary team or when an incident occurred if sooner. We reviewed shift-to-shift handover records and complex case meeting minutes and could see young person's key risk information was discussed and shared, with actions put in place when needed to ensure young people were kept safe.

- Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or minimising the harm caused. Staff used a structured professional judgement risk assessment tool called 'Functional Analysis of Care Environments' (FACE) to support this model of working. Staff completed training in risk management and assessment. As of the 31 July 2017, 100% of staff had completed this training. In response to the concerns raised during the course of the inspection, further risk assessment training was undertaken by nursing staff and members of the multidisciplinary team and was facilitated by the lead psychologist. As of the 5 September 2017, 83% of staff had completed this additional training.
- We were concerned there were unwarranted blanket restrictions and restrictive practice on the ward that were not justified. During our inspection in Sepetmber 2017, we reviewed eight young peoples' prescription charts and progress notes. We found six young people had recently had their medicines changed to liquid form when they were previously taking tablets or capsules. Staff we spoke with told us the reason for these changes was because one person had been found stockpiling medicines and having medicines in liquid form would stop this type of incident happening in future. However, we found staff had not undertaken individual assessments collaboratively with each young person taking into consideration their preference and individual needs. Neither had staff supported or enabled young people to understand the care or treatment choices available to them or discussed with them the rationale, risks and benefits involved in changing their medicine to a liquid form. For example, medicines prescribed in a liquid form have a quicker absorption rate compared to tablets or capsules.
- During our inspection in July and August, we found evidence that young people were being subjected to restrictive interventions in the form of restraint and prone restraint. We were significantly concerned that there was a high level of prone restraint being used by staff on young people. Prone restraint is where an individual is held in a restraint position with their face down. This can lead to physical health problems, including difficulty in breathing. We were further concerned that these episodes of prone restraint were not supported by any form of care planning or recorded rationale to support the decision as to why this may have been required. Evidence given to us by the provider showed that during the period of May 2017, there was a total of 48 incidents; 12 of these involved restraint. Of those 12, six involved the use of prone restraint which equated to 12.5%. We spoke with staff on the ward and senior members of the multidisciplinary team who were not aware of any restraint reduction programme that was currently in use by the registered provider at the service.
- During our inspection in September 2017, we found the service had taken action and improvements had been made. All staff re-read and familiarised themselves with the service provider's policy on the prevention and management of violence and aggression. Staff's understanding of the policy was assessed via a competence questionnaire and reviewed by the ward manager. As of 5 September 2017, 83% of staff had completed this.
- The number of episodes of restraint had reduced. Over a three day period, we counted 22 incidents on Knole ward, with less than one third requiring the need for restraint.
- Staff completed incident forms each time an incident happened and recorded if restraint had taken place. However, when a young person was restrained in prone position, staff did not record the reason why or for how long they remained in prone position. Where possible, the use of prone restraint should be recorded.
- The service had introduced a hospital lead and ward champion for Knole ward to work on reducing restrictive practice (RRP) alongside the provider's corporate team. Monthly meetings were planned as part of the service commitment to RRP. The clinical team spoke with us about plans to develop a specific RRP plan tailored to child and adolescent services. We were unable to gauge the effectiveness of either of these initiatives as they had not been fully embedded into the service.
- Staff received training in the prevention of management of violence and aggression. The training taught verbal de-escalation skills, break-away and restraint. The compliance rate for this training as of July 2017 was 100%.
- In response to the concerns raised in the July and August inspections, we found there was a renewed drive from the service to focus on de-escalation tecnhiques and primary interventions to minimise the need for restraint or medicines. During the inspection in

September 2017, we found young people, where needed, had a positive behaviour support plan in place that staff had collaboratively produced with the young person. Staff applied effective proactive strategies to de-escalate or prevent young peoples' challenging behaviour and applied reactive strategies when needed as per the young person's positive behavioural support plan (PBS). A proactive plan describes what to do on a day-to-day basis to help reduce the likelihood of someone resorting to challenging behaviour in the first place, therefore improving their quality of life. As part of the eight care records reviewed, we found PBS plans well completed and individualised to the young person's needs. For example, strategies such as triggers, boundaries and routine and structure were clearly identified. Reactive strategies were also clearly identified and advice how to minimise the likelihood that challenging behaviour will escalate. For example, we found least restrictive strategies in place such as offering the young person to take part in activity of interest instead of telling them to stop what they were doing.

- The service had an observation policy in place. Staff we spoke with were aware of the procedures for the use of observation. The multidisciplinary team determined the level of observation for each young person based on individual and clinical need. Nursing staff were able to increase the level of observation if required. For example, following an incident of self-harm. Throughout the course of the inspection, most young people were on general observations whilst on the ward, with a small number on enhanced observations, which included within staff eyesight.
- The service had a search policy in place. Staff we spoke with were aware of the procedures for the use of personal and room searches. Staff carried out routine and random searches, or when a risk was identified, of the ward environment, including young people's bedrooms. Staff told us that they would search young people if there were concerns they were carrying contraband items, for example, on return from leave to the ward. Staff had access to a metal detector to support them in carrying out searches. However, during the course of the inspection we found there was inconsistency in the way staff were carrying out and managing searches. Some staff would complete personal searches as soon as a young person returned to the service and prior to entering the ward. Other staff would not do this. Staff we spoke with felt that more training could be provided to support them in carrying out searches. We spoke with the hospital manager and clinical services manager who informed us that staff did not regularly undertake search training. We were made aware of a number of incidents on the ward because of contraband items, such as razor blades, being brought onto the ward.
- During our inspection in July and August 2017, we found evidence that young people were receiving rapid tranquillisation via intramuscular injections for agitation or aggressive behaviour. Rapid tranquillisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. We spoke with nurses on the ward and the clinical service manager who informed us that staff undertook monitoring of young people following the use of rapid tranquillisation and documentation was attached to the incident form in the logbook. We reviewed the incident logbook and young people's care records and found only two cases where such documentation was evident. We were significantly concerned that staff were not carrying out regular physical health monitoring following the use of rapid tranquillisation, including side effects, vital signs, hydration level and consciousness, to ensure no further concerns about a person's physical health. Staff did not operate in line with the service provider's policy and national guidelines.
- During our inspection in September 2017, we found the service had taken action and improvement had been made. Between the 8 August 2017 and 5 September 2017, there had been no use of intra-muscular rapid tranquillisation. The service put in place an action plan and told us that in future nurses would complete physical health reviews following the use of rapid tranquillisation to monitor for side effects. Staff would document in records the reason for the use of rapid tranquillisation, how effective it was and any adverse effects observed or reported by the young person. Records would then be reviewed by the ward manager and clinical service manager to ensure safe practice and adherence with the service provider's policy. However, we were unable to gauge the effectiveness of these planned actions as they had not yet been needed.

Child and adolescent mental health wards

- Knole ward did not have a seclusion room. During our inspection in August 2017, we were concerned about the use of seclusion and long-term segregation and found staff were not operating in line with the service provider's policy.
- All seclusion and long term segregation took place in young people's bedrooms whereby the practice was to place a staff member in a chair in their doorway to prevent them leaving. The provider did not act at all times in accordance with The Mental Health Act Code of Practice, Chapter 26, paragraph 26.151 which states "The environment should be no more restrictive than is necessary. It should be homely and personalised as risk considerations allow. Facilities which are used to accommodate patient's in conditions of long term segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person".
- We were concerned the use of seclusion and segregation on Knole ward was used to control and contain young people in the absence of other behaviour based approaches. We considered the approach to seclusion and long term segregation was punitive and used as a form of control. For example, one young person was care planned to go into segregation for a period of five days if they attempted to ligature or self-harm. This was contrary to the guidance in the providers policy (entitled "policy for seclusion and long-term segregation") which stated "Seclusion must not be used to manage self-harming behaviour. The only circumstances where a patient who is actively harming themselves can be secluded is when the risk they pose to others outweighs the risk they pose to themselves".
- As per the providers policy, the local safeguarding team should have been informed if a young person had been placed in long-term segregation. Where it had been agreed, family members should also have been informed of the outcome of seclusion/long-term segregation reviews. The outcome of all reviews and the reasons for continued segregation should also be recorded and the responsible commissioning authority should of been informed of the outcome. However, there was no evidence to demonstrate that this had been done in any of the records we reviewed.
- The recording of seclusion and segregation was poor. There was no evidence that the decision to seclude or segregate a young person was based on a multi-disciplinary team decision . There was no evidence in some cases about the length of time seclusion or segregation would last. Staff did not act at all times in accordance with The Mental Health Act Code of Practice, chapter 26, paragraph 26.154 which states "Staff supporting patients' who are long term segregated should make written records on their condition on at least an hourly basis. Furthermore, The Mental Health Act Code of Practice, Chapter 26, paragraph 26.155 which states, "The patient's situation should be formally reviewed by an approved clinician at least once in every 24-hour period".
- Following the inspection in August 2017, we took enforcement action and issued a warning notice for regulation 13, safeguarding service users from abuse and improper treatment. We told the provider they must comply with the requirements of the regulation by 9 October 2017. This will be followed up by the Care Quality Commission at a future inspection.
- During our inspection in September 2017, staff we spoke with told us they had recently attended additional training for seclusion and long-term segregation. All staff re-read and familiarised themselves with the service provider's policy on seclusion and long-term segregation. Staff's understanding of the policy was assessed via a competence questionnaire and reviewed by the ward manager. As of 5 September 2017, 76% of staff had completed this.
- The service put in place an action plan and told us that in future staff would be provided with training on completing seclusion records. Reviews of records would take place immediately and monthly audits would take place to ensure compliance. However, we were unable to gauge the effectiveness of these initiatives as they had not been fully embedded into the service.
- During our inspection on 8 August 2017, we found medicines were stored securely however; medicines were not always managed safely. We found one medicine, which required storage between 2oC and 8oC but had been stored at ambient temperature. Medicines

must be stored within the manufacturer's recommended temperature range or they may not work as intended. We raised this with the clinical team on the day of the inspection and immediate action was taken to address the concern.

- There were no records for the temperature of the medicines fridge from 01 July 2017 to 16 July 2017. Staff we spoke with told us they lacked record sheets to record this but had checked the fridge daily. Records for previous months were present and demonstrated the medicines in the refrigerator had been stored at the correct temperature, which meant they remained fit for use.
- We reviewed eight prescription and administration charts. These were signed and dated and allergies were well recorded. However, we found that medicines were not always available for young people at all times. For example, one chart showed that a young person did not have timely access to a medicine for epilepsy. The medicine was prescribed on the 25 July 2017 and recorded as not in stock on the 26 July 2017. There was no evidence to demonstrate that staff had attempted to obtain stock or had raised this with the doctor to get an alternative medicine prescribed. This meant the young person was put at risk, as they were unable to take the medicine prescribed.
- During our inspection on 4 September 2017, we found a medicine prescribed to stop prolonged seizures was still not available for a young person despite us raising concerns at our last inspection. Again, we brought this to the attention of the clinical team and were assured immediate action would be taken to address the concern raised; a doctor would review the young person and medicine prescribed.

Reporting incidents and learning from when things go wrong

- During our inspection in July and August 2017, we found a high level of incidents on Knole ward. The majority of incidents related to self-harm, in particular tying ligatures, swallowing of objects and deliberate cutting.
- All incidents on Knole ward were reported to the commissioners and guidance was sought if a root cause analysis investigation needed to be carried out, it was not clear what action was taken by the service to identify themes and trends or what measures were put in place to reduce that type of incident. For example, from the incidents we reviewed we saw many took place during the night shift. Learning across the ward was not evident. We reviewed the log for these and found investigation reports were completed within the agreed timescales.
- During our inspection in September 2017, we found the service had taken action and improvement had been made Staff we spoke with knew how to recognise and report incidents. Following our inspection in July and August 2017, the ward manager told us that they now reviewed all incidents daily and then forwarded them onto the clinical service manager, for sign off. The system ensured that members of the multidisciplinary team were alerted to incidents in a timely manner and could monitor the investigation and response to the incidents. All incidents were reviewed as part of handover meetings and during the young peoples' ward rounds.
- Medicine errors were recorded as incidents and staff we spoke with told us that they shared experiences of learning at clinical meetings and handovers. However, there was still no evidence that analysis of incident trends had been undertaken to support staff learning to reduce the risk of future reoccurrences.
- In response to the concerns raised during the inspections in July and August 2017, the service implemented weekly sessions with staff to share learning from incidents. For example, CCTV footage was reviewed to see what went well and what action staff could take to improve in future.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- During our inspection in July and August 2017, we reviewed 11 young people's care records, of which we pathway tracked five in detail. Pathway tracking is about capturing the experience of a sample of people who use a service. We track the experiences of people by a combination of feedback from people who use services and those involved in the person's care, a review of patient notes and records.
- We were significantly concerned that young peoples' physical healthcare needs were not being met. Out of

the 11 care records reviewed, we found that on admission 10 young people had a detailed physical health assessment completed by the doctor or nurse. However, there was very little evidence that staff were carrying out ongoing physical health monitoring. This included no regular assessment and screening or appropriate follow up and intervention. We found evidence where a doctor had identified a specific physical health need for a young person and had documented in their care records a need for staff to carry out physical health monitoring. However, staff did not follow this. Care plans and risk assessments did not reflect young peoples' identified physical healthcare needs. As per the provider's policy, staff had not completed a care plan with any young person on the ward about restraint.

- During our inspection in September 2017, we found the service had taken action and improvement had been made. All young people had a current, up to date, personalised care plan to support them through their care and treatment pathway. A care pathway is a structured approach to care delivery that clearly describes the journey a person is likely to take when moving through the care system. This ensures that individuals receive the most appropriate care and treatment, with clearly agreed timescales and in the least restrictive environment. Knole ward used the care programme approach for planning and evaluating care and treatment. However, we only found one restraint care plan out of the eight care records we reviewed. Although young people, where needed, now had a positive behaviour support plan in place, this focused on preventative strategies including de-escalation. Staff were not operating in line with the service provider's policy on managing violence and aggression which stated, all young people would have a restraint care plan in place which would detail their preference for future restraints.
- Staff assessed young peoples' needs and care was delivered in line with their care plans. Care records showed all young people had physical health examinations on admission completed by both a doctor and nurse. During the inspection in September 2017, we found physical healthcare needs were mostly incorporated into young people's care plans and were detailed. However, for one young person a physical health care plan was not in place despite a need for one due to ongoing substance misuse.

Best practice in treatment and care

- During our inspection in August 2017, we found records for physical health monitoring showed it was not always undertaken in line with what had been requested by clinicians. For example, for one young person it was recorded on the front of their prescription chart to monitor their temperature for the next five days. However, there was no evidence to show staff had done this.
- During our inspection in August 2017, we were concerned that young people were receiving medicines prescribed for "when required" use (PRN) and this was not done in a safe or therapeutic way. Staff did not clearly document the clinical rationale as for the reason why PRN was given and its effect. We were further concerned that these PRN medicines were being used in the absence of alternative therapies such as positive behaviour support and were therefore not always required.
- During our inspection in September 2017, we found the service had taken action and improvements had been made. On the 7 August 2017, the hospital manager carried out a baseline audit to review the use of PRN medicines. Because of that audit changes were made including, the introduction of a weekly review of PRN use in the young peoples' ward round. The ward manager facilitated an education session about PRN usage to young people on the ward and staff to better their understanding. More emphasis was put on the development of positive behavioural support plans and the use of de-escalation. We reviewed eight prescription and administration charts and found there had been a reduction in the use of "when required" medicines administered on Knole ward.
- The service had implemented the use of 'The Lester Tool'. This monitoring tool aims to guide staff to assess and monitor physical health needs for people experiencing psychosis and schizophrenia. The poster guide looks at six key areas including a person's smoking history, lifestyle, body mass index, blood pressure, glucose regulation and blood lipids with appropriate interventions and targets to improve a

person's physical health. The service had a physical health monitoring policy. One of the nurses on Knole ward took a lead on physical health and was available to all staff to provide support and advice when needed.

- Ongoing monitoring of physical healthcare conditions was taking place, where needed. For example, the modified early warning system (MEWS), to monitor a young person's physical health care needs, was now fully implemented on knole ward. This system worked by staff allocating a score to a series of physical health measures such as blood pressure and oxygen saturation levels. When a young person's score reached a given level this triggered what action was required from staff. Staff were trained to use the MEWS tool to observe changes in a young person's presentation. However, on three of the young people's care records we reviewed, we found staff did not always calculate scores on the MEWS charts. This meant it might have been difficult to correctly identify concerns about young people's physical health so they could be followed up and appropriate action taken.
- Where needed, young people had a positive behaviour support plan in place. Positive behaviour support looks at the meaning of behaviour for an individual and the context in which the behaviours occur. This understanding assists staff to design more supportive environments and to better support individuals in developing skills that will improve their quality of life.

Skilled staff to deliver care

- The staff working on Knole ward came from a range of professional backgrounds, which formed the multidisciplinary team and included a consultant and specialist child and adolescent doctor, nurses, occupational therapists, social worker, psychologists and therapists and healthcare assistants. A pharmacist visited the ward weekly to provide support.
- During our inspection in July and August 2017, we found staff did not have the necessary competence and knowledge to oversee and deliver certain aspects of physical healthcare, for example, diabetes and epilepsy, as specialist training was not provided. The service admitted young people to the ward with a diagnosis of learning disability, however staff did not have the skills to appropriately support them with all aspects of their care.
- During our inspection in September 2017, we found the service had taken action and improvements had been made. Additonal training had been sourced and staff were due to attend a training session on epiliepsy awareness on the 19 September 2017. Further additional training was still required to ensure staff could support young people with all their required needs.
- During our inspection in September 2017, we found the psychology team helped to facilitate training and awareness to staff on Knole ward. For example, the psychology department developed and delivered risk assessment training.
- Staff we spoke with said they felt supported by the local management structure and their colleagues. The ward manager and clinical service manager were highly visible and available on the wards to support staff and young people when needed. Staff told us morale was generally good but at times, it was low due to incidents on the ward.

Multi-disciplinary and inter-agency team work

- A multidisciplinary team meeting (MDT) is composed of members of health and social care professionals. The MDT collaborates to make treatment recommendations that facilitate quality patient care. We saw a number of different professions supported the young people on Knole ward and those we spoke with confirmed this.
- We reviewed multidisciplinary records and saw that each member of the team contributed during reviews and the discussion was focused on sharing information, young people's treatment and reviewing their progress and risk management. However, healthcare assistants were not invited to attend young people's ward round reviews, and those we spoke with felt they could contribute positively if they were given the opportunity to do so.
- Complex case management meetings took place weekly. Members of the clinical team met to discuss any issues of concern with a young person's care or treatment. For example, delayed discharges. We reviewed the minutes for these and saw actions were set and reviewed the following week.
- We found evidence of inter-agency working taking place, with members of the young peoples' external care team invited to attend meetings as part of young person's admission and discharge planning. We saw evidence of

effective working relationships with the local authority social services in respect of safeguarding concerns. The ward had strong links with a local general practitioner. However, the service did not notify the young person's care team, commissioners or local safeguarding team when incidents of seclusion or long-term segregation took place.

Are child and adolescent mental health wards caring?

Kindness, dignity, respect and support

- We spoke with nine young people and seven relatives/ carers during the course of the inspection and received mixed reviews on the service. Positive experiences included access to home leave and community leave. Some young people were keen to tell us about specific members of staff they felt had provided a high level of care. Everyone we spoke with told us they had a named nurse. However, some young people felt a small number of staff were not always approachable or forthcoming with support. Young people reported not always feel safe on the ward. Relatives and carers told us they were invited to attend care programme approach meetings, and some were aware of plans and goals for discharge. However, some relatives/carers said that staff did not communicate well with them and they were not always kept informed of every aspect of their relatives care and treatment. Some relatives felt their child was not safe on the ward, particularly during the night shift, due to the level of incidents and poor quality of staff.
- During the course of the inspection, staff spoke with us about young people; they discussed them in a respectful manner and demonstrated a good level of understanding of their individual needs. Staff appeared interested and engaged in providing good quality care to the young people on Knole ward. We observed staff interacting with young people in a positive, caring and compassionate way when in the communal areas or carrying out observations. However, some of the young people on the ward told us staff were not always readily available to respond promptly to requests for assistance and it was difficult to get their attention when they were in the nursing office.

The involvement of people in the care they receive

- During our inspection in September 2017, we saw evidence of young people's involvement in the care plans we reviewed. We found them to be person-centred and recovery orientated with goals identified and details of the support young people needed to achieve their goals. We saw young people had their care plans regularly reviewed with the multidisciplinary care team at ward rounds and with a member of the ward nursing team when required. However, young people we spoke with told us they did not have a copy of their care plan. Some could not remember if they were offered a copy or not.
- Young people we spoke with told us they were encouraged by staff to plan for ward round meetings by completing a document beforehand. Requests such as home leave, recreational activities and shopping purchases could be made for the multidisciplinary team to consider. Young people attended their care programme approach meetings. However, they were not invited to attend their weekly ward round meetings. Staff we spoke with told us this was because previously some young people had reported finding this stressful. In community meeting minutes, dated 14 August 2017, we found ward round attendance had been discussed and five out of seven young people said they would like to attend.
- There were weekly community meetings on the ward where young people were able to raise any concerns and help plan activities.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Access and discharge

- Beds were available on a referral basis. Referrals for admission to the service came from NHS England who commissioned Tier 4 beds across the country. The service accepted both urgent and planned admissions.
- Young people on Knole ward were accepted based on review of paperwork rather than face-to-face assessment. Urgent referrals into services like Knole ward would not necessitate staff carrying out a face-to-face assessment with the young person. However, where admissions were planned, face-to-face

assessments were not considered by the service. Although staff undertook thorough pre-admission assessments to ensure only young people who could be managed at the service were admitted, sometimes information provided as part of the referral was not accurate. Staff we spoke with told us that at times information about recent incidents or past forensic history and diagnosis was not provided and the service did not find this out until after the young person had been admitted to the ward. This meant there were occasions when people were not suitably placed and this had a detrimental effect of the young person and the service.

- Pro-active discharge planning took place from the point of admission. The service worked in conjunction with the young person, their relatives and partner agencies to facilitate discharge as soon as was safely possible. Young people's discharge was always planned and appropriate environments were identified before discharge from the service. Estimated discharge dates were discussed during weekly ward rounds and at care programme approach meetings.
- Staff completed discharge summaries and these were sent to the young person's external case manager as well as the general practitioner and commissioner.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and facilities to support young people on Knole ward. These included rooms for therapy sessions, a lounge with entertainment such as television and game consoles, an open plan kitchen and dining area and a large communal conservatory with direct access to an outside astro-turfed area. Outside there was seating available and sports equipment for the young people to use.
- The ward had a kitchen where young people could access snacks such as fresh fruit and cereal and hot drinks 24 hours a day.
- Young people were able to personalise their bedrooms. They had individual lockers in the communal area where the could store possessions if they did not want to keep them in their bedrooms.

Meeting the needs of all people who use the service

- It was not clear how young people with a learning disability were supported whilst on the ward. For example, for those young people with a diagnosis of learning disability, we did not see care plans offered in an easy to read format. Nor was it clear if the approach to the delivery of treatment interventions and therapies was altered to meet their individual needs.
- The service supported young people to continue with their education when admitted to the ward and provided all materials required. Some of the young people we spoke with told us they had recently taken their GCSE exams. One young person told us they were being supported by staff to enrol in college.

Listening to and learning from concerns and complaints

- Young people knew how to complain and information detailing how to was clearly displayed on the ward. Young people we spoke with told us they would use the community meeting to raise concerns.
- Complaints were reviewed by the hospital manager, responded to in a timely way and listened to. Parent's were invited to attend meetings with the service to discuss their concerns further. We saw some improvements were made to the quality of care as a result.

Are child and adolescent mental health wards well-led?

Good governance

- During the course of our inspection, we found there were systems in place to monitor performance on Knole ward. This was measured against a range of indicators, which included safeguarding, incidents and types of incident. However, it was not always clear where performance did not meet the expected standard, what action was taken to ensure performance improved. For example, identifying themes and trends. The learning from complaints and serious incidents was not always identified and there were some missed opportunities to improve the service.
- During our inspection in September 2017, the service had taken action to address this. However, we were unable to gauge the effectiveness of these initiatives as they had not been fully embedded into the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they have separate sleeping arrangements in place for males and females and must provide a female only lounge.
- The provider must ensure that when young people's medicines are changed, an individual assessment is carried out and any decision to change medicines is based on clinical need and not restrictive practice or to suit the needs of the service.
- The provider must ensure that medicines are always available for young people at all times. Where specific medicines are not available, appropriate action must be taken by staff to prevent the risks associated with not taking the medicine prescribed.
- The provider must ensure all staff operates within the service provider's policy and Mental Health Act Code of Practice to ensure young people are appropriately safeguarded when seclusion and long term segregation is used.
- The provider must ensure the use of seclusion and segregation is not used to control and contain young people in the absence of other behaviour-based approaches.

Action the provider SHOULD take to improve

- The provider should consider the use and effectiveness of the young person completing a self-assessment of risk prior to leave from the ward.
- The provider should ensure that temperatures for the medicines fridge are always recorded.
- The provider should ensure that staff are accurately scoring and recording on young people's MEWS charts.
- The provider should ensure that young people have a care plan in place for all identified physical health needs.
- The provider should ensure that staff are recording how long a young person is restrained in prone position.
- The provider should ensure that all young people have a care plan in place for restraint.
- The provider should ensure all staff are trained and competent to carry out personal and environmental searches.
- The provider should ensure that analysis of all incident trends is undertaken to support staff learning and to reduce the risk of future reoccurrences.
- The provider should ensure all staff have access to a range of specialist training to support them in their role.
- The provider should consider healthcare assistants attending multidisciplinary team meetings.
- The provider should ensure young people are offered a copy of their care plan and this is documented by staff.
- The provider should ensure that young people are supported to attend their ward rounds when they have expressed a wish to do so.
- The provider should ensure that young people with a learning disability have access to the appropriate support they need.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care and treatment was not always designed to meet individual's needs or preferences. The provider did not ensure that a change to young people's medicines was based on an individual assessment and clinical need as oppose to restrictive practice to suit the needs of the service. This was a breach of regulation 9(1)(2)(3)(a)(b)(c)(d)(e)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The provider did not have separate sleeping arrangements in place for males and females and lacked a female only lounge on Knole ward This was a breach of regulation 10(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider did not ensure that medicines were always available for young people at all times to prevent the risks associated with medicines that are not administered as prescribed.

This was a breach of regulation 12(1)(2)(a)(b)(f)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Staff did not operate within the service provider's policy or Mental Health Act Code of Practice to ensure young people were appropriately safeguarded when seclusion and long-term segregation were used. The use of seclusion and segregation on Knole ward was used to control and contain young people in the absence of other behaviour-based approaches. This was a breach of regulation (1)(2)(4)(b)(c)(d)(7)(a)(b)