Meadow Lodge

Quality Report

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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	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Good**
Are services responsive?	**Good**
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

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker

Chief Inspector of Hospitals

Overall summary

We rated Meadow Lodge as **inadequate** because:

- Neither the provider nor the local management team had been able to promote a stable, positive culture within the service. There was a high turnover of local managers and the provider had sent in additional managers to support the service. However, these frequent changes in the management structure had caused confusion amongst the staff team and they were unclear who was providing support to the local manager or had management oversight of the service. For example, the provider sent a manager from another service to support the local manager, but staff had only seen them once and were not clear if they had responsibilities or oversight in running the service.
- Due to the instability of the local management team and pressures within the service there was conflict in the team at all levels. Agency staff reported not feeling welcome or supported by the team when they arrived for shifts. Staff did not feel listened to and said that decisions were made without their involvement or consultation. Nursing staff said they did not have the opportunity to contribute to discussions about the strategy for their service. In the six months prior to the inspection nursing staff were present at only two of the six held monthly clinical governance meetings. There was a disconnect between the nursing team and the local management team
- The local management team did not have robust governance processes in place to ensure there was oversight of when staff were due supervision or whether they had attended all mandatory or additional training as required. Staff did not receive regular supervision, including clinical supervision in line with the provider's policy.
- The local management team did not have a robust process for supporting staff following incidents, learning from incidents or making improvements to the service. There was no process to debrief staff following incidents and the service had not made improvements to the observation procedure following a number of incidents involving agency staff sleeping on duty. Both the provider and the local management team were aware of the issue relating to this, but this had not been addressed and did not feature as a risk on the service's risk register.
- On seven occasions over a six-week period, registered general nurses (RGN) from an agency were left in charge of shifts. These nurses had little knowledge of mental health or child and adolescent mental health and had no experience of working in these areas so could not safely take charge of shifts. Following the first occurrence, the provider identified an action to put in place a safer system of work but this action wasn't taken and RGNs, without relevant knowledge or experience were left in charge of six subsequent shifts. These were not recorded as incidents. In addition, on-call arrangements were not robust. The RGNs and staff generally were unclear who they should contact in the event that they should need advice or someone

Summary of findings

with experience to come into the service to deal with an issue. Not all permanent staff had completed mandatory training or additional training required to undertake their role effectively and safely.

- Staff were not making appropriate safeguarding referrals consistently to the relevant authorities. Some incidents were not categorised as safeguarding that should have been and stakeholders told us that staff had not always referred some cases that they should have. The service did not always raise concerns with relevant organisations in cases of poor practice. For example, informing the Nursing and Midwifery Council (NMC) when an agency nurse displayed poor practice or acted outside of the NMC code of practice (The Code) whilst they were working at the service.

However:

- Staff went above and beyond when supporting young people during incidents. We saw CCTV footage showing staff putting themselves in harm's way to prevent a young person from injuring themselves. We saw that young people and staff had a good rapport. Young people were seen positively engaging with staff following incidents of restraint. Staff used restraint as a last resort, without excessive force, and only when de-escalation techniques had failed.
- Staff were completing observations of young people as directed in their care plans and we found no occurrences of staff asleep at night. This had previously been raised as a concern by the service through notifications to the Care Quality Commission.
- All young people's risk assessments, risk management plans and care plans were person-centred and regularly reviewed and updated. Young people were involved in their care planning and had copies of their care plans.
- The service was going through a period of enhanced public scrutiny. Local managers and the provider's senior management team provided support to staff, young people and their parents following the publication of allegations at the service.

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** 	Meadow Lodge is an independent inpatient child and adolescent mental health service.

Summary of findings

Contents

Inadequate

Meadow Lodge

Services we looked at

Child and adolescent mental health wards

Summary of this inspection

Background to Meadow Lodge

Meadow Lodge is an independent inpatient child and adolescent mental health service (Tier 4 CAMHS). The service provides specialist care and treatment for male and females aged between 13 and 17 years. The service is registered for 10 young people and is split between a two-bedded high dependency area and an eight-bedded general adolescent unit. Young people can be admitted informally with parental consent, if under 16 years, or detained under the Mental Health Act (MHA) 1983. Meadow Lodge is commissioned by NHS England to provide assessment and treatment for children and young people with complex emotional, behavioural or mental health difficulties that require inpatient treatment. The service accepts young people with a learning disability or an autistic spectrum disorder if their primary diagnosis is a mental health condition. The service is part of a specialist mental health services division of Huntercombe (Granby One) Limited.

The Care Quality Commission (CQC) registered Meadow Lodge to carry out the following regulated services: treatment of disease, disorder or injury, assessment or medical treatment for persons detained under the MHA and diagnostic and screening procedures. At the time of the inspection the service had a newly appointed manager in place that was in the process of applying to the Care Quality Commission to become the registered manager.

Four female young people were resident at the time of our inspection; one was detained under section 3 of the Mental Health Act (MHA). Two young people were discharged during the inspection.

Meadow Lodge has been inspected on three previous occasions by the CQC. In April 2018 we conducted an announced comprehensive inspection six months after it was registered with CQC. Following this inspection, the service was rated as requires improvement overall, with safe and effective rated requires improvement and caring, responsive and well-led rated as good. The service was issued four requirement notices for breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We told the provider it must take the following actions to improve Meadow Lodge:

- Care plans needed to be person-centred and the young people should be involved in developing their care plans.
- The anti-climb fence needed to be fit for purpose. The fence in place posed as a significant ligature risk and no action had been taken by the provider to mitigate this.
- The provider did not ensure that referral forms were completed in full, which could lead to the hospital accepting inappropriate referrals.

In September 2018 we were made aware of concerns through our anonymous whistleblowing process and through notification made directly to us by the provider. As a result of the concerns raised, and information from other sources, including reporting by The Huntercombe Group, Meadow Lodge was placed under enhanced multi-agency surveillance.

In November 2018 we conducted an unannounced focused inspection of the service following a notification directly from the provider that identified staff had not ensured that young people received urgent and emergency treatment when needed. Following this inspection, we issued the service with a warning notice under regulation 12 and regulation 20. We found that the service was not meeting the requirements to provide young people with safe care and treatment and that staff were not following their requirements under duty of candour.

Following this inspection, the service voluntarily stopped taking admissions to concentrate on addressing the concerns raised. The commissioners of this service supported this decision.

In December 2018, we conducted an unannounced focused inspection to determine if the service had met the requirements of the warning notice. Whilst the service had made significant improvements, the changes had not been fully embedded, and the warning notice remained in place.

Summary of this inspection

Following this inspection in February 2019, we found the service had met all the requirements of the warning notice and lifted the warning notice. Although the service remained closed to admissions.

Following this inspection, we were informed by NHS England that the service was due to close following a restructure of child and adolescent mental health services in the south region, which determined that Meadow Lodge would not be required. The planned closure date is scheduled for 18 April 2019.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one inspection manager, a specialist advisor, and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service. The specialist advisor had a significant professional background in CAMHS inpatient units.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. However, this inspection was brought forward because of ongoing concerns that had been raised with us.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before and after the inspection visit, we reviewed information that we held about the location, and asked other organisations for information, including NHS England and the local authority.

During the inspection visit, the inspection team:

- visited Meadow Lodge and looked at the quality of the service environment and observed how staff were caring for young people
- visited the service at night to interview the staff on duty
- spoke with three young people who were currently using the service
- spoke with six parents of young people who were currently using or had previously used the service
- spoke with the ward manager
- spoke with seven other staff members including senior nurses, nurses, agency nurses, a support worker, the nurse specialist, the social worker and the consultant psychiatrist
- spoke to the local pharmacist over the phone, who supplies the service with medication
- attended and observed four meetings including a handover meeting, an education review, a community meeting and a clinical governance meeting
- looked at three care and treatment records of current and previous young people
- carried out a check of the clinical room and looked at two prescription charts
- reviewed 48 incidents and CCTV footage of seven night shifts
- reviewed the service's rota leading up to the inspection and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with three young people that were using the service (one of whom was discharged during the inspection).

All young people said they felt safe whilst at the service and were able to ask staff for support at any time of the day and night. Young people told us the support they received was good and that they were treated with respect and dignity. We were told nursing and support staff were honest, open, caring and interested in their wellbeing.

Young people commented that there were few psychological interventions provided and that they were often bored at the weekends.

Young people were concerned that there were sometimes not enough staff on duty, particularly when incidents occurred. They said this meant that staff become stressed and abrupt when speaking to them. Young people also commented that some staff worked long shifts and it could make them uneasy if agency staff they didn't know were working at night.

We spoke with six parents of young people who had used the service. Generally, the feedback we received from parents was positive. Parents told us that staff kept them informed and gave them information relating to their loved one's care. Staff were caring, genuinely interested in their loved one's wellbeing and were available when needed. We were told that if their child required inpatient treatment again, they would want them to go back to Meadow Lodge. Parents commented that the consultant psychiatrist was "brilliant" and that the staff were "amazing". One parent told us "they could not praise Meadow Lodge enough".

Some parents said that staff often 'played-down' incidents or did not promptly inform them.

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:

- On seven occasions registered over a six-week time, registered general nurses from an agency were left in charge of shifts. These nurses had little knowledge of mental health or child and adolescent mental health and had no experience of working in these areas so could not safely take charge of shifts. Staff had identified this as a risk, but the provider and the local managers did not take any action to address this.
- Staff were unclear about the arrangements for contacting on-call managers if they required support from a senior nurse and the procedure in place was not robust. The local manager was on-call seven days a week informally. However, due to the local manager not living permanently in the local area staff were unsure if they would be supported at weekends. We were told by the provider that other senior staff would always be on-call, but staff were not aware of this. These senior staff lived some distance from the service and would not be able to get to the service in a timely manner if they were needed in an emergency. There was no formal on-call procedure displayed for contacting a senior nurse out of hours.
- Managers were not always making appropriate safeguarding referrals to the relevant authorities. Some incidents were not categorised as safeguarding that should have been and stakeholders told us that staff had not always referred some cases that they should have. The service did not always raise concerns with relevant organisations in cases of poor practice. For example, informing the Nursing and Midwifery Council (NMC) when an agency nurse displayed poor practice or acted outside of the NMC code of practice (The Code) whilst they were working at the service.
- Processes for learning from incidents was not robust so improvements weren't always made when they should have been. For example, there had been incidents where staff had fallen asleep at night whilst on duty. These occasions had been recorded as incidents and external organisations were informed, but an appropriate safe system of working was not put in place to prevent this from happening again.
- The provider's observation policy did not include a safe system for work which kept two staff in areas where young people were sleeping.

Summary of this inspection

- Not all staff had completed mandatory training or additional training required to undertake their role effectively and safely.
- Staff were not always offered a timely debrief session following incidents.

However:

- Young people's risk assessment and risk management plans were reviewed regularly and updated following incidents.
- We saw on CCTV footage that staff used restraint as a last resort and without excessive force.
- Staff were completing observations of young people within the time frames identified in care plans. We found no occurrences of staff asleep at night. This had previously been raised as a concern by the service through notifications to the Care Quality Commission.
- All agency staff that had or were due to work shifts at the service had completed an induction checklist. Staff were responding to medical emergencies appropriately and were managing these incidents safely. The service's ligature audit was up to date and contained actions taken to mitigate the risks. The service had removed and replaced the anti-climb fence that was found to not be fit for purpose. These were an improvement from the previous inspections.

Are services effective?

Inadequate

We rated **effective** as **inadequate** because:

- The service did not have access to a clinical psychologist or occupational therapist and so they could only provide a limited range of psychological or occupational interventions. The specialist nurse facilitated mindfulness and some one to one sessions with young people, but young people told us that this wasn't enough to meet their needs.
- Staff did not receive regular supervision, including clinical supervision. Nursing staff didn't feel supported or felt they could discuss issues with the local managers. We reviewed six staff files and found only two had a recent supervision meeting. Supervision statistics showed that only 21% for long-term agency staff received supervision and 40% for permanent nursing staff had received supervision.
- Staff undergoing performance management were not always supported to improve. We saw no examples of staff completing additional training, such as professional boundaries training, to help them improve in their role. Several staff had been suspended and on return to work had not been offered appropriate support to help improve their performce or help them develop in their role.

Summary of this inspection

However:

- Young people's care plans were personalised and recovery-oriented. Staff updated care plans regularly and reviewed these weekly with young people.
- Staff ensured that young people had good access to physical healthcare, for example, by inviting a dietician to visit the service, arranging optician appointments and utilising general nurses on shift who are trained in physical health checks.

Are services caring?

Good

We rated **caring** as **good** because:

- Staff attitudes and behaviours showed that they were respectful, responsive and had built good rapport with young people. Staff used humour appropriately to engage young people. Young people told us that staff were always available when they needed support.
- Staff went above and beyond when supporting young people during incidents. We saw CCTV footage showing staff putting themselves in harm's way to prevent a young person from injuring themselves. We saw that young people and staff had a good rapport. Young people were seen positively engaging with staff following incidents of restraint.
- Young people were involved in care planning and risk management plans. Young people had copies of their care plans and, when appropriate, parents were also given a copy.
- Staff involved young people in decisions about the service. Young people's attendance at the clinical governance meeting was part of every agenda. Young people fed back to staff any concerns, requests or suggestions for the service. Staff from the senior management team then updated young people on any progress on these requests.
- Young people were able to access advocacy. An advocate visited the service weekly and met with young people to ensure they understood their rights and offered support to attend meetings.
- Following the enhanced public scrutiny of the service, the provider's management team contacted each parent to inform them, offered support and gave parents the opportunity to share their opinion and ask any questions. A senior manager also visited the service to meet with the young people and staff to offer support and provide them with an opportunity to share their opinions and ask questions

However:

- Young people told us that some staff could be abrupt at times.

Summary of this inspection

Are services responsive?

Good

We rated **responsive** as **good** because:

- Young people would only be moved within the service if it was justified on clinical grounds. For example, if a young person required a quieter area with more staff supervision they would be moved to the high-dependency area of the service. There was always a bed available when young people returned from leave.
- Staff planned for young people's discharge and had good liaison with care managers and commissioners. When young people were discharged it was at an appropriate time of day. For example, during the inspection two young people were discharged in the morning and this was managed well by the staff.
- Education staff ensured that young people had access to education. Young people had access to a school on-site and the teachers liaised with their home schools to ensure consistency in education. The education staff supported young people to apply for college. Youth engagement workers had supported young people to access volunteer and employment opportunities in the local community.

However:

- Complaints were not always followed-up in a timely manner. Some staff and young people felt that complaints were not followed up by the local managers. Young people received a letter detailing the outcome of complaints, but some young people had been waiting a considerable time for the letter.
- Young people told us they were sometimes able to overhear handover meetings and staff talking in the nurse's office. The nurse's office was not adequately sound-proof.

Are services well-led?

Inadequate

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

- The management team at local and provider level had not been able to promote a stable, positive culture within the service. There was a high turnover of local managers and the provider had sent in additional managers to support the service. The provider appointed a manager from an agency to fill this position and sent senior managers from other services to provide support to the local manager. There had been four different senior managers in the six months prior to inspection

Summary of this inspection

that had provided additional support to the service. These changes in the local management structure had caused confusion amongst the staff team and they were unclear who was providing management support to the service.

- Staff did not feel listened to by local managers and said that decisions were made without their involvement or consultation. Nursing staff said they did not have the opportunity to contribute to discussions about the strategy for their service. In the six months prior to the inspection nursing staff were present at only two of the six held monthly clinical governance meetings. Staff felt there was a disconnect between the support and nursing staff and the management team.
- The management team did not have robust governance in place to ensure there was oversight of when staff were due supervision meetings or attended all mandatory or additional training as required. Managers were not ensuring that all incidents were investigated, actioned and closed and it was unclear who had oversight of ensuring actions from safeguarding concerns had been followed up.
- The management team did not have a robust process for learning from incidents and making improvements to the service. The provider nor local managers had not implemented an appropriate system to ensure staff had the right knowledge and skills to manage a shift safely. The service had not made improvements to the observation procedure following a number of incidents involving agency staff sleeping on duty. Neither the provider nor local managers had not ensured there was a robust on-call system for contacting senior nurses out-of-hours. The on-call system had been changed recently and staff were not fully aware of why or who to contact out of hours if the manager was not available.

However:

- The local manager had applied to become the registered manager and was going to relocate to the area permanently. The provider had seconded an experienced manager from another service to provide the manager with support and also seconded experienced staff to support the staff team and help fill outstanding vacancies.

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.

During the inspection we spoke to the service's Mental Health Act (MHA) administrator and reviewed relevant documentation.

We found that section 17 leave forms had been completed appropriately, consent to treatment had been recorded and that Mental Health Act assessments were completed prior to consideration of detention under the Mental Health Act.

The majority of staff (74%) had not been trained in the Mental Health Act but staff knew their responsibilities under the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act applies to young people aged 16 or over. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to understood the principles of Gillick and used this appropriately to include the young person in the decision making regarding their care.

Some staff had completed training in the Mental Capacity Act. Training compliance rates were 67% however staff were not provided with training specific to Gillick competence.

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Good
Well-led	Inadequate

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- Staff undertook regular risk assessments of the care environment. The service had a ligature audit which had been reviewed in January 2019. The audit identified potential ligature anchor points and detailed actions taken to mitigate the risks. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- The service had a series of corridors with many 90 degree turns. To mitigate blind spots convex mirrors were used and CCTV had been installed which was monitored by staff. Staff also completed regular observations of the corridors.
- The service complied with guidance on eliminating mixed-sex accommodation. All young people's bedrooms were en-suite and there was a female-only lounge available to use.
- Staff had easy access to personal alarms, which were tested regularly and before each shift. Young people also had easy access to a staff call system.
- The domestic staff were responsible for keeping the service clean and we saw completed daily cleaning records. The communal areas were clean and well furnished. However, once bedrooms had been vacated it was unclear whether they had been deep cleaned. We saw one room that had been cleaned after a young person's departure but there was still dust in the room and marks on the mattress. At the time of the inspection, the service's two pygmy goats had free access to the main garden. The patio and benches were covered in their droppings.
- The clinic and treatment rooms were both small and quite cramped due to the equipment and layout of the rooms. The clinic room contained resuscitation equipment which was being regularly checked by staff.

Safe staffing

- Managers had calculated the number of nurses and support workers required for each shift based on number and acuity of young people using the service. We reviewed the previous six weeks rotas prior to the inspection, which totalled 84 shifts. The rota did not state whether young people were on increased observations or the number of young people on site at the time. However, we found that the majority of shifts matched the minimum establishment levels. Staffing levels allowed young people to have regular one-to-one time with their keyworker. Staff shortages rarely resulted in staff cancelling escorted leave or activities. There were enough trained staff on each shift to carry out physical interventions safely and provide first aid if required.
- Due to a number of nurse and support worker vacancies, the service was using a high number of agency staff. Where possible, the agency staff were on long-term contracts however, some shifts were covered by ad-hoc agency staff. We reviewed the staff profiles of all agency staff on the previous six weeks of rota and found all had received an induction to the service. This was an improvement from the previous inspection.
- The service did not always have an appropriately qualified nurse on duty. We found seven occasions that had registered general nurses in charge of shifts. These

nurses were deployed by an agency and did not have mental health or CAMHS specific training. The service would be expected to have registered mental health nurses or nurses that have had additional training in mental health on duty. This could potentially put young people who experience a mental health change, decline or crisis at risk of not getting the support they require.

- Staff were unclear on the arrangements for contacting a senior nurse on-call and the procedure in place was not robust. The manager was on-call seven days a week, however, due to not permanently living in the local area staff were unsure if they would be supported at weekends. We were told that other senior staff were on-call however staff were not aware of this. We saw no formal on-call procedure displayed for contacting a senior nurse out of hours. There was adequate medical cover day and night and a doctor could attend the service quickly in an emergency. The service's consultant psychiatrist was part of the medical on-call cover, alongside another who works in the local area.
- Staff were not fully up to date with mandatory training. Thirty five percent of nursing staff had completed training required for their role and support staff were only 63% compliant. This training included, but was not limited to, basic life support, first aid at work, duty of candour and safeguarding. During the inspection, we reviewed the current training compliance rates for February 2019. Only 26% of staff had completed training in the Mental Health Act and 67% had completed Mental Capacity Act training. Only 56% of staff had completed immediate life support training. The service's training induction programme describes mandatory training to be provided to staff. The programme included therapeutic observations, boundaries and structure training, clinical risk management, suicide prevention and restrictive practice training, serious incident training, site induction, positive behavioural support training, relational security training and physical health training. The training compliance rates for these training courses were between 0% and 61%.

Assessing and managing risk to young people and staff

- All three of the care and treatment records reviewed contained an up-to-date risk assessment and risk management plans. Risk assessments and risk management plans were updated following an incident.
- Staff were aware of and dealt with any specific risk issues such as self-harm or a decline in mental health. Staff identified and responded to changing risks to or posed by young people. For example, by appropriately using restraint to prevent a young person from injuring themselves.
- Staff followed policies and procedures for use of observation. Prior to the inspection we had been notified by the provider of several incidents of night staff falling asleep. Due to this we reviewed CCTV footage of seven random night shifts. Staff were observed completing observations appropriately throughout the night in accordance with the providers policy. No staff were observed asleep. However, we saw one example of a male staff member left alone in areas during the period they were responsible for observations. There was no safe system of work which ensured two staff were always present in areas where young people were sleeping.
- Staff applied blanket restrictions to young people's freedom only when justified. The majority of restrictions were on an individual basis, for example being supervised to access mobile phones and social media.
- Staff used restraint only as a last resort, after de-escalation techniques had failed. Staff used the correct techniques and the service policy did not allow use of prone restraint. Prone restraint involves being held down in a face-down position, which when used inappropriately can restrict breathing. When the service had an increase in the number of restraints, this was correlated with incidents relating to a specific young person. Staff mainly used restraint to prevent young people harming themselves.
- Records of five recent incidents where restraint was used were reviewed by inspectors and compared with the CCTV footage. The records gave accurate descriptions of the incidents. No excessive use of force was observed in the CCTV footage – staff were observed trying to deescalate and only using restraint when needing to protect the young person or others. Staff were observed engaging with young people throughout the incidents including during the restraint. At times, prior to the restraint, staff were putting themselves in harm's way to stop young people hurting themselves or barricading doors before other staff arrived to assist. Following incidents staff were seen continuing to engage the young person. On observations of footage

later in the same shift, young people were seen positively engaging with staff involved in the restraints, demonstrating positive relationships between the staff and young people.

- Staff followed national guidance when using rapid tranquilisation. We reviewed incidents which involved the use of rapid tranquilisation. The rationale for its use was documented and staff completed the appropriate physical health observations of the young person afterwards.
- Young people were subjected to justified restrictive interventions, most of which were implemented on an individual basis. For example, some young people had restricted access to social media due to safeguarding concerns.

Safeguarding

- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
- We found that 97% of staff had completed safeguarding children and adult training. Staff we spoke to had a good understanding of safeguarding and their responsibilities for reporting safeguarding concerns to the relevant authorities. Staff informed local managers and the service's safeguarding lead if they had a concern that required escalating. Staff were not responsible for raising safeguarding concerns to the relevant authority.
- The social worker was the service's lead in safeguarding. They completed the safeguarding referrals to the relevant authority.
- We found that some incidents recorded on the electronic reporting system were not flagged as a safeguarding concern, and it was not documented what actions had been taken. We saw that some incidents reported over a month ago were still open and it was unclear what actions the service was taking. Local managers did not have oversight of these incidents.
- Managers was not always making appropriate safeguarding referrals to the relevant authorities. Some incidents were not categorised as safeguarding and stakeholders informed us that staff had not always referred some cases that they should have. The service did not always raise concerns with relevant organisations in cases of poor practice. For example, informing the Nursing and Midwifery Council (NMC) when an agency nurse displayed poor practice or acted outside of the NMC code of practice whilst they were working at the service.
- Safeguarding was discussed in the clinical governance meeting and the multi-disciplinary team meeting however, support workers and nurses did not regularly attend clinical governance meetings.

Staff access to essential information

- All records were stored electronically. All information needed to deliver care to young people was available to all relevant staff, including agency staff.

Medicines management

- We reviewed the prescription records of the two young people using the service. Staff followed good practice in medicines management and did so in line with national guidance.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. Staff reported incidents using an electronic incident system.
- Managers did not always learn or implement change when things went wrong. Staff had recorded the first occasion when a registered general nurse (RGN) was in charge of a shift as an incident as the agency had not sent a nurse with mental health or child and adolescent mental health experience or knowledge. Following this incident, the local manager's action was to implement a safer system of work to ensure this did not happen again. However, RGN were in charge of six subsequent shifts and this was not recorded as an incident and the manager did not implement a safer system of work. We raised this at the time of the inspection as it had not been recognised by the local managers that learning from the first incident had not led to improvements to ensure only nurses with the correct knowledge and experience were allocated to shifts. There had also been incidents where staff had fallen asleep at night whilst on duty. These occasions had been recorded as incidents and external organisations were informed but the local manager had not implemented a safer system of work or checks to ensure staff remained awake at all times.

Inadequate

Child and adolescent mental health wards

- Staff understood duty of candour and apologised to parents and young people when things went wrong. Parents were contacted when appropriate following an incident however feedback from parents said that staff often 'played-down' incidents or did not promptly inform them.
- Some staff told us they did not receive feedback after they submitted an incident or receive a debrief following incidents. Managers told us there was a weekly reflective practice session which staff were encouraged to attend. Incidents were discussed in morning handover meetings as part of team meetings.
- The manager had created a monthly 'lessons learnt' memo, which was emailed to all staff and displayed in the staff offices. Following incidents and in response to the previous inspections, the service's policies had been updated for example the response to medical emergencies and the safeguarding policy. Staff were encouraged to read a folder which contained all 'need to know' and updated information.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- Staff completed a comprehensive mental health assessment of the young people in a timely manner soon after admission. Staff developed care plans that met the needs identified during assessment. The service's nurse specialist conducted a psychotherapy assessment with all young people on admission to help to further identify their recovery and support needs.
- Young people's care plans were personalised, holistic and recovery-oriented. Staff updated care plans when necessary.

Best practice in treatment and care

- Although staff offered medication, arranging activities, facilitating groups and providing education young people were offered few psychological interventions. The weekly timetable contained one wellbeing group and a skills group. The nurse specialist facilitated the skills group for example, by holding mindfulness sessions. The service did not have access to a clinical psychologist and the therapy that the nurse specialist could provide was limited. The service had been unable to recruit a clinical psychologist and were considering accessing a clinical psychologist employed within the provider at another service. The service had three youth engagement workers who supported young people to improve with their daily living skills.
- Staff ensured that young people had good access to physical healthcare for example by inviting a dietician to visit the service, arranging optician appointments and utilising general nurses on shift who are trained in physical health checks. Staff had identified that young people struggled to access the local dentist as they were not NHS, and this was part of the service's risk register. If a young person required a dentist staff would arrange for them to visit their dentist in their local area if appropriate.
- Staff assessed and met young people's needs for food and drink by arranging for a dietician to visit the service and speak to the young people about healthy eating.
- Staff used recognised rating scales to assess and record severity and outcomes such as the Health of the Nation Outcome Scales.

Skilled staff to deliver care

- The team consisted of nurses, support workers, youth engagement workers, a consultant psychiatrist, a family therapist and a social worker. The service had been unsuccessful in recruiting a full-time clinical psychologist but did have a nurse specialist in post to provide a therapeutic role for example by holding a skills group with a focus on mindfulness or dialectical behavioural therapy skills.
- All agency and newly recruited staff were provided with an induction to the service. The service had recently updated the induction training programme which was due to start in March 2019. This improvement was implemented to address concerns that staff were not receiving appropriate specialist training to enable them to undertake their roles.
- Managers did not provide staff with regular supervision meetings. Supervision completion rates as of February 2019 were 21% for agency staff and 40% for nursing staff. The nurse specialist was receiving clinical

supervision from the consultant psychiatrist however the service was in the process of seeking external supervision from a qualified clinical psychologist to support their therapeutic role in the service.
- Staff had regular team meetings.
- Staff undergoing performance management were not always supported to improve. We saw no examples of staff completing additional training, such as professional boundaries training, to help them improve in their role. Several staff had been suspended and on return to work had not been offered appropriate support to help improve their performce or help them develop in their role.

Multi-disciplinary and inter-agency team work

- The service regularly held what it called multidisciplinary team (MDT) meetings. However, staff told us there was a gap in communication between the MDT and the nursing team. For example, we were told that a young person's complaint was raised in an MDT meeting but the named nurse for the young person was not updated following this.
- There were effective handover meetings held prior to every shift during which time staff shared information about the young people in their care.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- During the inspection we spoke to the service's Mental Health Act administrator and reviewed relevant documentation.
- We found that section 17 leave forms had been completed appropriately, consent to treatment had been recorded and that Mental Health Act assessments were completed prior to consideration of detention under the Mental Health Act.
- The majority of staff (74%) had not been trained in the Mental Health Act (MHA) but staff knew their responsibilities under the MHA.

Good practice in applying the Mental Capacity Act

- The staff we spoke to understood the principles of Gillick and used this to include the young person where possible in the decision making regarding their care.
- Staff were aware that for young people who were 16 years old and older, they needed to seek permission from the young person, if they had capacity to give permission, before informing their parents of anything related to their care.
- Some staff had completed training in the Mental Capacity Act (MCA). Sixty-seven per cent of staff had completed MCA training.

Are child and adolescent mental health wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- We saw examples of staff putting themselves in harm's way to further protect a young person from experiencing further harm, for example, we observed on CCTV a young person self-harming by hitting their head against the wall and staff placing their hand in between the wall and the young person's forehead until a board could be put in place.
- Staff attitudes and behaviours showed that they were respectful, responsive and had built good rapport with young people. Staff used humour appropriately to engage young people and young people engaged positively with staff following incidents of restraint. Young people told us that staff were always available when they needed support.
- Staff understood the individual needs of young people, including their personal, cultural, social and religious needs.

Involvement in care

- Staff involved young people in care planning and risk management plans. Young people had copies of their care plans and, when appropriate, parents were also given a copy.
- Staff involved young people in decisions about the service. Young people's attendance at the clinical governance meeting was part of every agenda. Young people fed back to staff any concerns, requests or suggestions for the service. Staff from the senior management team then updated young people on any progress on these requests. For example, previously

young people had asked for the plastic plates to be replaced with ceramic ones. This was discussed in the next clinical governance meeting and was agreed. This was then fed back to the young people.

- Young people were also able to give feedback during the clinical governance meeting and morning community meetings. We attended and observed an education review meeting. The head teacher encouraged the young person to share their opinions and ensured they were involved in the meeting.
- Young people were able to access advocacy. An advocate visited the service weekly and met with young people to ensure they understood their rights and offered support to attend meetings.
- Parents we spoke with told us that staff kept them informed and gave them information relating to their loved one's care however they were not invited to meetings or have further involvement with the service.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- When young people returned from leave their bed was always available.
- Young people would be moved within the service if it was justified on clinical grounds. For example, if a young person required a quieter area with more staff supervision they would be moved to the high-dependency area of the service.
- When young people were discharged it was at an appropriate time of day. For example, during the inspection two young people were discharged in the morning and this was managed well by the staff.
- Staff planned for young people's discharge and had good liaison with care managers and commissioners.
- Staff supported young people during referrals and transfer between services. For example, if young people required temporary transfer to a psychiatric intensive care unit.

Facilities that promote comfort, dignity and privacy

- Young people had their own bedrooms with en-suite facilities. Young people could personalise their bedrooms. Valuable possessions could be securely stored in a locker. There was additional storage space in the service downstairs.
- Young people had access to a range of rooms and equipment to support treatment and care. For example, the clinic room contained an examination couch and young people had access to an occupational therapy kitchen. There were quiet areas in the service and a room where young people could meet visitors. Young people had access to outside space, including a large garden.
- The service had an on-site school, which was registered with Ofsted but had not yet been inspected. The school was contained to one room and had limited space. The manager had plans to move the school into the large front lounge.
- The quality of the food was good and made fresh by the service's chef. However, we were told that the chef did not work over the weekend, so staff had to heat-up meals.

Patients' engagement with the wider community

- Staff ensured that young people had access to education. Young people had access to a school on-site and the teachers liaised with their home schools to ensure consistency in education. Staff supported young people to apply for college. Staff had supported young people to access volunteer and employment opportunities in the local community.
- Staff supported young people to maintain contact with their families for example by facilitating leave, encouraging phone calls and allowed family to visit the service.

Meeting the needs of all people who use the service

- The service could not accept young people with a significant mobility issue. The layout of the building would not accommodate a wheelchair, for example, as the corridors were too narrow in places. However, there were two bathrooms, one of which was equipped as an assisted bathroom.
- The service displayed information on how to access the independent mental health advocacy (IMHA) service.

There was also information on how young people could complain, and a suggestion box was available in a corridor near the nursing office. Information displayed was age-appropriate.
- The staff knew how to access interpreters and signers for young people.
- The service's chef also met the needs of the young people for example a young person needed a gluten-free diet and we saw their food stored separately and labelled appropriately. The chef was also aware of the young people's allergies, likes and dislikes.

Listening to and learning from concerns and complaints

- Staff empowered young people to raise complaints. However, complaints were not always followed-up in a timely manner. Some staff and young people felt that complaints were not followed up by the local managers. Young people received a letter detailing the outcome of complaints, but some young people had been waiting a considerable time for the letter.
- Young people knew how to complain and could do so in several ways. For example, using the suggestions box, speaking to staff and the independent advocate, raising in their individual review meeting or in the daily community meeting.
- In the 10 months prior to the inspection the service had received six complaints. Complaints were resolved locally, and the outcome was to send a letter to each complainant. Following one complaint a new procedure was implemented.

Are child and adolescent mental health wards well-led?

Inadequate

Leadership

- The service had previously undergone changes in the local management structure and had a newly appointed manager in post. Senior and other registered managers from within the Huntercombe group were supporting the manager. The changes in local management and various additional management support staff sent by the provider caused confusion amongst the staff team and they were unclear who was providing management support to the service. Staff told us there had been no consistency or continuity with local management as the provider had sent other local managers to provide support and it was unclear who was overseeing the service. Staff did not feel listened to by management and said that decisions were made without their involvement or consultation. Some staff's roles were changed and the rationale for this was not clear.
- The management team had a good understanding of the services they managed and could explain how the team were working to provide high quality care.
- The manager had recently changed the location of the management office to ensure they were visible in the service. The office had previously been located upstairs, away from the clinical area. Staff and young people commented that management were not always approachable.
- The local manager had applied to become the registered manager and was going to relocate to the area permanently. The provider had seconded an experienced manager from another service to provide the manager with support and also seconded experienced staff to support the staff team and help fill outstanding vacancies.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they applied in the work of their team.
- Nursing staff said they did not have the opportunity to contribute to discussions about the strategy for their service. In the six months prior to the inspection nursing staff were present at only two of the six held monthly clinical governance meetings.

Culture

- Staff at all levels within the service recognised that there were issues with the culture of the service. Due to the inconsistent support provided by the wider provider and pressures within the service there was conflict in the team at all levels. Agency staff reported not feeling initially welcome or supported by the team when they arrived for shifts. Young people told us they knew when staff were stressed or had a disagreement, and this sometimes affected how staff interacted with them. For example, staff could be abrupt or rude.
- Staff felt there was a disconnect between the support and nursing staff and the management team.

- The management team was working to improve morale and the culture within the service. For example, the they had arranged a team away day and was negotiating with the human resources department to reward staff with a retention bonus.
- The senior management team provided support to staff during the period of enhanced public scrutiny of the service, which had affected staff morale and emotional wellbeing. The management team were also aware of the communication issues raised by staff and were planning to hold specific team meetings with the nursing team and the support worker team to address this.
- Staff knew how to use the whistle-blowing process.

Governance

- The management team did not have robust governance in place to ensure there was oversight of when staff were due supervision meetings or attended all mandatory or additional training as required. Managers were not ensuring that all incidents were investigated, actioned and closed and it was unclear who had oversight of ensuring actions from safeguarding concerns had been followed up.
- The management team did not have a robust process for learning from incidents and making improvements to the service. The provider nor local managers had not implemented an appropriate system to ensure staff had the right knowledge and skills to manage a shift safely. The service had not made improvements to the observation procedure following a number of incidents involving agency staff sleeping on duty. Neither the provider nor local managers had not ensured there was a robust on-call system for contacting senior nurses out-of-hours. The on-call system had been changed recently and staff were not fully aware of why or who to contact out of hours if the manager was not available.
- The management team had implemented recommendations following the previous inspection. This included improving the service's procedure for responding to medical emergencies.

Management of risk, issues and performance

- The service's risk register was reviewed and updated during clinical governance meetings. Staff did not have access to the risk register but staff concerns matched those on the risk register.
- The service had plans for emergencies for example what to do if there was adverse weather or if the service had to be evacuated.

Information management

- Staff had access to the equipment and information technology needed to do their work.
- Records were all electronic and therefore young people's records were only accessible by authorised staff with a log-in.
- The management team had access to information to support them with their role. This included information on the performance of the service and young people's care. This was reviewed during the clinical governance meeting and the management team were able compare themselves against other services in the Huntercombe group.

Engagement

- Staff had access to up to date information about the service. For example, staff had access to an information folder which contained any updated policies, procedures or memos.
- During the time the service was under enhanced public scrutiny of the service, the senior management team contacted each parent to inform them, offered support and gave parents the opportunity to share their opinion and ask any questions. The senior management team also visited the service to meet with the young people to offer support and provide them with an opportunity to share their opinions and ask questions.

Learning, continuous improvement and innovation

- Staff were not given the time and support to consider opportunities for improvements and innovation, for example staff did not have access to regular supervision and staff did not feel heard by management.
- Staff attended a 'Friday clinic' where articles, research and other publications were discussed to share learning and improve practice.
- The manager distributed a monthly lesson's learnt memo to all staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must also ensure that it has a system in place to learn from incidents and make any improvements required. (Regulation 12)
- The provider must ensure that all staff complete mandatory training and relevant additional training to undertake their role effectively and safely. (Regulation 12)
- The provider must ensure that all nursing staff in charge of shifts have the relevant skills, knowledge and experience to manage the shift safely. (Regulation 12)
- The provider must ensure that all staff receive a regular supervision meeting in line with the provider's policy. (Regulation 18)
- The provider must ensure that there are robust on-call arrangements. (Regulation 18)
- The provider must ensure that all incidents of safeguarding are reported, investigated in a timely manner and that action is taken as necessary (Regulation 13)
- The provider must ensure that all appropriate concerns are raised with the relevant authority promptly for example the local safeguarding authority and the Nursing and Midwifery Council (NMC). (Regulation 13)
- The provider should ensure that young people have access to appropriate psychological interventions. (Regulation 9)
- The provider must ensure that the service has robust governance and quality assurance procedures in place. (Regulation 17)
- The provider must ensure there is appropriate and skilled managers in place to support the effective running of the service. (Regulation17)

Action the provider SHOULD take to improve

- The provider should ensure that staff have access to a debrief session as soon as reasonably practical after an incident occurs.
- The provider should ensure the confidentiality of conversations about young people.
- The provider should ensure that young people are kept informed on the progress of any complaints and provide a clear timeline for when they should receive a response.
- The provider should ensure it has appropriate performance management systems in place that support staff to improve and carry out their role effectively.
- The provider should ensure that all relevant staff are involved in multidisciplinary team meetings and any other meetings relevant to the care of the children and young people.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that staff providing care and treatment to young people had the appropriate qualifications, competence, skills and experiences to do so safely.** **The provider had not ensured that all staff had completed mandatory training and additional training required to carry out their role.** **The provider had not ensured that there were appropriate systems in place to learn from incidents.** **This was a breach of Regulation 12 (2)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that staff received appropriate support and supervision.** **The provider had not ensured that a robust on-call system was in place that was clearly understood by staff.** **This was a breach of Regulation 18 (1)(2)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not have a system in place to effectively investigate any allegations or evidence of abuse.**

This section is primarily information for the provider

Requirement notices

The service was not always making appropriate referrals to the local safeguarding authority.

The service was not always following up on on-going investigations and were relying on other organisations to make referrals to the Nursing and Midwifery Council.

This was a breach of Regulation 13(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service had not ensured that young people had access to psychological interventions to meet their needs. This was a breach of Regulation 9(3)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust systems or processes in place to assess, monitor and improve the quality and safety of the service. The service did not have appropriate observation process in place. The service did not have processes in place for monitoring staff supervision or the completion of mandatory training. The service did not have appropriate systems in place to ensure that staff were involved in decision making and developments. There were frequent changes of managers, a lack of oversight and poor culture at the service.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 17 (2)(a)(e)