Central and North West London NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services caring?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Child and adolescent mental health wards

Requires Improvement 

Lavender walk is a children's inpatient service provided by Central and North West London NHS Foundation Trust (CNWL). The ward offers assessment, management, and treatment on an inpatient and day basis for children and young people aged 13 up to their 18th birthday. The ward can accommodate up to 12 young people as inpatients and 4 as day patients.

The child and adolescent mental health wards core service was last inspected in 2015 with a rating of good across all domains and good overall. In 2020 we carried out a focussed inspection of a different child and adolescent ward within the trust and this inspection was not rated.

This was a focussed inspection where we looked at the domains of Safe, Caring and Well Led. Where we have found a breach of regulation, the rating for this domain is limited to requires improvement. Following this inspection, the ratings for Safe and Well Led were limited to requires improvement. The rating for Caring remained as Good, the same as the previous inspection.

The unit primarily accepts referrals for young people who are resident in or registered with a GP in any North West London borough.However, it also takes young people from London and surrounding counties if a bed is available. Providing care for young people with a primary diagnosis of mental illness and which does not exclude those with a mild learning disability, drug and alcohol problems or social care problems as secondary needs, some young people may require detention under the Mental Health Act. It does not accept referrals for young people with moderate to severe learning disability or those who require low or medium secure services.

The service is registered by the CQC to provide the following regulated activities:

Treatment of disease, disorder, or injury,

Assessment or medical treatment for persons detained under the 1983 Act

Diagnostic and screening procedures.

This unannounced inspection was prompted in part by notification of an incident following which a person using the service died. This inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of ligature. This inspection examined those risks.

At the time of the inspection the ward had reduced their inpatient numbers in response to this incident. During the first visit there were 7 young people and on the second visit there were 9 young people admitted to the ward.

We found several areas of good practice:

Our findings

- Staff had training in key skills and understood how to protect young people from abuse.
- The ward was visibly clean and well maintained. Staff managed infection risk well.
- The service used information from safety incidents to learn lessons and used information collected to improve the service.
- Staff assessed risks to the young people and acted on them. They provided effective care and treatment and offered emotional support when young people needed it.
- Most staff treated patients with compassion and respected their privacy and dignity. Staff provided emotional support to the young people, families, and carers.
- Young people told us that they enjoyed the range of activities the ward offered including therapies and education.
- Leaders were committed to running the ward well and using reliable information systems. All staff were committed to continually improving the service.
- Staff we spoke to said they felt supported and valued.
- The staff had improved their engagement with young people, families, and carers.

However:

- The ward continued to have a high vacancy rate among nursing staff. Although this had reduced significantly, there was a continued reliance on agency and bank staff, particularly overnight. The service also had a higher turnover and sickness absence rate than the trust average. This meant nursing staff were not always familiar with the young people and their care and treatment needs.
- The ward did not always manage risk well. We observed patient care and treatment records that were not always clear about a young person's risk behaviour and how this should be safely managed.
- Young people told us that they did not always feel safe on the ward and that some staff did not treat them with kindness and respect.
- Governance processes related to medicines management on the ward were not always effective. On the first inspection visit we observed several areas of concern around medicines management. For example, there were several expired medicines in the clinic room.

What people who use the service say

Parents and carers told us they found the staff team very supportive, responsive, and helpful. They also said the staff were caring, polite and interested in the wellbeing of the young people. They told us staff supported them in their parenting role.

All the young people we spoke with said they were happy with the activities on the ward, and they had plenty of things to do even at the weekend. They told us they enjoyed working with the education and therapies team.

The young people said most staff treated them with dignity and kindness. However, all of them told us they felt less safe overnight with staff they were unfamiliar with, and some young people told of us staff who did not treat them with respect and kindness.

Our findings

Is the service safe?

Requires Improvement  

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. We reviewed the most recent risk assessment audit dated February 2023 and all ligature points were identified and scored appropriately.

Ligature points were mitigated either through control measures or estate works. For example, gaps around the ward notice board and CCTV had mastic to seal the gaps. The ward garden was included in the ligature risk assessment with mitigations in place to ensure the safety of the young people when they used it.

Ligature cutters were available on all the wards and all staff we spoke to knew where they were located. Some risks were acknowledged and accepted due to the risk of potential injury being greater if they were removed. For example, smoke alarms systems.

The ward was in the process of installing mirrors in the female corridor to reduce blind spots and this was scheduled to be completed the week of the inspection visit. Staff knew about any potential ligature anchor points and mitigated the risks to keep young people safe.

The ward complied with guidance and there was no mixed sex accommodation. All bedrooms were ensuite, and the female bedroom corridor had a separate lounge area.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness, and infection control

The environment was well-maintained and clean. We observed some minor works that were needed in the sensory room. However, these were included on the ward improvement plan and funding had been sought to make improvements.

Staff followed infection control policy, including handwashing. The ward completed hand hygiene audits monthly which showed high levels of compliance.

The ward had a garden area which was well maintained.

Our findings

Ward staff were responsible for carrying out cleaning audits monthly. The yearly audit scores for the 12 months prior to our inspection visit showed most areas looked at scored 100% and none fell below the target audit score of 90%. The lowest score was 94%.

Clinic room and equipment

On the first inspection visit, the clinic rooms on the wards were not well organised or tidy. We observed broken equipment, unused medicines disposal bins and no evidence of cleaning rotas. We raised this with the provider on the day. When we went back to inspect, we found these issues had been rectified and the clinic rooms were organised, equipment repaired, medicines bins appropriately used and 'I am clean' stickers on equipment.

Resuscitation bags and oxygen cylinders were available. Staff checked the emergency equipment and drugs regularly and recorded this in a check book.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm. However, high nursing vacancy rates meant a continued over-reliance on agency and bank staff.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. However, the ward had high nursing vacancy, turnover and levels of sickness absence rates. Half of the young people we spoke to said they regularly had their escorted leave cancelled because staff were not available to take them.

There were enough staff on each shift to carry out physical interventions, such as restraint, where necessary.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. Managers used the daily safety huddles to determine patient acuity and staffing needs and worked with temporary staffing to adjust staffing levels as required.

Young people told us that they had regular 1 to 1 sessions with their named nurse or another member of the nursing team if their named nurse was not available.

Staff shared key information to keep children and young people safe when handing over their care to others. The ward had recently introduced a midday 'touchpoint' in addition to the safety huddles which happened twice daily at the handover of a shift. We observed a handover to the night shift, which was comprehensive, covering a range of areas for each patient including legal status, risks, mental state, and observation levels.

Managers made sure bank and agency staff had an induction and understood the service before starting their shift. All agency and bank staff we spoke to told us they had an induction to the ward, and they felt confident working with the young people. Temporary staff were included in the nurses' business meetings and had supervision every 6 weeks, which was recorded in a folder on the ward.

Permanent staff had access to supervision every 6 weeks including clinical supervision for nursing staff. At the time of the inspection staff were 100% compliant with management and clinical supervision.

Our findings

Although managers tried to limit their use of bank and agency staff and requested staff familiar with the service, this was not always possible due to the high vacancy rate.

At the time of the inspection the vacancy rate was 12%. Although this had reduced over the previous 3 months from 49%, we were concerned about the impact this had on the care and treatment of young people accessing the service.

The nursing vacancy rate meant that the service had a high rates of bank and agency nurse use, particularly overnight. In the 12 months prior to the inspection 17% of days were covered by agency staff and 11% covered by bank staff. This meant staff on night shift were often unfamiliar with the young people on the ward.

The service had a high turnover rate of 47%. Although this had reduced from 56% since March 2022. The leadership team were proactively working on recruitment and retention of new staff through a range of initiatives including targeted recruitment campaigns, financial incentives and enhanced continual professional development opportunities.

Staff sickness was higher than the trust average sickness. For example, the sickness absence rate for the ward in March 2022 was 7.5% compared with the trust average of 4.3%. However, sickness absence had gradually reduced over the 12 months prior to the inspection to 5.5% in January 2023.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

The ward had 2 whole time equivalent (WTE) consultant psychiatrists, and 2 WTE trainee psychiatrists.

The ward had access to an on call junior doctor. Although they were based on site, the doctor provided cover to 3 wards including an older adults ward based at another site. This sometimes impacted on their ability to attend the ward quickly overnight. The clinical lead had updated the policy to clarify procedures to ensure staff understood the on call doctor remit and when to contact them for support.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff.

The training programme including immediate life support, infection prevention and control, safeguarding adults and children, medicines management and mental health and mental capacity law.

Most staff had completed and kept up-to-date with their mandatory training. For example, 81% of staff were up to date with their emergency life support training. The training rate for management of violence and aggression was 68% for the whole staff group but rose to 84% when new staff, staff on long term sick or those booked onto the next available training date were included in the data. Managers identified staff dedicated to responding to emergency alarms at the start of each shift.

Temporary staff who worked regularly on the ward had an induction which included a range of subjects. For example, how to carry out and document observations, the location and use of emergency equipment, de-escalation protocol, ligature risk assessment and management plans and patient search policy and procedure. All temporary staff we spoke to confirmed they had received this induction and found it helpful.

Our findings

Managers monitored mandatory training and alerted staff when they needed to update their training. All training completed by staff was recorded. This enabled managers to see the training compliance for each staff member on a training dashboard. Managers discussed mandatory training compliance with staff during supervision and staff meetings.

Assessing and managing risk to children and young people and staff

Staff did not always manage risks to young people well. Staff followed best practice in anticipating, de-escalating, and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

All patient care and treatment records we reviewed showed risk assessment completed and updated on a weekly basis. Risks recorded were clear and rated in severity. Risks were related to discussion in the weekly ward round and reflected what was in progress notes.

Patient care plans and psychological formulation documents we reviewed regularly, after incidents and linked to the young person's risk assessment.

Management of patient risk

The ward matron had introduced a new safety huddle document for use during handovers. This document was comprehensive and was completed prior to the handover meeting by the nurse in charge of the previous shift. This meant that staff coming on shift understood the care and treatment needs of the young people.

We observed a handover meeting and noted the document supported a focused discussion around the young people's risks and needs. Staff proactively contributed to meaningful discussions about the progress of patients and changes to their individual risk following any recent incidents.

Handover meetings were clearly documented for staff to refer to and stored on the ward shared drive.

Staff observed patients in all areas of the ward and followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

However, risks were not always managed well. During the incident in October 2022 the initial review detailed several areas of concern related to management of patient risk including observations prescribed and carried out outside of the trust policy.

On the first inspection visit we had concerns about how observations were being conducted, with some intermittent observations being done at predictable intervals. On the second inspection visit we observed an improvement in this area.

Our findings

On the first inspection visit it was unclear how frequently PEWS should be taken (Paediatric Early Warning Score is a tool used to detect and respond to clinical deterioration in paediatric patients). Although documentation indicated this should be done daily but this did not match with what was recorded. On the second visit we observed improvements in this area with care plans clearly detailing PEWS frequency which matched up with the recording frequency with fewer gaps. For example, 1 of 3 records we reviewed had 2 gaps in consciousness level.

A review of patients' care and treatment records showed for one young person there was a lack of clarity around their care and treatment plan which could have led to serious harm. We were concerned this might lead to a lack of understanding on how to safely manage the young person's risk behaviours, particularly considering the current levels of bank and agency staff on the ward. We raised this with the ward, and they provided assurances about how the management of this patient's risks were being communicated to the whole team and that the young person's care plan was updated.

Use of restrictive interventions

At the time of the inspection, levels of restrictive interventions were low and had reduced significantly over the 12 months prior to the inspection. The trust incident reporting system had been updated to include the use of safety pods in restrains (the pods can be used to safely restrain patients without using prone or supine restraint on the floor).

Restraints had reduced to 4 incidents in January 2023 (their lowest level) from a high of 26 in April 2022. There had been no prone restraints on the ward in the 3 months prior to our inspection visit.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the young person or others safe. Attempts to use verbal de-escalation techniques before using restraint were clearly documented in patient care and treatment records on occasions where patients had become agitated.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The ward had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. At the time of the inspection, staff were 86% complaint with safeguarding level 3 training in adults and 93% complaint with their training in safeguarding level 3 in children. In both children and adults' level 3 training, 7% of staff not up-to-date were new starters and booked on to training courses.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, when supporting young people who did not identify with the gender they were assigned at birth, staff worked hard to ensure the young people's preferred pronouns were respected in their paperwork. The occupational therapist had ran a series of groups around gender identity to provide a safe space to discuss, explore and learn about these issues.

Our findings

Staff knew how to recognise adults and children at risk of harm and worked with other agencies to protect them. Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. Patient care and treatment records showed evidence of appropriate safeguarding referrals being made, where necessary and follow up discussions in the multidisciplinary team meetings (MDT).

The ward social worker took a lead for safeguarding including the use of a spreadsheet to track safeguarding referrals and keep the multidisciplinary team updated regularly at the ward round.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records, whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All information about a patient's care and treatment was stored on an electronic patient record.

Records were stored securely. Records could only be accessed by staffing entering a username and confidential password.

Medicines management

Although the service had systems and processes to safely prescribe, administer, record and store medicines, these were not always effective. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

The clinical pharmacist attended the MDT twice a week to provide clinical input and advice to staff and young people.

Medicines were dispensed by the pharmacy department. The ward held an amount of stock medicines to meet young people's needs and anything that was unavailable could usually be delivered that same day.

There was access to an out of hours pharmacy service for weekends and bank holidays.

Staff reviewed medicines regularly and provided advice to the young people and their carers about medicines.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

The weekly multidisciplinary meeting included a discussion around medicines. The young people were able to input into these meetings to ask for increase or reductions in dose or changes to prescribed medicines to meet their needs. These discussions were clearly documented in progress notes. For example, one young person had discussed a specific medicine with the doctor for their ear infection.

Use of a 'when required' (PRN) medicines had an appropriate entry to explain why it was needed and if it had the desired outcome.

Our findings

Any medicines or treatment regimens that required additional monitoring would have these carried out within the required timeframe. At the time of the inspection the service had no patients on high dose anti-psychotic therapy and no one on medicines with special monitoring requirements.

Staff stored and managed all medicines and prescribing documents safely.

Access to medicine storage areas and cupboards was appropriately restricted on the ward.

Medicines incidents were reported using an electronic system.

The service had a system to manage medicine safety alerts and would record actions taken.

However, on the first inspection visit we had several concerns about medicines management. This included the clinic room not being organised, broken equipment (including the fridge lock and pulse oximeter) and the medicines fridge being used to store juice.

Although staff ensured that medicine records were mostly accurate and up-to-date, a review of 5 patient prescription cards showed a medicines error relating one young person who received more than the prescribed dose of 'as required' medicine in one 24 hour period. We raised this with the provider on the day of the inspection.

Consent to treatment documents were in place for patients and updated throughout their admission.

Controlled drugs or CD (medicines with additional storage requirements) were held at the service and there was a policy in place. The service stored CD correctly, in line with legislation with access restricted to authorised persons. However, on the first inspection visit we noted that the CD logbook had 1 patient recorded but the CD cupboard contained medicines for 2 patients (1 had been discharged). There was no evidence of pharmacy oversight in logbook which had started on 31 January 2023.

Medicines management audits were conducted regularly. This included quarterly medical devices and controlled drugs (CD) audits and monthly safe and secure handling audits. Outcomes from these would be shared with the ward to help show where they were performing well and where improvements could be made around medicines optimisation. For example, we reviewed actions from the safe and secure medicines audits from 2022 which showed follow up actions including reminding staff to check fridge temperatures and lock medicines cupboard when not in use.

Medicines were stored appropriately so they remained safe and effective for use. The service used thermometers to monitor fridge and ambient room temperatures. We saw examples of appropriate action being taken when temperatures went outside of the recommended range to ensure the medicines continued to be safe and effective for use. However, we noted that the treatment room medicine fridge temperature recording was missed on 4 dates in February and 2 dates in January. The clinic room medicine fridge temperature recording was missed on 3 dates in February and 1 date in January.

On the second unannounced visit to the ward, we found that the issues we raised after the first visit had been addressed and we found no additional concerns relating to medicines management.

Track record on safety

Reporting incidents and learning from when things go wrong

Our findings

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 children and young people honest information and suitable support.

The ward had already begun to implement learning from the incident in October 2022 which resulted in the death of a person using the service. The leadership team met weekly with the key stakeholders in addition to a more condensed operational weekly meeting which monitored and tracked progress through an improvement action plan.

Key changes had already been implemented including the immediate termination of 5 minute observations requiring all observations to be prescribed in line with trust policy.

The ward had introduced a lanyard to be worn by nursing staff when undertaking observations. This meant the likelihood of them being interrupted whilst doing so was reduced and the lanyard itself also detailed observation expectations to support best practice.

Staffing rosters had been reviewed to make sure at least 1 permanent member of staff was on overnight.

There was evidence that changes had been made as a result of feedback. For example, a room had recently been converted into a dedicated area for patient searches following previous incidents. This enabled staff to search young people safely and effectively, whilst maintaining their privacy and dignity.

Staff knew what incidents to report and how to report them. Staff told us they were encouraged to report all incidents and near misses using an electronic incident reporting system in line with trust policy.

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

Managers debriefed and supported staff after any serious incident. Staff we spoke to told us they had opportunities to debrief and felt supported by management following incidents. Senior managers looked after staff wellbeing and attended the ward when things went wrong. For example, the service director had introduced weekly 'listening sessions' for all staff to raise concerns.

Staff received feedback following incidents, both internal and external to the service. Business meeting minutes from both wards showed staff routinely discussed learning from incidents.

The nurses' business meeting enabled staff to discuss more routine ward incidents, themes and learning from those incidents that did not meet the 'serious' threshold. This meeting was minuted and all nursing staff, including temporary staff were invited to attend.

We observed this meeting and found it was well attended and allowed opportunities for staff to hold routine discussions about learning from recent incidents and to prevent similar incidents re-occurring.

Is the service caring?

Good ➔➔

Our findings

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion, and support

Most staff treated children and young people with compassion and kindness, although feedback from patients described a small number of staff who did not. Staff respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment, or condition.

Patients told us most staff were respectful and responsive when caring for them. We observed that staff discussed young people with respect and compassion at handover meetings and were knowledgeable regarding patient needs. For example, staff were encouraged to offer one young person warm milk or apple juice as they were unlikely to ask for it because of paranoia and this had been on the list of preferred food items.

Bedroom doors displayed a poster detailing patient preferences including likes and dislikes, support network, communication needs and things to help them get up in the morning. We saw inclusion of the patient voice in 5 of 7 patient records we reviewed.

Staff gave young people help, emotional support and advice when they needed it. Young people told us they were able to meet with staff whenever they needed to.

Young people we spoke to were positive about the multidisciplinary team, permanent nursing, and education staff. They described the activities as ‘really good’ and said there was always lots to do to keep them occupied, even at weekends.

The ward therapeutic timetable included groups to support with emotional regulation. For example, a weekly distress tolerance skills group which helped young people manage emotions without feeling overwhelmed.

Staff took young people’s personal, cultural, social, and religious needs into account. For example, the education team would hold events to celebrate different religious holidays.

All the staff we spoke to described a culture of openness on the ward and said they felt confident in raising any concerns about disrespectful or discriminatory behaviour without fear of the consequences. Staff said they would raise concerns directly or use forums such as business meetings or reflective practice.

Staff followed policy to keep patient information confidential.

However, young people said not all staff treated them well or behaved kindly toward them. They described some staff laughing when they were distressed, discussions they thought were about them that were not in English or not interacting with them at all when they were supposed to be observing them.

Young people told us that they did not always feel safe on the ward. For example, 2 of the 3 young people we spoke to told us that they did not feel safe sleeping in their bedrooms at night and preferred to sleep in communal areas with CCTV because the overnight staff were often agency staff, they were unfamiliar with. At the second visit all the young people were sleeping in their own bedrooms.

Involvement in care

Our findings

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

Involvement of children and young people

Staff involved young people and gave them access to their care planning and risk assessments. Most of the young people we spoke to had been involved in their care planning although none of them had a copy. We reviewed 7 patient records of which 5 included a care plan and had a detailed sensory care plan which included the young person's voice.

Staff supported children and young people to understand and manage their own care treatment or condition. The ward had a positive behaviour support (PBS) practitioner who co-produced PBS plans with the young people which would include guidance for staff on how to have positive interactions with them. These were saved on the shared drive and in a folder in the nurses' station for ease of access.

Staff involved children and young people in decisions about the service, when appropriate. For example, the young people were consulted on how to decorate the bedrooms and had been able to decide on a theme and colours. They had also been supported to develop a community charter which set out expectations between patients and staff.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The ward held regular community meetings which were minuted and provided an opportunity for young people to make suggestions and give feedback on the service. Response to feedback was displayed on ward notice boards via 'you said, we did' posters. For example, the introduction of toiletry packs provided on admission which were co-produced with the young people.

Staff made sure children and young people could access advocacy services. We observed posters clearly displayed on the ward which provided details of how to contact an advocate.

The service had an admission pack which provided essential information about the ward. However, only half the young people we spoke to told us they had been given a copy and shown around the ward when they were first admitted.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families and carers. Records showed regular contact between the ward and families either over the phone or through attendance at review meetings and ward rounds.

Parents of young people were updated about their child's care and treatment regularly through contact with the nursing staff and the multidisciplinary team (MDT).

Carers, including their needs and input, were discussed in the MDT and handover.

The ward held a carers group however, this was not well attended. At the time of the inspection the managers were working on ways to involve carers more. For example, they hoped to organise a joint cinema trip with the young people and their families.

Our findings

Carers said staff were pleasant, friendly, and knowledgeable. They told us they were invited to attend review meetings and were given updates on their relatives' care and treatment, where consent had been provided to do so.

One carer told us that if she asked to speak to the doctor, they would not have to wait long for them to return the call. Another carer said they were regularly updated and communicated with the social worker by phone and through emails. Carers told us they found the staff supportive.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families, and staff.

At the time of the inspection several key members of leadership team had been in post less than a year including the service director, the matron, and the clinical lead. The ward had also been without a ward manager for 3 months, however successful recruitment meant a new ward manager was starting on 6 March.

Staff said leaders and managers in the service were supportive and spoke highly of them.

Leaders were aware of the key challenges and risks and were open in sharing them. They were clear about how staff were working to provide high quality care that was safe, whilst striving for continued improvement in challenging circumstances.

Managers were visible on the ward, interacting with patients and staff. They attended multidisciplinary team meetings and handovers regularly.

The ward leadership team was working to support and develop good relationships and to improve morale, culture, and safety on the ward through the ward improvement plan and by trying to integrate the wider multidisciplinary (MDT) team with the nursing team. For example, members of the MDT had changed their working pattern to include weekends and evenings.

Carers we spoke to were positive about leaders.

Vision and strategy

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

Our findings

The ward Statement of Purpose was rewritten following dedicated away days to ensure it was an inclusive process with all staff involved. This meant that staff understood, and were invested in, the ward vision and values and staff we spoke to understood how these related to the work they did.

The ward had recently submitted a proposal to the provider collaborative (a group of providers working together to improve care pathways for the local population) which detailed a more flexible, reactive, and less restrictive model of care. This model reduced the length of patient stay, created a day patient facility and post-discharge therapy capacity with the established inpatient therapy team working in collaboration with the community CAMHS service.

The post-discharge support service would include additional sessions with psychologists and family therapists. The ward had begun to trial this with some young people who had been able to go home overnight, even when unwell, with additional support and resources available during the day.

Culture

Staff felt respected, supported, and valued. They could raise any concerns without fear.

Staff were aware of senior leaders in the organisation and said managers visited the ward regularly. Staff we spoke to told us they felt well supported by their managers. For example, one person described having felt 'burnt out' recently but that they had received support and positive feedback from their manager which enabled them to continue working and feel valued at work.

We observed the current leadership team trying to create a supportive, learning culture which included senior nurses and members of the MDT spending more time on the ward in the evenings at weekends. For example, the inclusion of role model shifts, particularly in the evening and healthcare assistants being allocated to an registered nurse each shift for additional support.

The staff we spoke to told us they could raise concerns either formally or informally if they felt victimised and knew how to access the whistle blowing process if needed. Staff described the matron as visible on the ward and encouraging staff to seek support, if needed.

Governance

Our findings demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the ward. For example, the matron had introduced a weekly nursing business meeting providing staff with the opportunity to discuss successes and areas for improvement. This meeting was well attended by permanent and non-permanent staff.

Managers and staff were clear on the risks they faced and when they were missing targets and were working hard to make improvements and mitigate any risks. Performance and risks were routinely discussed in business and nursing meetings.

Our findings

The ward governance processes covered areas including risk, medicines, clinical audit results, referrals, and discharges. Leaders had reviewed these processes following the serious incident in October 2022 and tracked progress through the improvement plan.

However, there were still some areas of governance that needed strengthening. We were concerned that medicines governance processes were not always effective and that learning from audits was not always embedded across the staff team.

Whilst there were systems and processes to prescribe and administer medicines safely, these were not always followed. The ward improvement action plan detailed completed actions relating to medicines management, but this was not reflected in what we observed during our initial inspection visit. For example, all nursing staff had undertaken medicines optimisation training, however we observed numerous out-of-date medicines being stored in the clinic room, no up-to-date medicines stocklist available and a lack of clarity around who was responsible for checking expiry dates on medicines.

Additionally, despite the introduction of spot checks on nursing practice and competencies and managers visiting the ward out of hours, young people told us they often felt unsafe and unfamiliar with staff overnight.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Service level risks reflected those recognised by staff and risk registers had clear action plans to mitigate any risks identified. The risk registers reflected the key challenges and risks faced by the ward.

The ward risks were included on the service line risk register and included action plans, progress updates and risk ratings for each item. For example, recruitment was rated high risk but medium risk with mitigating actions in place which included a recruitment strategy which estimated the nursing team would be fully recruited to by June 2023 and monitoring supervision and appraisal compliance to support with improving staff experience and retention.

Leaders and managers had oversight of the risks both wards faced and demonstrated a clear understanding of how to improve performance.

Managers monitored performance indicators including serious incidents, infection control, outcome measures and the use of agency staff. Members of the MDT took part in audits which were reported on a quarterly basis with action plans and recommendations to reduce any shortfalls. Performance indicators were discussed at management and nurse business meetings to monitor progress and identify any barriers to mitigating issues.

The service stored care plans on the shared drive. The ward was actively working on improving care plan quality at the time of the inspection which included updating the care plan proforma. However, the shared drive was not as easy to navigate and find information quickly. This meant staff, including temporary staff, might miss important patient information.

Information management

Staff engaged actively in local and national quality improvement activities.

Our findings

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The electronic patient record system was effective for documenting patients' needs, care planning, monitoring mental and physical health as well as recording and updating risk assessments. Patient records were kept confidential.

We reviewed minutes of the care quality performance management group (CQPMG) and nursing and senior management meetings for the last 3 months. We also reviewed performance and quality reports and dashboard data for the 12 months prior to the inspection and found there was clear recording of information, updates, and actions.

The ward made notifications to external bodies as appropriate including statutory notifications to CQC and local authorities.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

The ward collaborated closely with local partners, including the provider collaborative who had undertaken an assurance visit in February 2023. Recommendations made and implemented following this visit included the design and introduction of a new post-incident debrief tool designed to support nursing staff have reflective conversations following an incident.

Leaders understood the importance of consistently engaging and involving staff in decision-making regarding improvements. In addition to regular team meetings, managers had organised an away day to work on the service statement of purpose. The day had been used to strengthen the team and reflect on the work that the staff group undertook to support the young people.

Innovative approaches were used to gather feedback from families of young people who used the service. For example, structured interviews undertaken by an independent parent peer support worker were done in December 2022. In addition to positive feedback, areas for development and next steps were identified as a result.

A parent / carers advisory board had been developed to work alongside a CAMHS young persons' board which formed part of the trust's commitment to improving services with the views and support of the people using them and their carers. Information from these boards flowed upwards to division and executive board level and down to the ward via the CQPMG meetings.

Learning, continuous improvement and innovation

The staff group were committed to wanting to improve through innovation and continuous learning.

The lead occupational therapist had delivered sensory room training to all nursing staff as part of their induction. This increased understanding of the benefits of supporting young people to use this space effectively with the aim of reducing restrictive interventions.

Our findings

The ward drove innovation through quality improvement projects. For example, the ward improvement plan identified staff needed to engage better with young people when they were on continuous observations. To support meaningful engagement, the ward had introduced activity belt bags. These were bumbags which held a range of items immediately available to facilitate conversation between nursing staff and young people and included games, conversation starters and sensory items.

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Our findings

Areas for improvement

MUSTS

- The trust must ensure clear lines of communication between the multidisciplinary and nursing team so that all staff have a shared understanding of young people's risk behaviours and how to safely manage them. Regulation 12 (1) (2) (b)
- The trust must ensure staff always follow NICE guidelines when administering rapid tranquilisation, including all necessary physical health checks and that these are clearly recorded on the incident management reporting system. Regulation 12 (1) (2) (g)
- The trust must review medicines management governance processes to ensure that all staff follow safe prescribing, storing and administration of medicines policies and procedures consistently. Regulation 17 (1) (2) (b) (c) (f)

SHOULDS

- The trust should consider completing regular audits of PEWS scores to ensure any gaps in recording continue to be reduced.
- The trust should consider increasing pharmacy oversight of controlled drugs to reduce the likelihood of discrepancies between what is recorded in the logbook and what is stored in the controlled drugs cupboard.
- The trust should continue to address nursing vacancies and ongoing work to increase the numbers of permanent staff on shift overnight.
- The trust should ensure all staff behave in a kind, caring and compassionate way to patients
- The trust should consider auditing patient information stored on the shared drive to ensure essential information contained in care plans is easy to access and navigate.

Our inspection team

How we carried out the inspection

This was an unannounced, focused inspection on Lavender Walk, part of the child and adolescent mental health wards core service.

During this inspection we looked at the following key questions:

- Is it safe?
- Is it caring?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the service.

During this inspection we:

- Carried out two unannounced visits to the ward. One visit was out of hours
- observed the nursing handover and the multi-disciplinary team handover
- conducted a tour of the ward environment and observed how staff communicated with the young people
- spoke with 18 members of staff, including the unit matron, service director and clinical lead
- spoke with 4 young people and 3 relatives
- looked at 24 patient care and treatment records including care plans, observation records, prescriptions records and Paediatric Early Warning Score (PEWS) charts
- reviewed the incident data for the ward
- looked at a range of policies, procedures and documents related to the service

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

The team that inspected the service consisted of 2 inspectors, 1 specialist advisor with experience working in CAMHS mental health services and an expert by experience. An expert by experience is someone who has experience of care and treatment in a mental health service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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	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	Regulation 17 HSCA (RA) Regulations 2014 Good governance