The Priory Ticehurst House

Quality Report

Ticehurst
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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

Ratings

Overall rating for this location

Are services safe?	Inadequate
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We undertook an unannounced, focused inspection of the child and adolescent mental health wards at The Priory Ticehurst House because we had received concerns from stakeholders, members of the public and carers. Concerns included poor staffing levels, the high use of agency staff, poor medicines management and the number of incidents occurring at the service.

The Priory Ticehurst House was last inspected as a full comprehensive inspection in November 2018, when it was rated 'good' in safe, effective, caring, responsive and well led. However, the service was issued with a requirement notice that related to regulation 18 of CQC (Registration) Regulations 2009. This was because the inspection found that the service did not make sure they informed CQC of notifiable events.

During this focused inspection we inspected the safe and well led key questions for the children and adolescent mental health wards. The rating for the safe and well led domain went down to inadequate since our last comprehensive inspection. Our overall rating of this service went down.

After our inspection, we issued the provider with a warning notice against regulation 17, good governance. This was because we were not assured that the provider operated effective audit and governance systems and / or processes to make sure they assessed and monitored the service in response to the environment, risks and incidents. The provider had not acted on risks identified about the environment for several months. There was not effective scrutiny of incidents and safeguarding to make sure that patients received safe care and treatment.

We returned to The Priory Ticehurst House on 12 December to check that the provider had complied with the requirements of the warning notice. We found that the provider had put in place some improvements to their audit and governance systems and processes relating to risks and incidents and was taking action to reduce environmental risks on Upper Court. We were satisfied that the provider had met the requirements of the warning notice and we have therefore lifted the warning notice. It will take time for the improved audit and governance systems and processes to demonstrate sustained improvement in learning from incidents and risk management.

We rated the children and adolescent mental health wards as inadequate because:

- The environment on Upper Court had blind spots that did not allow for clear lines of sight. There were risks rated red on the environmental risk assessment in January 2019 that had not had the identified actions taken to mitigate the risks. Two windows and a door had been damaged the night before our inspection. The on-call maintenance team had used perspex over the windows and doors as a temporary measure to make safe. The risks concerning the windows and doors had not been added to the assessment. The ward and communal areas were tired.
- Patients on Upper Court had to walk some distance to reach the designated outside area. The journey involved walking down narrow staircases, past the main reception and the outside areas of male and female wards. Fences had been covered to protect dignity and provide an enclosed area.
- A number of experienced staff had moved from Upper Court to Keystone ward when it opened in April 2019. In the previous 12 months, there had been seven consultant psychiatrists providing clinical care on Upper Court.
- There had been a gradual increase in incidents of behaviours that challenge involving physical restraint since April 2019. Data provided by the service showed that most incidents occurred after 6pm. There was no evidence of the provider acting on or learning from a recent spate of incidents involving the same patients. Patients said they were bored and that little or no activities took place outside of school hours.
- There was evidence of a lack of management review for incidents. There were inconsistencies in the detail and information recorded on the incident reporting tool. Missing information included the risk level and whether external agencies had been notified. Incidents were scored between one and five, with five being the lowest harm and one being the highest. Information was only cascaded to senior managers if a risk level

Summary of findings

had been recorded three or lower. None of the incidents we reviewed had been rated below four, despite some requiring police attendance. Managers had not reviewed many of the incidents for several weeks. Staff said that learning from incidents was not shared.

- The governance processes did not ensure that wards ran smoothly. There was insufficient oversight and scrutiny by senior managers to ensure actions identified in the environmental risk assessment had been carried out, risks were reviewed and learning was implemented. There was a lack of preventative action to avoid recurrence of incidents.
- Audits had not been updated to reflect the change from Upper Court's change from a high dependency unit to a tier four service.
- There was low morale of staff on Upper Court ward. Some staff said they felt unable to raise concerns without fear of retribution.

However:

- The environment on Keystone ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Both Keystone ward and Upper Court had enough nursing staff. Most of the nurses on both wards were regular agency staff.
- The social worker was shared across Keystone ward and Upper Court. There was a social worker assistant in post. There was a part time psychologist, an art therapist and family therapist available for the wards. A vacancy for a part time psychologist and assistant psychologist was being advertised. There was an occupational therapy assistant on the ward. The occupational therapist was shared across both wards.
- Patient risk assessments were comprehensive and up to date in all eight care records reviewed.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Managers ensured staff received appropriate training and supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	**Inadequate**	• The ward and communal areas on Upper Court were tired. There were risks rated red on the environmental risk assessment in January 2019 that had not had the identified actions taken to mitigate the risks. • A number of experienced staff had moved from Upper Court to Keystone ward when it opened in April 2019. In the previous 12 months, there had been seven consultant psychiatrists providing clinical care. • There had been a gradual increase in incidents of behaviours that challenge involving physical restraint since April 2019. There were inconsistencies in the detail of information recorded on the incident reporting tool. There was no evidence of the provider identifying themes or learning from incidents. • The governance processes did not ensure that wards ran smoothly. There was insufficient oversight and scrutiny by senior managers to ensure actions identified in the environmental risk assessment had been carried out, risks were reviewed and learning was implemented. There was a backlog of incidents waiting for a manager to review. There was a lack of preventative action to avoid recurrence of incidents. • Audits had not been updated to reflect the Upper Court's change from a high dependency unit to a tier four service. • The risk register and learning log included immediate actions taken by the provider to mitigate risks but there was no information about identifying themes or learning to avoid repetition. • The meeting structure provided the opportunity to review a range of audits. However, we were not assured that managers identified themes or learning. Actions identified on audits were not always acted on in a timely way. Audits had not been updated to reflect the change from Upper Court's change from a high dependency unit to a tier four service.

Summary of findings

However:

- The environment on Keystone ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Both Keystone ward and Upper Court had enough nursing staff. Most of the nurses on both wards were regular agency staff.
- The social worker was shared across both CAMHS wards. There was a social worker assistant in post. There was a part time psychologist, an art therapist and family therapist available for the wards. A vacancy for a part time psychologist and assistant psychologist was being advertised. There was an occupational therapy assistant on the ward. The occupational therapist was shared across both wards.
- Patient risk assessments were comprehensive and up to date in all eight care records reviewed.
- Staff had easy access to clinical information and it was easy for them to maintain clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

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Summary of this inspection

Background to The Priory Ticehurst House

The Priory Ticehurst House is situated in East Sussex. It provides mental health services for adults and young people. During this inspection, we only inspected the wards for young people because the concerns we had received were about these wards.

The child and adolescent mental health service at the hospital has two wards; Keystone ward is a 12-bed mixed sexed purpose built psychiatric intensive care unit. Upper Court is a 13-bed female only ward. Upper Court changed from a high dependency unit to a tier four service in June 2019. A tier four service provides assessment and treatment for children and young people with emotional, behavioural or mental health difficulties. During our inspection, there were eight patients on Keystone ward and nine patients on Upper Court.

The hospital also had three acute psychiatric wards. One ward was a 21-bed ward for female patients, another was a 13-bed male ward and there was one nine-bed mixed sex ward for private paying patients only.

The Priory Ticehurst House is registered for the following regulated activities:

- Assessment and medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder and injury

The Priory Ticehurst House was last inspected as a full comprehensive inspection in November 2018, when it was rated 'good' in safe, effective, caring, responsive and well led. However, the service was issued with a requirement notice that related to regulation 18 of CQC (Registration) Regulations 2009. This was because the inspection found that the service did not make sure they informed CQC of notifiable events.

The Priory Ticehurst House has been inspected seven times since it registered with CQC in November 2010.

There is a registered manager at the service.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one inspection manager, three specialist advisors with knowledge and experience of working within child and adolescent mental health services and an expert by experience.

Why we carried out this inspection

We carried out this focused inspection in response to concerns raised from families, external agencies and members of the public. Concerns included poor staffing levels, high use of agency staff, poor medicines management, the number of incidents and staff training.

Summary of this inspection

How we carried out this inspection

As this was a focused inspection, we only looked at the key lines of enquiry in the safe and well led domains to respond to the concerns received. We asked the following questions of the service:

- Is it safe?
- Is it well led?

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

During the inspection visit, the inspection team:

- visited both wards for children and young people at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the registered manager and managers or acting managers for each of the ward;
- spoke with three consultant psychiatrists
- spoke with eleven other staff members; including nurses, a night cover co-ordinator, social workers, health care assistants and agency staff
- received feedback about the service from the local authority designated officer and assistant local authority designated officer
- spoke with an independent advocate
- spoke with six carers
- attended and observed three hand-over meetings a multidisciplinary morning meeting and a safeguarding meeting
- looked at eight care and treatment records of patients
- carried out a specific check of the medication management on two wards
- reviewed and tracked 10 incidents, 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

Patients told us they were bored and there were no activities during the school holidays or outside of school hours. They said that there was a notable difference between the attitude and the use of de-escalation between staff who worked during the day and those who worked nights.

Patients said that they had to wait a long time for routine maintenance requests, such as putting up curtains, to be completed.

Carers told us that they felt there was enough staff on the ward and that overall they felt their relative was safe. They told us there was regular contact with staff. However, they said that there had been an inconsistency in consultants on Upper Court and that some had been rude to them.

Both patients and carer said there was a lack of activities and community leave was often cancelled at short notice because the service was short staffed.

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?

Inadequate

We rated safe as **inadequate** because:

- The environment on Upper Court had blind spots that did not allow for clear lines of sight. The ward and communal areas were untidy and unwelcoming. Staff said the environment on Upper Court was unsuitable and the therapeutic needs of the patients could not be met because of the acuity of some patients.
- Patients had to walk some distance down narrow stairs and past adult wards to reach the outside area.
- There were risks rated red on the environmental risk assessment in January 2019 that had not had the identified actions carried out to mitigate the risks. Two windows and a door had been damaged the night before our inspection. The on-call maintenance team had used Perspex over the windows and doors as a temporary measure to make safe. The risks concerning the windows and doors had not been added to the assessment. The ward and communal areas were tired.
- A number of experienced staff had moved to Keystone ward when it opened in April 2019. In the previous 12 months, there had been seven consultant psychiatrists on Upper Court. Staff on Upper Court were visibly stressed.
- There had been a gradual increase in incidents of behaviours that challenge involving physical restraint since April 2019. Data provided by the service showed that most incidents occurred after 6pm. Patients said they were bored and that little or no activities took place outside of school hours. The data suggested a correlation between the increase in incidents and the lack of activities. Parents and carers said that incidents were related to boredom. There was no evidence of the provider acting on or learning from a recent spate of incidents involving the same patients.
- A change in the electronic reporting system had affected how the interim safeguarding lead was informed of safeguarding incidents. Staff did not always send them information about any safeguarding incidents in a timely way.
- The quality and detail recorded about incidents was inconsistent. Missing information included the risk level of the incident and if other agencies, including the safeguarding team, should be notified. Many of the incidents had not been reviewed since August 2019.

However:

Summary of this inspection

- The environment on Keystone ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Both Keystone ward and Upper Court had enough nursing staff. Most of the nurses on both wards were regular agency staff.
- Patient risk assessments were comprehensive and up to date in all eight care records reviewed.
- Staff had easy access to clinical information and it was easy for them to maintain clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

Are services effective?

Start here...

Are services caring?

Start here...

Are services responsive?

Start here...

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- Staff morale on Upper Court ward was low. Several regular and permanent staff from Upper Court had moved to Keystone ward in April 2019. Staff appeared to be overwhelmed with the current level of risk and patient acuity on the ward. Some staff said that the change from a high dependency unit to a tier four service had not been managed well and some patients were inappropriately placed. Some staff said they felt unable to raise concerns without fear of retribution.
- Staff said that the high turnover of staff and inconsistent medical cover had been difficult. Challenges in recruitment had affected the quality and consistency of consultant psychiatrist support.
- The governance processes did not ensure that wards ran smoothly. There was insufficient oversight and scrutiny by senior managers to ensure actions identified in the environmental risk assessment had been carried out, risks were reviewed and learning was implemented. There was a lack of preventative action to avoid recurrence of incidents.
- The risk register and learning log included immediate actions taken by the provider to mitigate risks but there was no information about identifying themes or learning to avoid repetition.

Summary of this inspection

- The action log from the learning by experience meeting did not include any recent incidents involving patients absconding, barricading of patient allegations against staff.
- The meeting structure provided the opportunity to review a range of audits. However, we were not assured that managers identified themes or learning. Actions identified on audits were not always acted on in a timely way. Audits had not been updated to reflect the change from Upper Court's change from a high dependency unit to a tier four service.
- A handover form had been created to ensure consistency of information sharing across wards. We observed staff on Upper Court using the form during handovers, but staff from Keystone ward did not.

However:

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We did not review the service's adherence to the Mental Health Act as part of this focused inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the service's adherence to the Mental Capacity Act as part of this focused inspection.

However, as part of the well led key question, we reviewed policies and procedures for patient consent to the use of CCTV surveillance. Staff had recorded that one of the nine patients who had signed consent was not Gillick competent. Gillick competence is used to determine whether a person under the age of 16 has capacity to consent to medical treatment. Staff said that the consultant psychiatrist had the overall decision whether the surveillance was used.

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Effective	
Caring	
Responsive	
Well-led	Inadequate

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

Upper Court was a 13-bed female only ward. There were nine patients at the time of our inspection. The environment on Upper Court was tired and in need of decoration. The ward consisted of three corridors which affected staff lines of sight. Blind spots (places on the ward that could not be easily observed) were mitigated by the use of CCTV and by staff observation in communal areas. None of the bedrooms had en-suite facilities and bathrooms were not very clean. Many of the doors did not automatically lock when closing which increased the risk of patients absconding. Following a recent incident, windows in the main dining area had been covered with perspex and some of the doors had been altered to open inwards to reduce the risk of patients kicking the door open. However, two of the doors remained unchanged. Following the inspection the provider sent us plans of the measures identified to be taken to improve the security of the doors on Upper Court.

Patients had to walk down narrow staircases and along several corridors past the main reception and male and female adult wards to reach the designated outside area. The allocated outside area was the furthest from the building. The walkway had been covered to protect dignity and create an enclosed area.

Staff completed daily environmental checks including fire records and key checks.

The environmental risk assessment for Upper Court had not been updated to include damage to the environment following two recent incidents. Inspectors raised this with the manager who confirmed that they planned to complete a ligature assessment the following week. Issues that had been rated red in January 2019 on the environmental risk assessment were still outstanding. The assessment had not been updated to reflect the change from a high dependency unit to a tier four unit in August 2019.

Keystone ward was a purpose built psychiatric intensive care unit. The environment was clean, open and welcoming. The ward was a 12-bed mixed-gender ward with separate male and female bedroom areas. The bedrooms all had ensuite bathroom facilities. The nurses station was in the centre of the ward which allowed staff clear lines of sight. Staff used CCTV monitors to support patient observation. Patients had supervised access to a large outside area which was accessed from the communal lounge.

The seclusion room on Keystone ward allowed clear observation and two-way communication. The service used CCTV in the room and planned to install a mirror to mitigate risks because of a blind spot. The service had acted on findings from a recent Mental Health Act reviewer visit and covered chains to secure the key to the door of the seclusion room. Keystone ward had used the seclusion room on 15 occasions since April 2019. Upper Court had not used seclusion during the same period.

Staff carried alarms to summon help if needed. A member of staff from each ward was allocated to respond if staff from another ward needed support.

The clinic room on Upper Court was small and contained all relevant equipment. Equipment was well maintained and in good working order. An electrical circuit breaker unit in the room posed a potential risk to patients because of its accessibility. The clinic room on Keystone reflected its

purpose-built structure as part of the PICU ward. The clinic room was neat and tidy with evidence of staff completing appropriate checks. Stock was stored securely and clearly labelled.

Safe staffing

The provider had a system in place to calculate the number of nurses and healthcare support workers. Staffing levels were discussed during the daily morning meeting. Staff could be transferred from other wards at the service to ensure sufficient cover.

Data provided by the service showed that 89% of nursing shifts had been covered by agency staff on Upper Court and 99% of shifts on Keystone ward. Agency health care assistants had covered 31% of shifts on Upper Court and 34% of shifts on Keystone ward. The service encouraged agency staff to sign a 12 month contract to enable consistency on the wards. Agency staff who regularly worked more than one shift per week were called locums.

Staff comments regarding staffing levels varied from sometimes short staffed to regularly short staffed. They said that staff would often be brought in from other wards at the service. Agency and locum staff received an induction, supervision and training.

Almost half of the staff from Upper Court had transferred to Keystone ward when it opened in April 2019. The provider had experienced difficulty recruiting a consultant psychiatrist to Upper Court. There had been seven consultant psychiatrists on Upper Court since January 2019 which had affected the quality and consistency of medical care on the ward. Staff, patients and carers told us the high turnover of staff and lack of clinical leadership had a negative impact on the ward. A permanent consultant for Upper Court had started their employment on the first day of our inspection.

There was 90% nursing vacancies on both Upper Court and Keystone Ward. The provider used a number of longer-term locums, bank and agency staff to cover vacancies on Upper Court. Locums included one of the deputy ward managers on Upper Court. On Keystone ward, vacancies were covered by eight contracted locum nurses and two locum deputy ward managers.

There was a vacancy rate of 29% for health care assistants on Upper Court and 57% on Keystone ward. The provider used agency and locum staff to ensure safe staffing.

We heard mixed reviews about safe staffing levels from patients and carers.On Keystone ward, there was a minimum of three nurses and eight HCA's per shift. There was a minimum of two nurses and three HCA's per shift on Upper Court. Staffing numbers were based on bed occupancy and patient acuity at the time of our inspection. Managers could adjust the staffing levels to account for the number and level of acuity of patients.

The social worker was shared across all five wards at the hospital. Staff said this affected the time available to support individual wards although patients had not been affected.The social worker was also the safeguarding lead. They said that it had been a difficult period since the previous safeguarding lead had left because of their additional responsibilities. There was a vacancy for an assistant psychologist or assistant occupational therapist, shared across both wards. The provider had recently agreed to the post of an activities co-ordinator. The post had been advertised to provide activities during the evening.

All agency staff received an induction and were familiar with the wards. Agency staff were issued an induction booklet that required a signature from a permanent member of staff to confirm competency. Agency staff had access to the electronic care records.

The contracted staff on Keystone ward had received a comprehensive two-week induction prior to the ward opening in April 2019.

Patients, parents and carers told us that escorted leave was often cancelled because there wasn't enough staff. One to one meetings between staff and patients appeared to be reactive rather than scheduled.

There were enough staff across the hospital to carry out physical interventions safely. All staff except four ad hoc agency HCA's had completed the prevention management of violence and aggression (PMVA) training. The remaining four staff had completed training in the management of actual or potential aggression. The prevention management of violence and agression refresher training was provided each year and staff could request this sooner if required.

Staff completed mandatory training. There was a rolling training programme for staff that included safe wards, working with young people and understanding and working with self- harm and therapy skills.

Inadequate

Child and adolescent mental health wards

Assessing and managing risk to patients and staff

We reviewed the care records of eight patients. The majority contained comprehensive risk assessments that were updated after ward rounds or following any incidents or changes in risk.

Staff on Keystone ward had identified and responded to changing risks to, or posed by, patients. Staff gave an example of introducing a protocol to reduce the risk and mitigate incidents of self harm by patients banging their head against a wall, when they had become aware of triggers to this behaviour.

Staff followed policies and procedures for observations. Nurses had the authority to change observation levels. Staff maintained an observation competency spreadsheet for agency staff.

We saw staff providing two-to-one observations for a patient considered at risk of harm from others. The patients perceived to be likely to cause harm had no such observations in place.

In response to lessons learned on the use of mobile phones, a new phone policy was implemented on the day of our inspection. Patients' personal smart mobiles were limited to one hour a day with staff supervision and at other times patients had access to a basic mobile phone that could only make and receive calls and send and receive text messages. There had been recent incidents of patients accessing the internet inappropriately.

Staff did not individually assess patient access to their bedrooms. All bedroom doors were locked during school hours and during meal times.

The service used CCTV surveillance to observe patients. Feedback from the CCTV provider about staff consistency in managing patients had been positive. Staff asked patients for consent to use CCTV during the admission process. We reviewed nine consent forms and found that one patient who had given consent was under 16 years of age and was not considered to be Gillick competent. However, the only consent recorded was the patient's. Gillick competence is used to determine if a person under the age of 16 has capacity to make decisions. The responsible clinician had signed consent for another patient under the age of 16, not Gillick competent. Staff said the consultant psychiatrist had the overall decision whether CCTV surveillance was used.

Informal patients had to be assessed by a nurse before they could leave the ward. Staff accompanied informal patients when they left the ward.

Data provided by the service showed that between 1 April and 16 August there had been 220 incidents of restraint on Keystone ward and 186 on Upper Court. There had been a gradual increase in incidents of behaviours that challenge involving physical restraint since April 2019, when Keystone ward opened. Data provided by the service showed that most incidents occurred after 6pm and spiked between 8pm and 11pm. Patients told us there was a lack of activities and they were bored during these periods. They said that staff who worked nights were quicker to use restraint than those who worked during the day. Staff told us they used restraint as a last option and only when attempts at verbal de-escalation had failed. All staff were trained in restraint techniques as part of the prevention management of violence and aggression training.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquillisation. Staff said that they only used rapid tranquillisation as a last resort and would always offer patients oral medicine first. Staff completed appropriate physical health monitoring when rapid tranquillisation was deemed necessary.

Upper Court did not have a seclusion room and had not used seclusion in the four months prior to inspection. Staff from Upper Court used the seclusion room on Keystone ward if required. Staff said they avoided using seclusion unless absolutely necessary. Staff on Keystone ward had used the seclusion room on 15 occasions since it had opened on 1 April 2019. Staff said that seclusion was used as a last resort and for the shortest period. Medical staff said that patients were usually kept in seclusion for at least two hours to allow them to become fully calm. They said that although not a blanket rule, the period of seclusion following assaults on patients or staff was usually for a minimum of two hours. They said that the longest period of seclusion in recent months was 23-25 hours, when two patients had attempted to seriously assault another patient. A doctor spoke with patients who had been in seclusion to reflect on what happened before they came back onto the ward.

Safeguarding

Staff completed safeguarding training during their induction and as part of the rolling training programme for staff working on children and adolescent mental health wards.

Staff discussed safeguarding during the daily morning meeting. Managers attended a weekly safeguarding meeting. Managers identified safeguarding concerns on a communication report which was discussed in the daily meetings and actions agreed.

An administrator maintained a spreadsheet with a log of all safeguarding incidents.

Staff relied on the internal sign off policy for safeguarding incidents and progression into a safeguarding referral.

An interim safeguarding lead had been appointed since the director of clinical services and former safeguarding lead had recently left the service. The safeguarding lead was responsible for managing safeguarding referrals for Keystone ward and Upper Court as well as their usual day to day responsibilities.

In the ten incidents we reviewed, staff did not always record if they had completed a safeguarding referral. Staff did not always send a daily update of safeguarding incidents to the safeguarding lead. There was a backlog of incidents waiting to be reviewed by the managers. This meant that there was often a delay in the safeguarding lead receiving or acting on concerns and sharing information with relevant professionals.

Staff access to essential information

Staff used electronic care notes for patient records. Staff had easy access to information and it was easy for them to maintain care records.

The wards held paper records that contained information about referrals, admissions and medical assessments. Staff were aware where to find relevant information.

Medicines management

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

Medicines were reviewed at the weekly multi-disciplinary meeting. We saw evidence that patients were given information about medicines.

All 14 medicine charts reviewed were accurate and staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence (NICE) guidance.

A local pharmacy provided pharmacy support to the service. A pharmacist completed regular audits and attended both Keystone and Upper Court each week to provide stock medicine, review medicines charts and complete regular audits. Medicines management was discussed during the medicines management bi-monthly meeting and in the clinical governance meeting. The pharmacist delivered medicines management training for staff.

There was bi-monthly medicines management meeting. Medicines management was also discussed during the Clinical Governance Meeting.

Track record on safety

Data provided by the service recorded 38 serious incidents between 1 April and 16 August 2019. These consisted of 19 serious incidents on each ward during this period.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Permanent and locum staff recorded incidents on the electronic reporting system. Agency staff had to ask permanent staff to record incidents as they did not have access to the electronic incident reporting system.

We reviewed the details of ten incidents. The quality and detail recorded about incidents was inconsistent. Missing information included the risk level rating and if other agencies, including the local authority designated officer, had been notified. Incidents were scored between one and five, with five being the lowest harm and one being the highest. Information was only cascaded to senior managers if a risk level had been recorded three or above. None of the incidents we reviewed had been rated lower than four, despite some requiring police attendance. Staff had recorded nine of the 10 incidents as no harm or impact, despite some involving police attendance.

There had been a gradual increase in incidents since April 2019, when Keystone ward opened. There were 448 incidents on Keystone ward and 510 incidents on Upper Court between April and August 2019. Data provided by the service showed that incidents peaked between 6pm and

Inadequate

Child and adolescent mental health wards

11pm. The post of twilight activity co-ordinator was being advertised at the time of our inspection. There was no evidence of the provider acting on or learning from a recent spate of incidents involving the same patients.

There was a back log of incidents awaiting review from a manager. Incidents on Keystone ward had not been reviewed by a manager since 14 August. Incidents on Upper Court had not been reviewed by a manager since 23 August.

Staff were aware of the service's Duty of Candour Policy. Patients' relatives confirmed that staff were open and transparent and contacted them after an incident.

Incidents were discussed during handovers and in team meetings. Managers attended a monthly learning by experience meeting. Staff did not receive formal feedback from the investigations of incidents. There was no formal process to share learning from incidents with staff.

Changes made following incidents included reversing the direction that doors opened on Upper Court to reduce the risk of patients kicking the door open and absconding from the ward.

Staff were debriefed and received support following serious incidents.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Start here...

Are child and adolescent mental health wards caring?

Start here...

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

Start here...

Are child and adolescent mental health wards well-led?

Inadequate

Leadership

The quality and consistency of clinical leadership on Upper Court had been affected because there had been seven consultant psychiatrists providing medical cover since January 2019. A permanent consultant psychiatrist began their employment on the ward on the first day of our inspection.

Leadership development opportunities were available for staff. Managers completed a two-day leadership course. There was a provider wide ward manager programme. New managers were mentored by the Director of Clinical Services. The hospital director offered an open-door policy.

Staff said the executive team were approachable. The medical director visited the wards and spent time with the patients. Senior managers completed regular walk rounds of the service.

Vision and strategy

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

The manager on Upper Court had been involved in creating a tier four implementation action plan. However, it was still very much a work in progress. Staff from Upper Court had attended an away day in May 2019 to improve staff engagement.

Staff said that many of the issues on Upper Court including décor and general state of the environment were affected by lack of funding. The Provider had applied for funding to redecorate the corridors and communal areas.

Culture

There was a noticeable difference in culture between the wards. Staff morale was good on Keystone ward. Staff on Upper Court had low morale and were clearly stressed during the inspection. Staff appeared to be overwhelmed with the current level of risk and patient acuity on the ward. They said that the environment was unsuitable and the therapeutic needs of the patients could not be met because of the acuity of some patients. Staff said that the

high turnover of staff and inconsistent medical cover had been difficult. Most staff told us they felt supported, but funding and challenges in recruitment limited the level of support available to them.

Some staff said the change from a high dependency unit to a tier four service had not been managed well and some patients were inappropriately placed.

Some night staff said that the rationale for changing day and night staffing rotas had not been explained to them. They said that they would leave if they were asked to work day shifts.

Staff said they were aware of the whistleblowing process but were afraid of repercussions if used.

The monthly rolling programme for staff included monthly reflective practice. Staff could also attend monthly supervision with an external provider. This was usually group supervision, although staff could request one to one meetings.

Governance

The governance processes did not ensure that wards ran smoothly. Processes did not sufficiently assess, monitor and improve the quality and safety of the service.

There was insufficient oversight and scrutiny by senior managers to ensure actions were carried out, risks were reviewed, themes identified and learning was implemented.

The meeting structure included the opportunity to review a range of audits including the environmental risk assessment, ligature audits and incidents. However, we were not assured that managers identified themes or learning.

Processes did not mitigate the risks relating to the health, safety and welfare of patients. Actions identified on audits were not always acted on in a timely way. Audits had not been updated to reflect the change from Upper Court's change from a high dependency unit to a tier four service.

We saw a weekly newsletter that included information about concerns and learning. The learning explained where staff could find information about actions to take to ensure they follow policy rather than learning from specific incidents. The newsletter was sent to staff and displayed on notice boards.

We reviewed the minutes of two learning from experience meetings. Outstanding issues had been carried over from both meetings and not acted on. The risk register had not been updated to include actions agreed at the meeting.

The action log from the learning from experience meeting did not include any recent incidents involving patients absconding, barricading or allegations against staff. After the inspection, the provider told us these incidents would have been reviewed at the meeting planned for 11 September 2019. The meeting had been cancelled because of the inspection.

The support services manager maintained oversight of the environmental risk assessment. Smaller works could be completed by the local maintenance team. There were sometimes delays with some requests because of the planning permission implications.

The service had recently introduced a handover form to ensure consistency of information across the wards. We saw that staff on Upper Court used this form during the handovers we observed, but Keystone staff did not. Senior managers and the night co-ordinator regularly attended handovers.

The service had arranged for a team away day for staff on Upper Court. Two of the 20 actions on the Upper Court action plan dated August 2019 had been completed, the remainder were in progress. One action that had been rated red was outstanding at the time of our inspection.

Management of risk, issues and performance

The hospital manager maintained the local risk register. The risk register and learning log included immediate actions taken by the provider to mitigate risks but there was no information about identifying themes or learning to avoid repetition. The risk register had not been updated to include several recent incidents involving absconsion, barricading and damage to Upper Court. Staff concerns matched those on the risk register.

Incidents were discussed during daily meetings. However, there was a lack of evidence of formal lessons learnt from incidents. There was no evidence to demonstrate effective oversight of incidents to monitor themes and trends. There was a lack of preventative action to avoid recurrence of incidents. Staff said lessons learnt from incidents were not communicated to them.

Inadequate

Child and adolescent mental health wards

The quality team had oversight of incidents reported on the electronic incident reporting tool, but not the content. Governance processes did not ensure that action was taken to mitigate risks on a practical level and avoid recurrence of incidents.

There were inconsistencies in the quality and detail recorded about incidents. The rating of no harm or impact was not always reflective of the seriousness of the incident. There was a backlog of incidents awaiting review by the manager. The lack of review and action meant that similar incidents were subsequently taking place. Only incidents rated three or above were immediately escalated to the senior management team. This meant that there was a risk that senior managers would not immediately be aware of all incidents reported by staff.

Risks concerning patient group dynamics were discussed during ward rounds. We heard an example where staff had met with the consultant to discuss concerns about one of the patients. However, there was no evidence of the provider acting on or learning from a recent spate of incidents involving the same patients.

Ward managers said that with the exception of a recent admission, they were always involved in reviewing referrals prior to admission. The hospital director was supportive of staff decisions concerning admissions.

Senior managers completed regular quality walk rounds of the wards.

Senior leaders were aware of the issues concerning staffing levels and the environment. However, they did not always act on issues that affected the environment. For example, the risks identified as a high risk on the environmental risk assessment for Upper Court dated January 2019. Senior leaders explained strategies to try to retain staff and improve recruitment.

Information management

Staff had access to the equipment and information technology required to do their work. Minutes of recent learning from experience meetings noted that a poor signal affected staff radios on Keystone ward.

Some professionals that we spoke with expressed concern that they did not receive information in a timely manner.

Engagement

Parents and carers said they received regular telephone contact from staff. The service did not produce a specific newsletter for parents and carers.

Patients and carers said they did not have opportunities to provide feedback about the service. They said they were not involved in decision making about changes to the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must make sure the environmental risk assessments are accurate, up to date and appropriate action taken to mitigate risks.
- The provider must make sure that the environment is safe and that required adjustments take place in a timely manner to ensure the safe care and treatment and health and safety of patients.
- The provider must ensure that incident recording is comprehensive and consistent.
- The provider must make sure that there is effective oversight and scrutiny of incidents and that appropriate action is carried out, risks reviewed, themes identified and learning implemented.
- The provider must ensure that activities are available for patients outside of school hours.

Action the provider SHOULD take to improve

- The provider should ensure consistency of information and documentation on wards.
- The provider should ensure appropriate support for staff from senior managers to avoid staff feeling stressed or overwhelmed.
- The provider should continue with efforts to recruit permanent staff and ensure consistency of staffing on the wards.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The provider did not act on risks identified in environmental risk assessments in a timely manner The provider did not make sure the environment was safe by making the required adjustments following incidents.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
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 The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). The provider did not have effective oversight and scrutiny of incidents to ensure that appropriate action was carried out, risks reviewed, themes identified and learning implemented. The provider did not operate effective audit and governance systems and/or processes to make sure they reviewed and acted on risks in response to the environment on Upper Court. The provider did not ensure that activities were available for patients outside of school hours.