Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

St Nicholas Hospital
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Ratings

Overall rating for this service	Good
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Requires Improvement**

Our findings

Child and adolescent mental health wards

Good

We carried out a responsive, unannounced inspection over three days. This was because of information we had received giving us concerns about the safety and quality of the services.

This was a focused inspection looking at safe effective and well led key questions. We did not rate key questions at this inspection. However, due to a regulatory breach in well led this domain has been limited to requires improvement.

Summary

- The use of restrictive practices had increased significantly since the last inspection, including the use of mechanical restraint.
- Governance systems had identified that limited formal debriefs were taking place. Managers had started to implement changes to address this. However, at the time of the inspection the level of formal debriefs taking place was not in line with trust policy.
- There was evidence of oversight and scrutiny of the use of restrictive practice within the trust management forums. However, the trust had not maintained a continued reduction in restrictive practices within services for children and young people.

However,

- The wards had enough nurses and doctors. Staff usually assessed and attempted to manage risks well.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff felt respected, supported and valued by local leaders.

How we carried out the inspection

We visited four wards at Ferndene and two wards at Alnwood. We spoke with 23 staff members including clinical managers, nurses, support workers and members of the multidisciplinary team, four young people, two carers and reviewed 15 care records and attended three meetings. We also spoke to the advocate and commissioners before the inspection.

What people who use the service say

We were able to speak to four young people who all said that they felt safe on the wards and that staff supported them. The young people said that staff had spoken to them after incidents of restraint, but one young person felt that they weren't listened to about their experience of a restraint.

Our findings

Is the service safe?

Inspected but not rated

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The service had vacancies for one band six nurse, 14 band 5 nurses and 21 support workers, however, shifts were covered by bank and agency staff who were familiar with the wards.
- Training compliance for Prevention and Management of Violence and Aggression was below the trust target due to the cancellation of face to face training during the covid pandemic. Staff were being supported to attend training courses during November 2020 and this was a trust wide risk on the risk register. At the time of the inspection there were eight members of staff who had not completed Prevention and Management of Violence and Aggression training and they were placed on other duties until they could complete the training.
- Staff usually assessed and managed risks to patients and themselves well and attempted to use de-escalation to manage challenging behaviour. However, we found that incidents of restraint were high and had increased significantly since the last inspection. Staff reported that the acuity on the wards had increased since the last inspection and the use of restrictive practices had increased to manage incidents. Records showed that staff used restraint and seclusion after attempts at de-escalation had failed and the ward staff participated in the provider's restrictive interventions reduction programme. However, debriefs were not always taking place to review practice and discuss alternative interventions.
- The incidents of mechanical restraint (the use of a device such as belts or cuffs) had increased in the two years since the last inspection to 241 in 2019/20.
- Staff told us that the use of mechanical restraint was only used in an emergency to transport the young person to a place of safety or back onto the ward from outside areas. Records showed that staff followed the trust policy before mechanical restraint was used and director approval was sought. However, formal debriefs were not always taking place after incidents allowing the team to consider other strategies and interventions which may have avoided the use of mechanical restraint.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff had introduced a new system for patients coming back from leave in response to patients absconding when returning to the ward. This was individually risk assessed for each patient.

Is the service effective?

Inspected but not rated

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Care plans contained examples of the activities patients enjoyed and trigger words that should be avoided with patients.

Our findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide care and treatment to children and young people. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff including agency staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation including education and social services.

Is the service well-led?

Requires Improvement 

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- However, our findings from the safe domain demonstrated that governance processes did not always operate effectively.
- The use of mechanical restraint and opportunity to explore alternative approaches through formal debriefs did not always take place. Debriefs should be completed after the use of restraint including mechanical restraint in line with trust policy. Limited debriefs had taken place between May 2020 and September 2020 at Ferndene. However, there was evidence of some improvement taking place in October 2020.
- The trust had failed to sustain a reduction in restrictive practice. At our previous inspection the trust had achieved a significant reduction in restrictive practices. At this inspection there has been a significant increase in all types of restrictive practice. There was evidence of scrutiny and discussion about the levels of restrictive practice at local and trust wide meetings. However, there was little evidence to show what interventions had been put in place to challenge the high levels of restrictive practice being used, including mechanical restraint or that the least restrictive approaches were being considered for those patients that were subject to the use of restraint, including mechanical restraint.

Our findings

Areas for improvement

The trust must review the use of restraint and mechanical restraint in the children and young person's inpatient services. The use of mechanical restraint should be used as a last resort in line with Department of Health *Positive and Proactive Care* . There should be a clear debrief process for the team after an incident and for the person who has been restrained.

Regulation 17 (2) (b)

Our inspection team

The team that inspected the service comprised of three CQC inspectors and a specialised advisor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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