Four Seasons (Granby One) Limited

Child and adolescent mental health wards

Quality Report

The Huntercombe Hospital Norwich
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-280143864	The Huntercombe Hospital Norwich	Rainforest Ward	NR10 5RH
1-280143864	The Huntercombe Hospital Norwich	Coast Ward	NR10 5RH
1-280143864	The Huntercombe Hospital Norwich	Sahara Ward	NR10 5RH
1-280143864	The Huntercombe Hospital Norwich	Sky Ward	NR10 5RH

This report describes our judgement of the quality of care provided within this core service by The Huntercombe Hospital Norwich. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by The Huntercombe Hospital Norwich and these are brought together to inform our overall judgement of The Huntercombe Hospital Norwich.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- The ward environment on Sahara ward was not fit for purpose and did not promote the recovery and dignity of the people being cared for on the ward.
- There was evidence of the organisations safeguarding policy not being followed which meant the risk to a young person was increased.
- Seclusion records were not being kept to the standard required by the Mental Health Code of Practise.
- Seclusion rooms were did not meet the standard required by the Mental Health Act Code of Practice.
- The ward environments did not meet the criteria for mixed sex accommodation as required by the Mental Health Act Code of Practice.
- Staff reported a lack of support and supervision.
- Medication records had been amended after audits. This meant that the records were no longer accurate about what medication dose had been given and when.
- We observed a lack of meaningful interaction with young people by staff.

However:

- Ward managers and team leaders showed good leadership skills at ward level and we observed them dealing with a variety of issues in an appropriate way.
- Young people told us that they had good relationships with staff.
- Young people reported enjoying psychology sessions and occupational therapy sessions.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

- We found evidence of safeguarding processes not being followed as set out in the hospitals safeguarding policy. This meant young people were placed at risk. We highlighted this to the provider.
- Staff were not trained to the recommended level in safeguarding training. NHS England recommend that 'Clinical staff working with children, young people **and/or their parents/carers** and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained to level three. Three members of staff at the service were trained to this level. All other staff were trained to level two.
- Medication records were amended after an audit had been completed which had highlighted gaps in records. This meant that the records were not a true reflection of medication doses dispensed at the time of dispensing.
- The ward environments did not meet guidance for mixed sex accommodation as required by the Mental Health Act Code of Practice and Department of Health guidance.
- The seclusion rooms did not meet the standards required by the Mental Health Act Code of Practice.
- Some seclusion records reviewed were not completed in full and to the standard required by the hospitals policy and the Mental Health Code of Practice.
- One qualified nurse was available per ward; this meant that during breaks wards were left without a qualified nurse. Some staff told us that this arrangement meant they were not able to take breaks.
- Risk assessments were not reviewed regularly. This meant that they did not reflect current risks in relation to young people's treatment and behaviour.
- There were issues with recording of restraint and seclusion. Missing information meant that records were not kept to the standard required by the Mental Health Code of Practise.

However:

- Staffing numbers were good on each ward we visited. This meant observations were being completed as required.
- Health and Safety meetings took place on a monthly basis to review issues with the environment.

Summary of findings

- There had been no serious untoward incidents in the last 12 months.

Are services effective?

- Care plans were standardised in the files we reviewed. They did not contain information that was personalised to the young person.
- There were no senior psychologists working at the hospital at the time of inspection. This meant that the support available for the assistant psychologists and the treatment offered to the young people was limited. Young people told us they were able to access limited psychology appointments and they would like to access more.
- We found three out of six staff files contained appraisals.
- Staff on the wards told us that they did not receive regular supervision. This was contradicted by statistics given to us by the provider.
- We were not able to review supervision notes during the inspection as we could not establish where the records would be located after speaking to the registered manager and ward staff.

However

- Young people were able to access healthcare appointments as and when required.
- We saw evidence of contact with different agencies, such as social workers, to support young people's treatment.

Are services caring?

- Young people told us that the majority of staff were nice to them.
- We saw evidence of young people being involved in wards rounds where they were able to make requests about their treatment.
- Young people were given the opportunity to give feedback on the service during ward assemblies.
- The hospital had arranged a barbeque for young people and their families the day before the inspection which the young people gave positive feedback on.

However

Summary of findings

- Staff interactions with young people were limited. They consisted of responding to young people's requests and did not show there was an existing therapeutic relationship between staff and young people.
- Three young people told us there were times when staff had hurt them during episodes of restraint. We made the provider aware of this during the inspection.
- There was an advocacy service available to young people; however the information displayed throughout the hospital listed details for the wrong service.

Are services responsive to people's needs?

- The facilities did not promote recovery for young people. We observed several broken fittings and fixtures. Sahara ward was not fit for purpose and was neglected. This did not support the recovery of people being cared for on this ward.
- The hospital was undertaking renovations at several parts of the premises. None of the work was completed and staff were unable to tell us when the work would be finished. This effected the environment of the hospital.
- The displays in the hospital were not children and young people friendly.
- Young people told us they knew how to complain, however they were not always happy with the outcome.

However

- Young people were able to make private telephone calls in their rooms.
- The hospital had a designated school and occupational therapy area.

Are services well-led?

- We were not able to establish the process for supervision during inspection. Ward managers and the registered manager gave us conflicting information about how supervision records were stored.
- Staff reported a lack of supervision.
- The management team gave us conflicting information about the purpose of Sahara ward.
- There was a lack of comprehensive planning regarding the renovations of the hospital site.
- We found evidence of safeguarding processes not being followed.

Summary of findings

- The layout of the wards did not meet the requirements of the mental health code of practise.
- We did not receive a satisfactory explanation from the manager about the medication audit process.

However

- There were monthly governance meetings in place.
- Staff reported a recent improvement in morale.
- We saw a certificate of participation in QNIC. This certificate is awarded by the Royal College of Psychiatrists as confirmation of the service's commitment to on-going evaluation and quality improvement.

Summary of findings

Information about the service

The Huntercombe Hospital Norwich is an independent hospital offering secure facilities for young people detained under the Mental Health Act 1983. [CL1]

The service has four wards used for the care of young people: Coast, Rainforest, Sky and Sahara. The total capacity of the service is 35 beds. At the time of the inspection the bed capacity was restricted to 22 whilst recruitment of staff took place.

Rainforest and Coast wards are low secure units. Sahara was being used as a transitional ward for people who had turned 18 years old and Sky ward is a PICU (Psychiatric intensive care unit).

Our inspection team

The team included two CQC inspectors and two Mental Health Act Reviewers. The inspection was carried out over a two day visit.

Why we carried out this inspection

We carried out an unannounced focused inspection of this core service following concerns identified by the Care Quality Commission.

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 the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Spoke with six young people who were using the service.
- Interviewed the registered manager for the service.
- Spoke with 11 staff members including qualified staff, support workers, administrators and ward managers.

We also:

- Reviewed nine treatment records of people who use the service.
- Examined in detail six staff personnel files.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Visited all four of the wards at the hospital site to look at the quality of the ward environment and to observe how staff were caring for young people
- Carried out checks of the medication management on three wards.

Summary of findings

What people who use the provider's services say

Young people told us that the majority of the staff were nice. They told us that the food was ok at the hospital.

They told us that they are able to give feedback about the service in ward rounds and in ward assemblies.

Three young people told us that they had been hurt when they are being restrained. They also told us that they know how to complain but are not always happy with the outcome as it tended to be in favour of the staff.

Young people told us that they enjoy psychology and occupational therapy appointments, but they would prefer it if they could access more sessions.

Areas for improvement

Action the provider MUST take to improve

- **The provider must ensure that all safeguarding concerns and allegations of abuse are escalated immediately through the hospital safeguarding policy.**
- **The provider must ensure that all environments are fit for purpose and appropriate to support the recovery of young people. The issues identified in the report must be fixed to reduce the risk to young people who have a history of self-harm. The provider must ensure that any risks of this nature are resolved quickly through the maintenance reporting system.**
- **The provider must ensure that young peoples privacy and dignity is protected at all times.**
- **The provider must ensure that there is an effective and regular supervision process in place for all staff. This includes the recording of sessions and the management of storing supervision records.**
- **The provider must ensure that all staff are supported with personal development through a yearly appraisal system.**
- **The provider must ensure that seclusion rooms and recording of seclusion meet the requirements of the mental health code of practise.**
- **The provider must ensure that all risk assessments and risk management plans reflect current and up to date information about young people.**
- **The provider must ensure that medication records for young people are completed appropriately.**

Action the provider SHOULD take to improve

- The provider should consider the access to psychological therapies for young people. Young people have stated they want to access more time and this would contribute towards their treatment.

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Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Huntercombe Hospital Norwich	The Huntercombe Hospital Norwich

Mental Health Act responsibilities

- On Sky ward we looked at four records. The section papers were available in three of the four records checked. For a young person recently admitted the section papers were not uploaded onto the Care Notes system and were later provided by the MHA Administrator.
- Records for a young person that had been admitted two days prior to our visit showed no evidence of being fully clerked on admission. The Multi-Disciplinary 24-48 hour assessment form was not completed.
- All three records on Coast ward had detention papers in them[CL1] . They were in order. Section 132 rights were present on all three records. Certificates for consent to treatment (T3) were present were needed and in order.
- Section 17 leave forms were seen on file, authorising leave to attend another hospital for medical emergencies that had originally been completed by a previous Responsible Clinician (RC) and subsequently counter signed and dated by another RC who was no longer the RC at the time of the visit. Staff told us that they had never given a young person a copy of their section 17 leave forms.
- We saw evidence in case notes that section 17 leave was being authorised when leave forms could not be found by staff.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environment

- We saw evidence of ligature audits that were completed in January 2015 for Coast and Rainforest. High risk issues had been identified and actions had been put into place to reduce risk. Actions were listed as 'staff to maintain observations when room is in use by a young person'. We saw evidence of the audit schedule being discussed in an audit meeting in April 2015. A action plan was put in place for team leaders to complete an annual ligature audit in June 2015.
- We observed potential ligature points around the service. This included on two door closures in the gym and an alarm on the wall in a bedroom corridor on Coast ward. All curtain rails in bedroom and day spaces were not anti-ligature and could be a risk to the young people. These risks were not identified in the ligature risk audits.
- We saw evidence that environmental issues were discussed in health and safety committee meetings which took place on a monthly basis.
- We observed a young person asleep in their room during the inspection. The door was left open as the person was under observation. This was detailed in the care records. Due to the mixed sex bedroom corridors this meant the person could be seen by other people including members of the opposite sex. This means that the young persons privacy and dignity was not upheld.
- The layout of the wards did not meet the standards of same sex accommodation as required by the Mental Health Code of Practice and Department of Health guidance. All wards were mixed sex and there were no designated bathroom or toilet facilities. Bedroom corridors were not separated by gender. There were no designated lounges for females.
- We observed seclusion facilities on Sky, Rainforest and Coast wards. We were told that seclusion was rarely used and that the rooms were used as quiet rooms and for de-escalation.
- The seclusion room on Sahara ward was not clean. There was evidence of bodily fluids on the walls and flies in the sink and on the floor.
- The temperature in the seclusion room on Sky was high and there was no thermostat to control the temperature. There was a call bell inside the room for young people to use if they wanted to summon help from staff. We saw an observation mirror, a mattress and strong bedding. The door handle used to enter the room was not an anti-ligature fitting. There was no clock. The room was not ensuite, in order to use a bathroom the young people would have to leave the room and use the bathroom opposite. There was no shower in the bathroom. The seclusion room was at the end of the bedroom corridor and next to one of the lounges. There was no privacy as the area could be seen by people in the bedroom corridor and lounge due to glass panels in the doors.
- The seclusion room on Rainforest ward had two mattresses in it. Staff kept the door locked at all times. There was no thermostat to control the temperature and there was no clock visible to young people. The manager told us that this was not used a seclusion room but a low stimuli area for young people. This was because the quiet room on the ward had a TV in it. The room was not ensuite.
- We looked at the seclusion room on Coast ward . We were told that the seclusion room on Coast ward was the only seclusion room that was fit for purpose in the service. It had been updated recently. The room was open plan with a toilet, sink and shower. The room included a mattress, an intercom to aid communication between staff and young people and a thermostat to control the temperature. However we were unable to get the thermostat to work. There was no clock. We saw four large observations windows were staff would observe the young person. There were blinds in the room that could be closed if required. The observation room was cluttered with a mattress, suitcase and two black bin bags. The room where the young person entered also had access to an outside area. However, the room was dirty with hair and dust. One wall in the seclusion room was observed to have bodily fluids on it.

Safe staffing

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Staffing on the Sky Ward consisted of one ward manager, five male staff and two female staff.
- Staffing on Coast ward consisted of seven staff including the ward manager.
- Staffing on Rainforest consisted of six staff.
- Staffing on Sahara consisted of one member of staff. One young person was being cared for on this ward at the time of inspection.
- We were told by staff that there was one qualified nurse on shift for Rainforest, Coast and Sky. Sahara ward was supported by qualified staff when required. There was no allocated member of qualified staff to support Sahara ward. The wards was staffed by support workers. This meant that during break times the qualified staff would have to hand over keys to a member of qualified staff on another ward. Staff told us that there were occasions where qualified staff did not take breaks. If this happened they would log this on their time sheets and they would be paid for this. This means that there is a risk of staff becoming tired due to lack of breaks and this could put the standard of young people care at risk.
- The hospital followed the QNIC (Quality Network for Inpatient CAMHS) guidelines for staffing levels. This required one responsible clinician per 12 young people.
- At the time of inspection there were vacancies for two senior psychologists, a ward manager, an administrator and five support workers.
- The registered manager told us that they have the ability to increase staffing based on the acuity of the young people in the hospital. This would be decided in the clinical meetings which took place every morning.
- There were dedicated contracts in place with employment agencies to provide staffing if required.
- We met with four young people who told us they did not know who their named nurse was. All young people stated that they had one to one time. However we looked at records and saw that one of the young people had two one to one appointments with their named nurse in May 2015.
- Young people told us that they had missed sessions due to staff shortages and that there were times when access to outside space was restricted due to staffing levels.

Assessing and managing risk to patients and staff

- There were five recorded episodes of seclusion at the hospital since February 2015.
- Seclusion records were not completed to the standard required by the Mental Health Code of Practise. There was information missing such as which medical professional attended the seclusion.
- We looked at one record of segregation that happened on Sky ward. The time of segregation was not recorded. There were no records that showed the segregation had been agreed with a responsible clinician. There was no records of a four hour review by the nurse in charge. This did not follow the segregation policy used by the hospital which is based on the mental health code of practise.
- Episodes of restraint were as follows: April, 308 incidents, March statistics were not available, February 207 incidents and January 173.
- From April 2015 monthly reports showed the reason for seclusion, ward location and patient name. This meant the hospital was able to identify themes and trends. We were told that information about young people should be discussed in ward rounds, however this was not recorded in the ward round review notes.
- The description of restraint in the DATIX records was variable for April. We reviewed eight records. One record named the staff member involved in the restraint. Two records indicated the length of time the young people was restrained for. Six records named the restraint techniques used. Two of the records stated 'PRICE'. [CL1] The service used the PRICE restraint technique, which is intended as a child friendly restraint technique where no pain is inflicted. However the actual PRICE technique used to restrain should be recorded specifically.
- 150 episodes of restraint recorded in April 2015 were to prevent self-harming behaviour.
- The highest rate of restraint during April 2015 at 59 episodes was on Sky ward (PICU).
- We observed a restraint on Coast ward on the day of inspection. We saw that staff used correct techniques and were communicating with the patient in a calm manner. They had to take the patient to the floor during the incident, at no point did they use the prone position, and the patient started on their back but then was moved into the recovery position.
- However three young people told us that they had been hurt by staff in episodes of restraint. We made the provider aware of this during the inspection.
- We reviewed nine case records and saw that a risk assessment was completed on admission. Three records showed that the risk assessment had not been

reviewed since admission. This means that they did not contain up to date information to support the young person with their needs. The tool used for the risk assessment was Salford Tool Assessment of Risk (STAR) this has been adapted for children.

- Risk management plans were present in files however they were not personalised to the patient and were in a standard format.
- Three young people told us that they had been involved in recent incidents on the ward but we could not find evidence of this in the risk assessments of risk management plans.
- Young people told us that there were blanket restrictions on the wards but that they understood this was due to low secure standards and for safety reasons.
- Three staff had been trained in Safeguarding to level three. All other staff were trained to a level 2.
- We reviewed an incident where staff had not followed the correct procedure for reporting a safeguarding incident that happened during a night shift. The hospital safeguarding policy details an out of hours reporting procedure to report and incident to the local safeguarding team. This procedure was not followed which meant that a young person was placed at risk until the incident was reported and action was taken the following day. We highlighted this to the provider at the time of inspection.
- We reviewed medication records on all wards. We saw some staff initials were highlighted by a green circle. We asked the registered manager to explain this and they could not provide an answer. We were told by staff that medication administration records (MARs) were audited by a Pharmacist on a weekly basis. The audit would highlight gaps on the MAR sheet where staff had not signed the record after a dose had been administered. We saw that staff had retrospectively signed the records once the audit had been completed as their initials were within a green circle. This meant that the MAR sheets were not accurate as they had been completed after the dose had been administered and not at the time of administration.

Track record on safety

- There were no reported serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

- The service used DATIX to report all incidents within the service.
- Staff were able to tell us what types of incidents they needed to report.
- Staff told us that learning from incidents would be discussed in clinical meetings.
- The manager told us that learning from incidents was also discussed in supervision with staff on a one to one basis.
- We reviewed eight DATIX records alongside looking at care records and found the information contained in DATIX reports to be variable. There was missing information regarding which staff were involved, which patient the incident related to and the immediate actions taken to reduce risk to young people.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Our findings

Assessment of needs and planning of care

- The care records that we reviewed showed three occasions where the admission paperwork was not fully completed. One admission pack we looked at had not been completed at all. This meant that information regarding young peoples' needs was not recorded and used to inform their care plan.
- Three records included a comprehensive assessment of physical health needs and included all future appointments that had been made to support people with these needs. Three records did not have this information.
- All care records had care plans in place. However four records we reviewed contained standardised plans for people and did not reflect individual preferences for young people. For example, de-escalation plans did not include individual ways to support young people's behaviour and were the same in each file.
- We saw that case records were stored in paper format and on an electronic system. The provider was in the process of working towards an electronic system only but we found all records were easily accessible to our team and to staff.

Best practice in treatment and care

- There were two vacancies for senior psychologist roles at the time of inspection. The roles were being advertised. There were three assistant psychologists employed within the service and the provider was in the process of investigating supervision arrangements for them as an interim solution.
- Psychological therapies were available to young people, however this was limited at the time of inspection due to the senior vacancies.
- Young people told us that they enjoyed psychology appointments, but wished they were able to access more sessions.
- We saw evidence in case notes that people were able to access healthcare appointments as and when required.
- We saw within the case records that HONOSCA (in full) and HONOS (in full) secure is used. One record was not dated. The Children's Global Assessment Scale (CGAS) was used in the service.

Skilled staff to deliver care

- We reviewed six staff employment files. Three files contained appraisals. One was out of date, it was due for review in October 2012. There was no evidence in the file to suggest further reviews had been completed. The other files did not include appraisals.
- Staff were told that staff were able to access Clinical Supervision. Statistics given to us showed that during January to March 2015 94% of staff who were eligible for supervision received it. This was an improvement from October to December 2014, where 55% of eligible staff received clinical supervisor.
- We requested to see supervision records. We were told by ward managers that the records were stored centrally in the administration block. We visited the administration block and were told that supervisions records were kept locally on each ward. We spoke to the registered manager who told us about the arrangements for notes of people they supervised. We could not establish the process for supervision notes and they were not made available to us during inspection.
- However, staff from the wards told us that supervision did not happen regularly, with one staff member telling us they had not received supervision for over six months.

Multi-disciplinary and inter-agency team work

- There were regular morning MDT meetings attended by a variety of staff members.
- We saw evidence in ward round notes of actions for outside professionals to be contacted to support young peoples' care. For example, contact made with local social workers.

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

- On Sky ward we looked at four records. The section papers were available in three of the four records checked. For a young person recently admitted the section papers were not uploaded onto the Care Notes system and were later provided by the MHA Administrator.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- A records for a young person that had been admitted two days prior to our visit showed no evidence of being fully clerked on admission. The Multi-Disciplinary 24-48 hour assessment form was not completed.
- All three records on Coast ward had detention papers in them. They were in order. Section 132 rights were present on all three records. Certificates for consent to treatment (T3) were present where needed and in order.
- Section 17 leave forms were seen on file, authorising leave to attend another hospital for medical emergencies that had originally been completed by a previous Responsible Clinician (RC) and subsequently counter signed and dated by another RC who was no longer the RC at the time of the visit. This meant that the leave was not authorised by the appropriate person. Staff told us that they had never given young people a copy of their section 17 leave forms.
- We saw evidence in case notes that section 17 leave was being authorised when leave forms could not be found by staff.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Our findings

Kindness, dignity, respect and support

- We observed interactions between staff and young people and saw that the engagement was limited. Staff spent time observing young people from corridors and responded to basic requests. We observed this across all wards.
- Three young people told us that there had been times when staff had hurt them during episodes of restraint, including bending their arm up behind their back. The young people told us that they had reported these incidents to ward staff and the social workers at the hospital. We raised these issues to the hospital manager during the inspection.
- All young people told us that the majority of staff were nice to them and cared about them.
- We observed caring interactions on Rainforest ward when the manager was caring for a young person who was feeling unwell.

The involvement of people in the care that they receive

- We saw in the care records that all young people had 72 hour care plans [CL1] to support their admission to the ward and orientate them to the environment and meet members of the team.
- We saw some examples of young people being involved in their care. We saw one record where the young person had been involved in a self-assessment.
- We found evidence in ward round notes that young people were engaged with ward round meetings where they are able to make requests about their treatment.
- We were told that a hospital barbeque had taken place the day before our inspection which involved young people and their families and carers.
- Young people had access to ward assemblies which were the hospitals form of community meeting. This gave them the opportunity to provide feedback on the service.
- The advocacy service for the young people was provided by PowHer. We saw posters for this service although the rights leaflet given to young people gave contact details for Voicability.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Our findings

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a designated school and occupational therapy area.
- There were separate lounges on each ward, although some of these were locked, with young people having to request access from the staff.
- Areas of the service had been redecorated however there was a lack of pictures and notice boards on the wall containing information for young people. The pictures that we did see were not young person specific.
- The link lounge on Sky ward did not contain enough seating if all young people wanted to access the room.
- The dining room on Sky ward had two chairs missing which were reported as broken. However this left exposed metal brackets which could have increased risk to young people.
- Sahara ward was neglected. Lights were broken meaning the ward was very dark. Pictures had been removed from the walls. There were holes in the walls that had not been filled to a high standard.
- On Rainforest ward we saw one lounge had four seats available and the second lounge had three seats. We saw exposed wires in a fitting in the ceiling. There was a hole in the lino in the bedroom corridor.
- On Coast ward we saw 10 seats in the lounge. The quiet room had specialist equipment including a de-escalation chair and sofa. In the bathroom we saw a broken soap dispenser. We highlighted this to the manager as it could have posed a risk to young people.
- We saw three broken fire exit signs across Sahara, Coast and Rainforest. Staff told us that this had been reported but in the long term they were looking to replace them with stickers to reduce risk to young people.
- We saw that wards and seclusion rooms had CCTV. The TV's to monitor the CCTV on coast ward were in the main offices and could be seen by looking through the window. This did not protect the privacy and dignity of the young people.The other wards had covered windows and monitors were in a different place
- There were quiet areas on the wards but they were often locked. Staff told us they used the seclusion room as a low stimuli or quiet area.
- Young people were able to make phone calls in private in their bedrooms.
- Young people told us that the food was ok. They told us they could access snacks three times per day.
- Young people did have access to the kitchen if they had a risk assessment in place.
- There were numerous areas of the hospital that were undergoing forms of renovation including wards and outside areas. We asked for dates when the work would be completed as this effected the environment of the hospital. We were not able to establish a comprehensive plan for completion of the work when we asked the management of the hospital.

Meeting the needs of all people who use the service

- Information on how to complain was included in the admission process.
- Young people told us that they knew how to raise a complaint. However, they told us that they were not always happy with the outcome as they felt it was always in favour of the staff.

Listening to and learning from concerns and complaints

- We saw complaint statistics and there were 37 complaints between January 2015 and April 2015. Six were resolved on the ward, 22 were not upheld, three were partially upheld, none were upheld, three were ongoing and two were classified as other.
- For the same period three related to patient on patient issues, 23 related to staff behaviour, two related to loss or damage to patient belongings, five related to staffing levels including agency usage, three related to medication and one was received from a parent/carer.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

Good governance

- There were local governance meetings that involved senior managers and the agenda included incident monitoring, seclusion, restraint, medication errors, and staff injuries. Each member of the meeting had a lead role for the service including restraint and seclusion, and safeguarding.
- Monthly audits were carried out by department leads including health and safety and medication. Results of audits were discussed in the monthly governance meetings. It was the responsibility of the heads of department to feed the information to the ward staff, however there was no formal process in place for this to happen.
- There were daily multi-disciplinary meetings to discuss incidents and young peoples issues.
- We were not able to establish, during our inspection, the frequency and policy for staff to receive supervision. We were not able to access notes as staff and managers were unclear about where they were stored. Staff and managers told us three different systems for storing notes and who was responsible for this. Staff told us that supervision was not frequent which means staff were not receiving the appropriate level of support.
- There have been ongoing issues with recruitment which has led to increased use of agency staff. There were no senior psychologists in position and this had impacted on the support for the assistant psychologists and psychological interventions for the young people. A recruitment plan was in place to create a bank support worker staff for the future.
- The management were not clear on the purpose of Sahara ward. We were told at the start of the inspection that Sahara was a transitional ward to support young people transferring to adult services. However, during the tour of the premises we were told that the ward was used for 'holding' young people and it was not a transitional ward for young people, but this was a plan for the future. The purpose of the ward was not clear due to the conflicting descriptions were received from two members of the management team.
- There was no comprehensive plan in place for the renovations taking place around the hospital site. This meant that we saw lots of unfinished work which effected the environment for young people using the service.
- We found evidence of safeguarding processes not being followed correctly.
- The layout of the wards did not meet the requirements for mixed sex accommodation as required by the Mental Health Act Code of Practice or Department of Health guidance. This had not been considered as part of the management of the hospital.
- The registered manager was not able to explain medication audit practise when we asked about the medication records. We were able to establish this process by speaking with ward managers.

Leadership, morale and staff engagement

- Staff reported an improvement in morale. They told us that staffing has been an issue in the past but this had improved. However they did raise concerns about the use of agency staff as they were not trained in all aspects of the role which had an impact on the workload for regular staff.
- Staff raised concerns about the lack of supervision.

Commitment to quality improvement and innovation

- We saw a certificate of participation in QNIC. This certificate is awarded by the Royal College of Psychiatrists as confirmation of the service's commitment to on-going evaluation and quality improvement.

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 12 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (a) Assessing the risks to the health and safety of service users of receiving the care and treatment. (b) Doing all that is reasonably practicable to mitigate any such risks (g) the proper and safe management of medicines. Risk assessments were not person centred and were not reviewed regularly. This meant that the information about the risk to young people was not current and up to date. Medication records had been altered following an audit. This meant that the information on the records was not accurate as it was not completed at the time of dispensing. Staff had made entries retrospectively.

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 17 Governance

This section is primarily information for the provider

Requirement notices

(1) Systems or processes must be established to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable that registered person, in particular to –

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to care and treatment provided:

The provider did not keep complete seclusion records. Information was missing that means the standard required by the mental health code of practise was not being met.

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 18 Staffing (2) Persons employed by the service provider in the provision of regulated activity must – (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Supervision records were not available to inspectors during the inspection. There was no clear indication of the system for storing supervision records. Staff reported that they do not have access to regular supervision. Staff files reviewed did not always contain an appraisal.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **10 Dignity and respect** (1) Service users must be treated with dignity and respect. (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular – (a) Ensuring the privacy of the service user; The layout of the wards must protect the privacy and dignity of the patient.

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 **13. Safeguarding service users from abuse and improper treatment:** 2. Systems and processes must be established and operated effectively to prevent abuse of services users. 3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

This section is primarily information for the provider

Enforcement actions

Safeguarding concerns and allegations must be reported immediately in line with the hospitals safeguarding policy.

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 15 HSCA (RA) Regulations 2014 Premises and equipment **15. Premises and equipment:** (1) All premises and equipment used by the service provider must be – (a) Clean (b) Suitable for the purpose for which they are being used. (e) Properly maintained (2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. The provider must address the maintenance issues that pose a risk to young people. Sahara ward should not be used to care for people as the ward is not fit for purpose.