Huntercombe Hospital - Stafford

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?	Inadequate
Are services responsive?	Inadequate
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.

Summary of findings

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 Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

The CQC is 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.

we rated Huntercombe Hospital Stafford as inadequate because:

- The safety of young people using the service was compromised due to concerns related to staffing, restrictive interventions, poor physical health monitoring and a poorly trained and supervised staff group.
- The application and understanding of the Mental Health Act & Mental Capacity Act was of a poor standard.
- Documentation related to patient care such as care plans and risk assessments weren't complete or up to date and failed to reflect the views or involvement of young people.
- Feedback from young people and their carers was largely negative and reflected a hospital that did not take into account the individual needs of those using the service.
- Governance systems used to monitor the quality, safety and effectiveness of the service were poor and did not capture or lead to action on the concerns raised by staff and young people.

Despite being aware of the safety concerns at the hospital, the executive team within the wider Huntercombe group did not act or respond at the pace required to address the issues in a timely or decisive manner.

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 	Start here...

Summary of findings

Contents

Inadequate

Huntercombe Hospital Stafford

Services we looked at

Child and adolescent mental health wards

Summary of this inspection

Background to Huntercombe Hospital - Stafford

Huntercombe Hospital-Stafford is a child and adolescent mental health inpatient service for up to 39 young people of both genders aged 8 to18 years. The hospital can admit young people detained under the Mental Health Act (1983).

The hospital is divided into three separate wards, Hartley, Thorneycroft and Wedgewood wards. A dedicated consultant child and adolescent psychiatrist leads each ward team.

- Hartley ward is a Psychiatric Intensive Care unit (PICU) providing 12 beds for male and female young people. The PICU offers inpatient care to young people suffering from mental health problems who require specialist and intensive treatment to address their needs. It is a locked secure unit, which means that young people cannot leave or enter the building unless they have authorisation from their doctor. All young people admitted to the PICU are detained under the Mental Health Act (1983).
- Thorneycroft ward is a general CAMHS acute assessment unit with 12 beds for young people aged 12-18 years. The young people treated in this unit have a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm.
- Wedgewood ward has 15 beds and provides a specialist eating disorders service. The young people treated on the eating disorders unit have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or other similar eating disorders.

The CQC registered Huntercombe Hospital - Stafford to carry out the following services/activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act
- Diagnostic and screening procedures

The hospital did not have a manager registered with the CQC in post at the time of the inspection.

The CQC carried out an inspection of the site on 29 May 2014, the hospital did not to meet the standard around environmental safety. The hospital was compliant with the other four outcomes the CQC inspected against, including the assessment and management of risk.

Following serious concerns raised by a member of staff on 28 April 2016 about patient safety the CQC organised an urgent unannounced inspection. CQC staff attended the hospital on the 29 and 30 April and 03 May 2016 to complete an investigation into these complaints. We found that the hospital's safeguarding system was not effective and put young people at risk. A warning notice was served on the provider to improve the system by 24 June 2016. The training, support and supervision of staff was also found to fall short of the standard required and hospital managers were instructed to put plans in place to improve the situation.

Our inspection team

Team leader: Michael Fenwick, Inspector

The team that inspected the service comprised of a Mental Health Act Reviewer, clinical pharmacist, five CQC inspectors, an assistant inspector and an inspection manager.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

Summary of this inspection

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 this service, asked a range of other organisations for information. We visited the site on four occasions during the day on the 16, 17, 19 and 24 May 2016 as announced visits, and on the night of the 19 May unannounced.

During the inspection visit, the inspection team:

- reviewed CCTV footage of specific incidents and activity on the wards.
- reviewed 22 clinical records including care plans, correspondence, risk assessments and nursing notes.
- individually interviewed eight young people (five on Hartley ward and three on Thorneycroft ward.)
- conducted a focus group on Wedgewood ward that 11 young people attended.
- spoke with eight parents and heard of the concerns of another through CQC's Share Your Experience mailbox.
- spoke with the ward managers, six staff nurses, six healthcare support workers, the dietician on Wedgewood ward and the occupational therapist on Thorneycroft ward.
- spoke with the consultant psychiatrists, hospital director, head of quality and clinical effectiveness, social workers and ward managers.
- interviewed staff based at the hospital reception and reviewed the security and visitor policies.
- visited the hospital on the night of 19 May 2016 to interview nursing staff on all wards about their experience and knowledge of safeguarding and their ability to maintain patient safety. In total, we interviewed 19 staff working that night.
- conducted a focus group for therapy staff at the hospital attended by ten people. A psychologist, two occupational therapists, two occupational therapy technical instructors, two art therapists a dietician and the sports and activity manager all participated.
- examined training records for all clinical staff and personnel files.
- spoke with the local safeguarding team leader and subsequently the safeguarding lead for the Staffordshire County Council and correlated the number and detail of safeguarding alerts received since 01 January2016. We also attended a safeguarding strategy meeting.
- spoke with commissioners at NHS England and the local police.

What people who use the service say

Young people we spoke to on Hartley Ward complained about the overuse of restraint. They showed us bruising on their arms because of restraint, which they reported had not been examined by a Doctor. These young people felt there was no regular system to follow up these incidents and debrief them about what had happened and how through working together improvements could be made.

Young people we spoke to felt many of the problems on the ward resulted from boredom due to a lack of activities and if they tried to organise things to do together staff would stop them.

On Thorneycroft ward, the main concerns shared with us by young people were around short staffing that limited their ability to go out. There was no direct access to the outside from this first floor ward. Their care plans and timetables were held in the nursing office and staff were not always available to access them. One young person we spoke to had seen their care plans however, they did not feel their views were taken into account until their parent had complained.

From the focus group we held with the young people on Wedgewood ward, there was common concern about access to medical professionals and their agreement to

Summary of this inspection

leave. This was a cause of concern for the eleven young people in our focus group on the ward. The consultant would only see them once a fortnight and the young people felt this was too long to have change recognised and treatment reviewed. They felt this system limited the opportunity for discussing leave as they reported opportunities for seeing medical staff in between times as being rare.

They were also concerned that the ward had suffered because of staffing shortages across the hospital as regular Wedgewood staff were being used to fill vacancies elsewhere. The young people described feeling uncomfortable in the presence of unfamiliar agency staff and complained of disruption to planned activities on the ward.

Through the CQC's share your experience team we had also received concerns from two young people who had previously received care and treatment at this hospital.

The first young person had been an informal patient at the hospital for four months. They said the consultant was rarely available and there was not much interaction between the young people and the consultants. This young person told us she was often only seen by her doctor for 10 minutes each week.

This young person told us that the staff never noticed her having her mobile phone on her for three weeks even though she searched by staff. She also added that the staff were unaware another young person had brought in a blade hidden in a sanitary towel to self-harm. The wards had in place a ban on some personal items that a young person may have used to self-harm or, as with mobile phones, distract from therapeutic activity.

Our other informant had passed on information to the CQC through ChildLine and reported that they had received little therapeutic input during their time at the hospital. They had concerns about inappropriate staff behaviour and overuse of restraint. They had complained about this at the time but remained worried that other young people may remain at risk.

Complaints about inappropriate staff behaviour were the most common formal complaint made by young people at the hospital.

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:

- Hospital managers failed to maintain a consistent system of secure entry to the hospital site.
- There was continuing evidence of a lack of knowledge and timely action on concerns about abuse. There was no effective management system in place to monitor safeguarding concerns.
- The use of restraint was often a first rather than last response to a patient's distress. We found staff did not use de-escalation routinely. Staff did not accurately document restraints and failed to offer follow up care to the young people involved.
- Staff had not regularly checked emergency equipment on two of the three wards. A majority of staff on one night shift did not know where they would find the response bag or ligature cutters on the ward they were working on.
- Staffing levels for registered nurses did not meet the local minimum standard for a majority of night shifts on Wedgewood and Hartley wards and a quarter of day shifts.
- Staff did not regularly review and update risk assessments.
- Personal searches were ineffective in protecting young people from obtaining contraband items to use in self-harm.
- Medication was not securely stored in all areas.

Are services effective?

Inadequate

We rated effective as **Inadequate** because:

- The multi-disciplinary team was not supporting the psychological needs of young people.
- Staff did not receive regular clinical supervision or annual appraisals.
- Specialist training was not available to support clinical interventions such as naso-gastric tube feeding.
- Consent to treatment decisions did not consider age and for those young people under 16 years of age used the wrong legal framework to assess their ability to make a decision.
- There was little knowledge amongst staff and no training on the revised Mental Health Act Code of Practice issued in April 2015. Young people subject to restrictive physical interventions were not protected by the safeguards outlined in the code of practice.

Summary of this inspection

Are services caring?

Inadequate 

We rated caring as **Inadequate** because:

- Young people reported that staff were uncaring and inappropriately used restraint as a first response to their distress.
- Young people were not involved in care planning and care plans were not shared with them
- Community meetings and other opportunities for patient feedback were very limited on Hartley and Thorneycroft wards.
- Feedback from carers was negative who described staff behaviour as punitive.
- The hospital did not take account of the large distances that some families had to travel to visit their child. The process for family visits did not meet young people's needs and blanket restrictions on visitors coming onto the wards often prevented visits from being effective.

Are services responsive?

Inadequate 

We rated responsive as **Inadequate** because:

- There was no designated space on Hartley and Wedgewood wards for young people to have visitors. Overall, visiting space very limited.
- Blanket restrictions were in place regarding the use of telephones by the young people and there was no privacy offered when making calls.
- Access to snacks and drinks was only via staff members.
- Access to activities and outdoors were limited, particularly at weekends. Young people spoke of the boredom and frustration at the lack of anything to do.

Are services well-led?

Inadequate 

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

- Concerns raised by senior clinical staff had not led to action by the organisation's senior management team.
- Staff did not feel confident in raising concerns with local managers.
- Governance systems were not operating with sufficient authority or information to be effective.
- There were no clear lines of leadership for ward staff due to disruptive changes in management.
- Staff morale was very low.
- Transformation plans for the hospital had de-stabilised ward teams.

Summary of this inspection

- There had been a lack of a senior management team presence on the wards in order to lead change and manage day-to-day safety concerns.

Detailed findings from this inspection

Mental Health Act responsibilities

- Training on the Mental Health Act (MHA) at the hospital was limited to registered nurses, medical staff, the Mental Health Act Administrator and business manager. This group totalled 40 staff in 2015; only 12 of the 40 staff had received their annual update. There was no record of any MHA training at all in 2016.
- Staff, including the MHA administrator, told us they have not had specific training on the revised MHA Code of Practice that came into effect 01 April 2015. However, we did see a copy of the revised Code of Practice in a ward office.
- Training records evidenced that only 30% of qualified nursing and medical staff had received training since the introduction of the new Mental Health Act Code of Practice in April 2015. Support workers and allied health professionals working on the wards had not received any training or updates in the Mental Health Act.
- Staff failed to recognise the inappropriateness of using long-term segregation to manage a young person's non-aggressive behaviours. Our previous inspection report detailed the failure of staff to apply the required safeguards during a series of restrictive interventions. There was a failure by clinical staff to understand and apply the principles of the Mental Health Act and the Code of Practice.
- We reviewed the statutory treatment forms required after three months of compulsory treatment to evidence if a detained patient is consenting to (Form T2) or refusing to comply with treatment (Form T3). If they are refusing, a second opinion from another psychiatrist is required to check and approve the prescribed medicines. On Hartley ward, we found a number of errors in the recording and authorising of treatment. One of the young people had a T2 issued dated 2 May 2016, however, medication on the T2 had been crossed through and dated 10 May 2016. Medical staff had not completed a new T2 recording no evidence of continued consent regarding this change. A second patient had one regular medication (diazepam) crossed out on a T2 form issued 25 February 2016; the crossing out was dated 10 May 2016. However, medical staff still prescribed and nursing staff had administered diazepam even though there was no current evidence of consent. On Thorneycroft ward, all T2 and T3 forms were complete and in order. On Wedgewood, we found two statutory treatment forms (T2 and T3) together in one patient file. This provided contradictory information to any nurse dispensing medicines about their authority to require the young person to comply. The responsible clinician explained this was an oversight and removed the T3 during our visit.
- Staff explained rights to young people detained under the Mental Health Act (MHA) at infrequent intervals and failed to meet the monthly frequency required. For one detained patient, we were unable to locate evidence that staff had ever explained their rights to them during their admission.
- The MHA administrator normally worked at another Huntercombe hospital but had been seconded to Stafford for a period of three months before our inspection. Hospital managers had appointed a full time MHA administrator who had yet to commence working at the hospital. The MHA administrator did not hold formal qualifications for the role and had not received specific training on the revised MHA Code of Practice, which came into effect 01 April 2015. She was unaware of any planned training.
- Management had failed to revise key clinical policies related to restrictive interventions in line with the revised Mental Health Act code of practice issued in April 2015. Policies on visiting, locked doors and supportive observations were last reviewed in May 2013. Managers had last reviewed the rapid tranquillisation policy in January 2015. They had updated policies on seclusion and long-term segregation in line with the new code of practice in July 2015.
- Detention paperwork was available for inspection on all wards. However, in two files on Wedgewood ward, we were unable to locate the Approved Mental Health Professional (AMHP) reports. In one file, the original medical recommendations were not present and in another, the transfer forms were not present. Record of admission forms (known as H3) was unavailable in each of the records that we looked at.

Detailed findings from this inspection

- Hospital staff had completed audits to check the MHA was correctly applied. The MHA administrator informed us that a recent audit showed that staff were not explaining to young people their rights on a frequent basis. As a result, staff were to read young people their rights every four weeks on all of the units and future compliance monitored.
- Mental health advocacy was available a voluntary sector organisation, for all detained young people. The support of a locally commissioned advocacy service was also available to young people normally resident in Staffordshire.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was available as an online module. a; as of 19 May 2016, 48% of staff had completed the module. There was a specific e-learning module on the Deprivation of Liberty Safeguards (DoLS) which all clinical staff were required to complete annually. In 2015, 100 out of 185 staff (54%) had completed this training.
- The hospital managers had made no DOLS applications in the six months from December 2015 to May 2016.
- There was a policy on MCA including DoLS that staff could access.
- There were no arrangements in place to monitor adherence to the MCA within the hospital.
- On Wedgewood ward, we found that medical staff were assessing the ability of young people under 16 to consent to treatment using a test for mental capacity. This was an inappropriate use of the Mental Capacity Act, which does not apply to under 16 year olds in this circumstance. Staff on the ward, including medical staff, did not recognise the difference between establishing evidence of mental capacity and the concept of Gillick competency. This is a legal test to decide whether a child younger than 16 years is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Children must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.
- The issue of competence/capacity was particularly relevant to young people on Wedgewood and Thorneycroft wards where young people were most likely to be admitted on an informal basis. On Wedgewood ward, seven out of 16 young people were under the age of 16 years old as were two out of 12 young people on Thorneycroft. Medical staff on Wedgewood ward had asked parents to sign parental consent forms authorizing naso-gastric feeding of their children in advance at the point of admission. This was not appropriate and undermined the need to assess the potentially changing competency of the young person or the requirements of the Mental Health Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- The hospital comprised of three wards split between two buildings. At the time of our inspection, each building operated a separate system for monitoring access and issuing keys to clinical areas.
- Thorneycroft and Hartley wards shared a similar layout, being two floors in the same building. CCTV was used extensively in the social areas of the wards and staff could maintain clears lines of sight from the nursing station to the end of the two main corridors. There was no signage on these wards to highlight the use of CCTV recording to young people and visitors. Wedgewood ward was divided across two floors and was housed in an older building than the other two wards. Bedrooms were located on the first floor for all young people. Social amenities and the nursing office and clinic rooms were on the ground floor. There was no clear line of sight down through the stairwell where the exposed handrail was a potential ligature point. When a young person was using an upstairs room, a worker was always with them. Apart from the family therapy room, there was no CCTV installed on Wedgewood ward.
- Site security had been a concern raised during our previous unannounced inspection at the end of April 2016. We investigated a report that reception staff did not check the identity of visitors to the unit and gave out keys that could allow access the wards. An internal investigation found that staff covering the desk at the time were new starters and had not completed an induction to the hospital's security procedures. Hospital managers had put in place an action plan to inform staff about these issues and increase the number of staff on reception. This included extending the hours of dedicated reception staff that would remove the need for ward staff to attend to reception duties outside of normal office hours. Managers had recruited two full time receptionists to provide a service from 08:00 to 20:00 seven day a week. They were not in post at the time of our visits and admin and clinical staff covered reception on a temporary basis. We inspected the integrity of the ID checks during our visits to the hospital and found procedures to be in place to check the ID of visitors, issue a visitors badge and require signing in and out for each building visited. However, we did find that staff on reception did not carry out these checks. During our out of hours visit on 19 May 2016, staff did not challenge us to produce formal identification and the inspection team were all offered sets of keys to the clinical areas.
- None of the wards had undertaken a formal ligature risk assessment in the 12 months prior to our inspection. On Wedgewood ward there was a series of potential ligature risks identified by our inspectors in the communal and private areas of the ward. We identified door closers in social areas, exposed railings on the stairwell and open pipework in the toilets as possible risks. The hospital manager told us that there is always a staff member in attendance when any young people are upstairs to mitigate any risk of self harm. In the bedrooms, there was evidence of action to reduce ligature risks in the provision of ligature free furniture. On Thorneycroft and Hartley wards, which shared a

common layout, there were fewer concerns. It was possible, that in bedrooms, electrical conduits could be exposed to create a ligature point. Ligature cutters were available as an additional piece of equipment to the main emergency bag. These are hooked knives are designed to allow staff to safely cut any material tied to a patient without harming the person. There was a gap in staff knowledge, across all three wards about where these cutters were kept and how to use them effectively. This was most evident on our visit to interview staff on the night shift of 19 May 2016. Only one out of four staff (25%) we interviewed on Thorneycroft and 50% on Hartley ward knew the location of the ligature cutters. Permanent staff members on all wards told us that they had not received training in the use of the ligature cutters and would not feel comfortable using it. Staff on Wedgewood expressed a concern that there was no ligature cutter kept upstairs where staff moved to overnight. The impact of this would be in the additional time taken by staff having to go down a double flight of stairs to the main nursing office on the ground floor to retrieve potentially lifesaving equipment.

- The wards did not comply with guidance on same-sex accommodation within the Mental Health Act Code of Practice. The bedrooms on Wedgewood ward were located on the first floor; there were three single rooms and the rest were double rooms. The two male patient rooms were next to each other, however, along the same corridor there was a single female room. There were separate washing facilities for the young men and young women, however, the females would have to pass the male rooms to reach the toilets and showers. On Thorneycroft and Hartley wards, where male young people were in the minority, staff would place female young people in an adjoining room. Bathrooms and toilets were segregated and required staff to unlock them for use. However, both male and female young people would have to pass by opposite sex bedrooms to access them.

- Emergency resuscitation equipment was available on each ward; however, there was no common process in place to store and check the equipment. On Wedgewood, ward staff had not completed the weekly check of the emergency equipment since 23 April 2016. On Thorneycroft, the emergency medical equipment checklist evidenced that staff had checked the emergency bag, oxygen grab bag, fire response bag, emergency medicines all weekly since 20 December 2015. On Hartley ward, there was no evidence of checks in 11 out of the 20 full weeks since the beginning of January 2016. When we interviewed staff on the night shift of 19 May 2016, one out of four staff interviewed on Thorneycroft ward (25%), two out of four staff on Wedgewood ward (50%) and five out of ten staff on Hartley ward (50%) could tell us where the emergency grab bag was stored. The lack of checks and staff knowledge about the location of emergency equipment meant that the inspectors had no confidence that in an emergency, staff would respond in a timely manner with equipment intact and ready for use. We requested the hospital mangers to put in place an immediate plan to rectify this situation. The potential risk to the young people on the ward was a failed resuscitation attempt due to unnecessary delay or potential absence of or impaired equipment failure.

- Clinic rooms on each ward were well equipped with the equipment needed to perform a physical examination, observations of physiological function and to take blood and other samples for analysis. On Hartley ward, the clinic room was clean and tidy, although the floor was very sticky. The edition of the British National Formulary (BNF) held for reference was an out of date 2012-2013 version. Protocols and pathways on display in relation to NICE guidance, the MHA code of practice and local policy were also out of date. The clinic rooms on the other two wards were clean and well-organised but also displayed outdated clinical information. Across the hospital, the protocols on rapid tranquillisation were not in line with current best practice guidance from NICE referencing the 2005 guidance and not the relevant 2015 update.

- Seclusion is the supervised confinement of a patient in a room, which staff may lock the door. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others. Hartley ward had a seclusion room. Managers had withdrawn it from use following an internal assessment that it was not safe or compliant with standards set out in the Mental Health Code of Practice. We saw that staff used the low stimulus area outside the seclusion room and off the main corridor as a de-escalation suite. We were aware from our previous inspection in April 2016 that staff had used this area to seclude a young person without following the safeguards outlined in the MHA Code of Practice.

- Ward staff on Hartley ward had completed monthly infection control audits, only two out of five monthly infection control audits in 2016 had been completed on Thorneycroft. Wedgewood had not completed any monthly reports in 2016. Only annual reports had been completed for Wedgewood ward (only records submitted for October 2014 and October 2015). The rota for cleaning staff was limited and they had to work around clinical need on the ward. There were daily jobs allocated and a communication book to hand over anything outstanding or of concern to next day staff. We did find records in the ward kitchens that staff regularly recorded fridge and food temperatures and maintained a cleaning record. Some furnishings showed sign of wear on Hartley ward and not all ward areas were clean. Young people on Hartley ward complained of dining tables being left unwiped and being sticky at meal times. On Wedgewood ward, we found areas of the ward to be untidy and in need of redecorating. There had been some recent work to address this need. Thorneycroft ward had also been partly re-decorated before out inspection.
- Managers had not provided prompts to hand hygiene at the entrance to the wards or in the dining rooms. When managers reviewed audits submitted by ward staff at the clinical effectiveness meeting in January 2016, they identified a need for more training on hand washing and on handling spillages of bodily fluids. We did not however find any evidence that managers had addressed these needs.
- The hospital's support services manager assessed environmental risks through a series of regular audits. There were Huntercombe Group wide policies and training available to estates staff to keep them up to date with legislation and new control methods. Most recently, in April 2016, the team had been for training on the management of potential legionella bacterial infections, an area of growing concern in healthcare settings.
- Nurse call systems were available on all wards and in addition, staff could summon help from the other wards as required.
- During out inspection we identified issues with fire alarm systems on both Hartley and Wedgewood wards. The fire alarm system on Hartley was vulnerable to tampering by young people who could trigger the system from their bedrooms. We observed this happening during our inspection visit on the night of 19 May 2016. On that night, nursing staff had to call in a service engineer to reset the alarm. The nurse in charge told us that during this time the alarm system would not recognise a true fire warning. On Wedgewood ward on 16 May 2016, we had found that the magnetic door closer at the top of the stairs was not working and would not close automatically on the activation of a fire alarm. Both of these issues were highlighted to hospital managers for urgent action as part of our feedback during the inspection.

Safe staffing

- Each ward had an allocated ward manager, six team leaders (experienced qualified nurses) and four staff nurses and 29 support workers as their basic nursing establishment. There was one vacancy for a ward manager with a new starter expected to take up their post in June 2016.
- In the first four months of 2016, average staff sickness for qualified staff was 5.3% and for health care support workers 4.3%
- At the end of February 2016, there had been 11 qualified nurse vacancies out of 30 full time posts (four on Hartley, four on Thorney and three on Wedgewood). At the time of our inspection in mid May 2016, vacancies had increased to 14 (47%) staff nurse vacancies.
- From 01 Jan 2016 to April 30 2016, four qualified nurses and eleven HCSW left the hospital. Overall, staff turnover in those four months for ward based nurses and support based staff was 12%. One consultant psychiatrist and four therapy staff had also resigned in this period. We looked at personnel files to determine if there were common themes for resignation. In two out of the thirteen records we examined, working hours and conditions were identified as the reason for leaving. Another three staff had left following health problems and in the remaining eight staff had not recorded a reason.
- We found that many shifts were run with just one qualified nurse on duty. We analysed the rotas for all three wards from the 01 March 2016 until the 11 May 2015. We found that for Hartley ward (PICU) 24% of day shifts and 58% of night shifts had only one qualified nurse on duty. On Thorneycroft 46% of day shifts and

76% of night shifts and Wedgewood 26% of days and 80% of nights. On both Hartley and Wedgewood wards, minimum staffing levels for day shifts during this period should have been two staff nurses. Of those shifts when only one staff nurse was on duty on Hartley ward, one day shift and nine night shifts were covered by an agency nurse. We found that agency workers were unable to access records on care notes and make entries onto the system. This limited the amount of information available to them to make clinical decisions and understand risks. On one night shift during our inspection period, there was only staff nurse on duty to cover both Thorneycroft and Hartley ward. Although the nurse was able to access telephone support overnight from the ward manager, they would not have been able to maintain a clear leadership role on both wards in the event of a clinical emergency. Although this situation was extraordinary, the lack of experienced staff nurses, particularly on night shifts, available to attend to emergencies and manage episodes of disturbed behaviour and restraint was highlighted in the investigations conducted by the local authority into reports of a series of complaints about inappropriate use of restraint or other restrictive practice.

- The calculation that ward managers could use to adjust staffing levels had been introduced in April 2016 to take account of case mix (the overall care requirements on the ward) was limited in its design. The calculation used by managers was based on the number of young people on the ward and not in a constant ratio. Previously, staffing was based on a 1:4 (staff to patient ratio), after 1:1 clinical observations were accounted for. Staff felt that there had been more staff available to attend to fundamental ward needs as additional staff, to the basic ward establishment, had carried out 1:1 observations. Support workers felt that their shifts were wholly occupied with observation duties and time for keeping the ward clean and tidy, providing activities and spending time with the young people was very restricted. However, the new staffing model present did not allocate staff by observations, but in ratio to the number of beds occupied with some flexing allowed to cover for changes in patient need. There was no guidance on how a ward manager would assess the level of patient need to determine if minimum or maximum numbers of staff were required.
- The hospital director reported that she believed there had been a dependency on the use of observations in the past that was part of a custodial culture on the wards. Managers were trying to change that over time. Their aim was to support staff in developing the confidence to manage the clinical environment safely by engagement and use positive risk taking as opposed to placing young people on high-level observations and minimal engagement. However, the effect had been to limit staffing numbers on the wards whilst high levels of observations were still in use. This had meant that staff could be on continuous observation duties for the whole of their shifts with no time to engage with young people in activity. The cultural change presupposed in the new staffing model and its proposed beneficial effects on patient care had not been realised before managers implemented the change in staffing model.
- The very limited number of permanent qualified staff on Hartley ward (three) meant that there were no opportunities for one to one time on a regular basis. The two nurses that we spoke to felt that on the shifts they did work, they were always the nurse in charge or the sole nurse on duty and had to prioritise basic ward routines over personalised patient care.
- Staff supported section 17 leave to home or to community-based activities. Young people on the wards told us that unless they had staff allocated to them for 1:1 clinical observations; it was difficult to find staff free to help with planned leaves or to help with other needs.
- Medical staff were not able to attend the hospital in an emergency out of hours. General medical advice was available for non-emergencies from a medical on call service. For medical emergencies out of hours, staff called a 999 ambulance. We also heard concerns from staff about the on call manager system introduced in April 2016. This new arrangement offering only telephone advice from a senior nurse, was a replacement for a having Senior Nurse on Site (SNOS).
- Mandatory training for staff was split between on line, computer based training and training delivered face to face, sometimes with a practical component. On 19 May 2016, out of the 15 on line training modules, staff were compliant with seven at a rate over 75%. Child protection was at 45%, fire safety at 31%, information governance 50%, Mental Capacity Act 48%, safeguarding vulnerable adults 40%, food hygiene 15%, Boots

monitored dosing system 54% and domiciliary care 10%. Mandatory training delivered face to face included PRICE (Protecting Rights In a Caring Environment) which trained staff in the safe management of physical restraint. In 2015 88% of ward based clinical staff had completed a compulsory two day update. Training in life support skills was another mandatory training requirement. It was offered at two levels; basic life support (BLS) for all ward staff and the higher intermediate life support (ILS) for qualified nurses. The use of cardio pulmonary resuscitation (CPR) was the key skill practiced in these sessions. There was a Huntercombe Group policy requirement for all staff to receive annual Basic Life Support (BLS) training based on Resuscitation Council (UK) standards. Training records we examined showed that only nine out of 120 permanent nursing staff (Qualified and Support Worker) had received a BLS up-date in the 12 months prior to our inspection. Some permanent staff reported having never receiving this training. BLS training had not been part of the induction programme in 2016. Only five out of 16 qualified nurses had received their mandatory annual update in Intermediate Life Support in the previous year. With attainment of training at such low levels, the ability of staff to provide an effective response to any crisis that required the use of CPR before the attendance of emergency services was in doubt. The high use of restraint, rapid tranquillisation and incidents of self-harming all heightened the probability of such an emergency. We required the urgent assurance of management that young people remain safe in the care of all three wards and shared our concerns with NHS England.

- We also raised our concerns about staff training and effectiveness in conducting patient searches. Managers informed us that training in personal searches was part of the PRICE training compulsory for all clinical ward staff. They agreed to urgently discuss these incidents with the PRICE trainers and organise focused training updates on search procedures for ward staff.
- Managers explained that difficulties in accessing some of the online courses and a lack of time for staff to complete them had contributed to these low figures. The low levels of training in recognising and reporting potential abuse (safeguarding) contributed to the CQC issuing an enforcement notice. Managers were required to put in place an effective safeguarding system that included training all staff in safeguarding procedures.

Assessing and managing risk to young people and staff

- There were no records of episodes of seclusion between 01 September 2015 and 29 February 2016. Managers had reported that there was one incident of the use of long-term segregation on Wedgewood ward in that time.
- Hospital managers had informed the CQC that there were no incidents of prone restraint inside the hospital during that period.
- We examined 16 care records in total during inspection (six care records on Hartley ward six on Thorneycroft and four on Wedgewood). We found that staff had completed risk assessments around the time of admission but there was no evidence of regular ongoing reviews. A close examination of all risk assessments on Thorneycroft found that in nine out of twelve care records there had been no update to the risk assessment. On Wedgewood ward, there had been no updates made to risk assessments in any of the four case notes examined. All four cases related to young people at the hospital for at least a month; the longest length of stay was for a young person admitted in December 2015.
- We tracked the risk assessment and care plans for one patient on Hartley ward in detail. There was no risk plan based on their historical risk assessment and no reviews of general risk assessments since their admission. We found a record that staff had raised safeguarding on 15 February 2016 but had not notified the CQC as required. Staff had not reflected changing levels of clinical observations in response to self-harming behaviours in care plans or risk assessments. A weekly MDT risk review led to no actions or changes to existing care plans/risk assessments. We found inconsistencies about levels of observation on a further two occasions. For another patient, on Hartley ward, admitted in September 2015, staff had highlighted a history of drug/alcohol abuse in their initial clinical risk assessment. Staff did not create a care plan to mitigate this risk at the time. A care plan to say that staff should screen the patient periodically for illicit substances was not created until 04 May 2016 eight months after admission.

- There were a number of blanket restrictions across the wards including availability of mobile phones, access to the internet, access to bedrooms, access to toilets, access to the outside space, access to lockers and smoking. These applied to all young people irrespective of whether they were detained under the MHA or were informal. Staff only allowed the young people mobile phones that did not have internet access and cameras. They could only access their mobile phones after 5pm. One patient told us that staff exercised no flexibility with this; she explained that when she is upset and needs to speak to her mum, she has to wait until 5pm. The patient felt the rules were not individualised and unfair. Staff did not allow the young people to take the mobile phones to their rooms; they have to use them in the communal areas. Young people told us that staff allow them no privacy; they use the corridor and try to find quiet corners to make contact with their families. Access to bedrooms was allowed at 8:15pm, outside of this there were few quiet areas for young people to use. We saw young people asleep on sofas and sitting in the corridors on all wards. One patient told us he had exams and was finding it difficult to find a quiet place to revise, as he was not allowed in his bedroom. An informal patient told us should she need to access her room if she had forgotten something staff were not always willing to allow it. Access to the outside, bedrooms, lockers and toilets was locked and was only accessible by staff. Young people did not hold a key to their own rooms. Smoking for young people was prohibited on the grounds and off site even where young people are of the legal age to smoke. There was also a blanket restriction on any visiting onto the two acute wards at the hospital. If a young person wished to have a visit from a child, a brother or sister, a visiting room would need to be booked in advance.
- There were informal young people on Thorneycroft at the time of inspection who were not detained under the Mental Health Act. W; we could find no information at the door to inform them of their right to leave at will. In three case notes, we saw written instructions that in the event of an attempt to leave, the young person should be stopped and detained under the Mental Health Act. On Wedgewood, ward five young people were detained under the Mental Health Act (MHA) and ten were informal. The main ward door on Wedgewood was locked, there was no evidence of a sign on the door to advise informal young people they could leave if they so wished. The young people did not have a key to unlock the door. Staff on the ward were not clear how having parental consent would affect the rights of young person to leave the ward.
- We were concerned about staff understanding and implementation of the organisation's observation policy. On one occasion, we observed a failure of staff to maintain a patient's safety despite being on 2:1 observations by allowing the patient to self-harm repeatedly without intervention. Our inspector had to prompt the staff nurse in charge to intervene and ask another member of staff to support the patient. NHS England case managers had also highlighted the failure of staff to intervene to stop this behaviour the day before during a visit to the hospital. The risk assessment and care plan were clear in their instructions to staff that there should be zero tolerance of this behaviour because of the potential harm the young person would incur. An incident on the 18 May 2016 highlighted concerns about staff ability to conduct a personal search to prevent harm to a patient. The young person required emergency hospital treatment to treat their injuries. They were able to cut themselves with a blade fashioned from a contraband item that staff had failed to recover after an earlier search. Managers identified the incident for investigation and the report was not available at the time of this report. However, a previous service user had reported to the CQC how they and a peer had been able to bring banned items into the hospital that staff did not discover in searches. In one case, this was an item to aid the young person to self-harm.
- The use of restraint in between 01 September 2015 and 29 February 2016 had been reported as 252 incidents on Hartley ward involving 32 young people, 366 incidents on Thorneycroft ward involving 26 young people and on Wedgewood ward there were 70 restraints involving five young people.
- However we found the use of restraint at the hospital was not reported or monitored with any reliability so we could not be assured that it was only used after de-escalation techniques had been attempted. The hospital's own clinical effectiveness group had partly recognised this problem in January 2016. The minutes note that restraint incidents were wrongly categorised as abuse to enable the sub category of self-harm and that staff did record the use of any physical intervention

to manage the situation.We could find no evidence that managers had followed up this this concern. A lack of consistent record keeping of the use of restraint was also a finding of our previous inspection. It was a concern of the local authority safeguarding team who had been unable to find written evidence of the use of physical restraint they required as part of child safety investigations they had conducted at the hospital. On investigation into two incidents, we reviewed CCTV footage and found that staff had not documented multiple incidents of restraint on each occasion. In one case the inspection team watched three hours of CCTV and observed there were 6 restraints of which only 2 had been recorded.

- There was one incident of long-term segregation of a young person reported to the CQC; this involved a young person on Wedgewood ward as part of their treatment plan to reduce risk of weight loss through excessive exercise. The trigger for the decision to segregate the patient was the patient's compulsive exercising by way of pacing. The MHA Code of Practice is clear that either seclusion or on long-term segregation are interventions meant to protect others from a patient's behavioural disturbances. The young people' pacing and compulsive exercise would not meet the criterion for seclusion or long-term segregation. The clinical team needs to explain the use of segregation for other reasons and the restriction on movement justified in terms of urgent clinical need. The care plan stated the patient was to be cared for in his bedroom and could only access the shower and toilet facilities. All meals, schoolwork and other activities were to take place in his bedroom under constant staff supervision. He was re-integrated back to the unit as he gained weight. We also saw that documentation used the terms seclusion and long-term segregation interchangeably when in fact they are distinct. For example "nursed in seclusion due to high risk behaviours" and "patient is no longer nursed in segregation". In the care notes, we also found reference to "partial seclusion review". This reflects is a lack of understanding in terms of what constitutes long-term segregation and seclusion. Staff informed us they have not received any training in respect of long-term segregation and seclusion. The forms used to record long-term segregation did not demonstrate that staff had completed all the regular reviews and other safeguards required by the Mental Health Act Code of practice. This included the lack of any notification to the local authority to inform them of the use of segregation.

- We found several issues of significant concern about the prescription and use of rapid tranquillisation on Hartley ward. Rapid tranquillisation is the treatment of young people with sedating medicines to manage episodes of agitation when other calming or distraction techniques had failed to work. Common themes included the lack of clear instruction about timings and specific dosing for a young person taking into account weight and dosing reflecting the relative take up of the medication by different routes of administration. For example, a greater percentage of a drug may be absorbed if given by an intra muscular injection than if in tablet form and taken orally. Seven young people had additional, when required ('prn'), plans in the medication files, with instructions regarding order of prn usage, all dated 06/05/2016 when there was clear evidence of an initial prescription before that date. Four of the plans stated not to use Haloperidol as patient has not had an ECG. All of the nine prescriptions had instructions for the use of Lorazepam given by mouth or through intramuscular injection at the same dosages. There was no weight recorded on chart, to demonstrate that dose was appropriate, as dosing should be weight dependant. On all ten prescriptions of promethazine for oral and intramuscular administration, all had the same standard dose, and maximum dose, however, there was no minimum time interval between doses on the prescription. For three young people, medical staff had prescribed an intramuscular injection of Olanzapine as rapid tranquilisation as well as intramuscular Lorazepam. There was nothing written on the charts to indicate that this should not be given within 2 hours of an intramuscular dose of Lorazepam. Staff had given one patient this combination within two hours on both the 20 and 21 April 2016. Serious side effects can occur when these two medicines are given together, their manufacturers recommend leaving two hours if intramuscular (IM) olanzapine given after intramuscular Lorazepam IM and one hour if administered in the reverse order. They should not be given together simultaneously. The rapid tranquilisation policy used at the hospital was dated February 2014 and had been due for review in January 2015; it did not incorporate the

latest NICE guidelines published May 2015. The laminated flowchart for rapid tranquillisation found in the Hartley clinic room followed the outdated 2005 NICE guidance. Together the prescription errors noted and the lack of NICE compliant guidance raised concerns about the potential harm from rapid tranquillisation as prescribed. Our lead inspector and pharmacy specialist took these concerns directly to the senior consultant psychiatrist who acted immediately to bring the prescriptions into line with national recommendations.

- Less than half of the clinical staff were up to date with their safeguarding training at our inspection in April 2016 and there was no improvement during the visit described in this report. The impact of staff not receiving up dates or initial training in safeguarding is that they are less likely to recognise and report abuse. The CQC consequently instructed the hospital managers to ensure that all clinical staff was up to date in line with local recommendations. There had also been a failure by hospital managers to meet their obligations under the Children Act to inform the local authority if a young person had been on the unit for a consecutive period of three months. Reporting procedures did not meet the standards outlined in the Local Safeguarding Children Board and the local authority had called a strategy meeting to discuss these failures with the provider.
- During our inspection, we identified several concerns relating to the management and storage of medicines on the wards. On Hartley and Wedgewood wards, we found that staff were accessing the clinic room using an override key rather than a specific key held by only the qualified nurse. The override key was of a very simple design and easily duplicated. This meant that access to the clinic rooms was not secure. As we found prescription only medicines lying out on the counter on Wedgewood ward prior to dispensing, there was a significant risk that a patient or non-authorised member of staff could access these medicines. We immediately reported this incident to the hospital director and within an hour the facilities department had found specific keys to use on the clinic room doors. An explanation was given that staff had found the use of the override key more convenient as it allowed general access to the clinic room to carry out physical observations and dressings that did not require qualified staff.
- A pharmacy inspector looked at medicines management on Hartley ward; spoke to staff involved in the administration of medicines, and examined ten peoples' prescription charts. Medicines were stored safely and securely, in locked cupboards in the locked treatment rooms. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely. Medicines requiring cold storage were kept within a locked monitored refrigerator in the treatment room. On Thorneycroft ward, the fridge temperature had been out of range 22 times in the three months prior to our inspection with no action was recorded in response to this. In addition, although there was a system in place for the checking of expiry dates; two out of date medicines were found to be available for administration in the refrigerator. At Wedgewood ward clinic room, the record of room and fridge temperatures were missing. Medicines had been prepared for dispensing and left on the counter tops. Other medicines were secured in locked cupboards. There were clear and effective systems and processes of ordering and receiving medicines. Administration of the medication was recorded clearly on prescription charts. There were no omissions in the administration records in use. The provider maintained accurate and up to date records for the receipt and disposal of medicines. People's allergies were always, clearly recorded. However, in one case on Wedgewood ward, we found that an antibiotic had been prescribed but had not been available for 14 days following the date of prescription.

Track record on safety

- The hospital managers had reported to the CQC that there had been no serious incidents reported in the 12 months prior to inspection. We were however aware of a Serious Incident Report generated by a referring NHS organisation regarding the delayed transfer of care of a young person. Managers at Huntercombe Stafford had not produced any reports or learning from this incident to reflect their discussions and conclusions with the investigating officer from the referring NHS Trust and NHS England as the commissioner.
- During our inspection on, a young person seriously self-harmed by cutting herself with a blade fashioned

from a contraband item. They required emergency hospital treatment. Managers recorded this as a Serious Incident and an investigation was requested into the root causes that led to the incident.

Reporting incidents and learning from when things go wrong

- Staff completed an electronic report form on the electronic incident reporting system following any incident. It allows staff to record the details of incidents, categorise the nature of incident, and rate its impact to allow managers to monitor and analyse risk events. The electronic incident reporting system automatically forwarded these reports to the consultant psychiatrist for that ward to review and action.
- Following our previous responsive inspection, we looked for evidence that ward incident reports forwarded to medical staff were reviewed and that the current system produced any actions or learning from incidents. We found that the hospital manager had implemented this system in mid-December 2015. In the twenty weeks since its implementation, we found evidence of reviews on Wedgewood ward on only three occasions, sixteen occasions on Thorneycroft ward and on Hartley there was evidence of only three weekly reviews since February 2016 out of a possible thirteen. Senior managers and clinical nurse leaders on the wards did not receive immediate alerts through an electronic incident reporting system. This meant there was a delay before they could receive and process. The same was true for the social work staff who led on safeguarding within the hospital. The social workers were unable to conduct any immediate investigation through lack of access to the CCTV recordings from the wards. These were only available in the office of the Hospital Director. This means managers and responsible clinicians were unable to identify incidents immediately. Managers did not learn of incidents by any effective reporting system but through complaints raised by the young people or chance discovery in the examples we reviewed. The impact of failing to operate an effective system is to put young people at risk of abuse that will not be reported, investigated and managed immediately to reduce any ongoing impact of the their health and well-being.
- Apart from the meetings, discussed above, led by the Consultant Psychiatrist, we could not find evidence that any lessons learnt were reliable and regularly fed back to staff. On Wedgewood, there was no evidence of any reflective practice or active learning from events. Staff on Thorneycroft told us that managers' had planned a reflective practice for the week before our inspection but cancelled it due to staff shortages.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We examined 22 care records across the three wards during our inspection.
- The referring clinical team completed an initial mental health assessment as part of the admissions process and reviewed by NHS England. Hospital staff completed their first local multi-disciplinary team assessment within the first 72 hours of admission and shared this with the commissioners at NHS England.
- On Hartley ward, we found that after admission there was only one completed physical health care plan in place out of the six care records we examined. Three files had physical health assessment forms that were empty. Only two out of twelve records on Thorneycroft ward had any physical health assessment recorded post admission. On Wedgewood, all four of the records had a physical health assessment recorded; however, all had been created on the 06 May 2016 irrespective of admission date.
- Care records were incomplete and care plans out of date. There was clear evidence that risk assessments and care plans had been reviewed as a group across all wards on the first weekend in May 2016. Our inspectors on Thorneycroft ward initially identified a number of errors within the care plans they examined. They found evidence that substantial elements of care plans were common to multiple young people, that gender and sometimes names had not been changed suggesting that the detail had been cut and pasted between young people. There was no evidence that young people had been involved in the creation of these care plans. We heard concerns from ward staff about the use of their

names as signatories on care plans they had not produced. On our challenge about these anomalies, the hospital managers explained that when they had recognised that care notes were incomplete they had employed external nursing staff to update them prior to the CQC inspection. Following complaints from a trade union representative, a senior manager from another Huntercombe hospital was investigating the scope of the changes and probity of this decision.

- The majority of clinical information was stored electronically as part of the carenotes electronic patient record. Staff secured this information by using a password login to the carenotes programme. However, following an internal audit of care notes, doubts were raised if this system was open to abuse with logins being shared. There were in addition paper case files for all young people containing key information such as admission profiles and risk assessments for the use of agency staff working on the wards. Temporary staff were not allowed access to the care notes system.

Best practice in treatment and care

- NICE guidance was not followed in prescribing medication. Some local policies were out of date against both the latest NICE guidance and the Mental Health Act Code of Practice. A consistent prescribing concern was a lack of recording of weight on medication cards where particularly in the case of eating disorders very low weights would have an impact on dosage and the effectiveness of medicines.
- Access to psychological therapies was limited due to ongoing staff vacancies in psychology and therapy posts. Only Wedgewood ward had any regular psychological input. The lack of psychological support was a concern for nursing staff on the ward and parents who felt it was a vital component in their child's recovery.
- Physical healthcare was another area of concern raised by parents. We found that regular physical observations were being taken weekly and recorded; however, staff did not use these records to inform physical health care plans which, as evidenced above, were in the vast majority of times absent for young people being treated at the hospital. On Wedgewood (an eating disorders unit), we found inconsistent access to physical health care by specialists or trained staff. We found that young people were receiving nutritional support by a naso-gastric tube. Huntercombe Group policy requires the procedure to be carried out by qualified nursing or medical staff who have been trained in passing nasogastric tubes and in administering nasogastric feed. We could find no evidence of any training or ongoing competency assessment for this procedure. From one member of medical staff we heard of other specific concerns about physical health care. Problems of the collection and delays in the analysis of blood and other samples taken from young people were highlighted as a cause for treatment delays. The system in use took a few days to a week to get bloods results. The analysing laboratory send results back to the hospital by post, as there is no electronic portal to access the results. We saw evidence that the blood results that had come back on 17 May 2016 had been sent on 20 April 2016. There were delays noted in obtaining a specialist opinion about a physical health problem. The hospital does not routinely register young people with a local GP.
- The lack of specialist knowledge and training was a concern for parents we spoke with. One parent related to us their concerns that staff on Thorneycroft and Hartley wards were not able to manage her child's nutritional needs when transferred from the eating disorders unit.
- On Wedgewood ward, a dietician led on the assessment of young person's' nutrition and hydration and provided support to the nursing staff. The ward team used the Royal College of Psychiatrists' MARSIPAN (Management of Really Sick Young people with Anorexia Nervosa) inpatient guidelines to plan and evaluate care.
- Two recognised rating scales were in use and required by NHS England commissioners to monitor clinical progress and recovery. These were the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the Children's Global Assessment Scale (CGAS).
- There was some evidence that clinical staff carried out clinical audits. We saw that monthly infection control audits had been completed for Hartley ward, only partial compliance on Thorneycroft ward (two monthly infection control audits in 2016) and only annual reports completed for Wedgewood ward (only records submitted for October 2014 and October 2015).

Inadequate

Child and adolescent mental health wards

Skilled staff to deliver care

- During our inspection, we found a multi-disciplinary staff group working at the hospital. In addition to nursing and medical staff, Wedgewood ward also had a dietician in daily attendance. All wards received support from a small social work team of two based at the hospital. In addition, a clinical pharmacist visited each ward weekly. There were vacancies for psychologists to cover Thorneycroft and Hartley ward. A psychologist was in place on Wedgewood ward. Two occupational therapists supported by two occupational therapy technical instructors and two art therapists provided further therapy input onto the wards.
- There was also a sports and activity manager and activity workers attached to each ward; this was a new initiative started in April 2016.
- Qualified nursing staff were made up of a number of different registrations. On Thorneycroft and Hartley registered mental health and learning disability nurses were employed. There were general and children's nurses on Wedgewood ward. This could mean that there were occasion with just one registered nurse working there was no registered mental health nurse (RMN) on the ward. Recently qualified staff nurses were being left in charge of shifts unsupervised.
- We heard from three non-nursing professionals who had joined the service since January 2016 that they had not received a handover or formal professional induction to work at the hospital. In addition, they did not know the identity of their line manager or who would be their supervisor.
- Inductions for new starter agency and bank nurses were not routine on the wards. On the night we visited, 20% of the staff had not previously worked on that particular ward and had not been orientated to its layout or to the client group.
- On Wedgewood, there was no evidence of any reflective practice or active learning from events. Staff on Thorneycroft told us that managers' had planned a reflective practice for the week before our inspection but cancelled it due to staff shortages.
- In its guidance, the CQC highlights that registered providers must have suitable arrangements in place to support employees to enable them to deliver care and treatment to people who use services safely and to an appropriate standard. Clinical supervision and regular appraisals are two ways to achieve this, but the evidence was that across the service, supervision was not as regular as the Huntercombe Group policy required. The target was for all staff to receive supervision every four to six weeks. Due to significant disruption in the clinical nursing leadership of staff teams on the wards, it was difficult to track the regularity of supervision offered to registered nurses and healthcare support workers on the wards. We looked at the records available for the three months prior to our inspection:
- On Wedgewood ward in February 2016, only one HCSW received supervision, in March one registered nurse and nine support workers and there were no record of any supervision sessions in April.
- On Thorneycroft ward, five out of six registered nurses and 13 out of 19 support workers received supervision in February 2016. There was no evidence of any supervision taking place on Thorneycroft in March and April.
- On Hartley ward, two out of seven qualified nurses and 15 out of 30 support workers received supervision in February 2016. In March, five out of seven qualified staff and 14 out of 27 support workers completed supervision. As with the other two wards, there were no supervision records available for April.
- Appraisals in the year to 29 February 2016 were at a low level with only 41 out of 123 (33%) nursing and support worker staff having had an appraisal.
- We found that specialist training in the management of eating disorders, nutrition and personality disorder and personalised care planning was not completed by the majority of staff as planned for in the training plan for 2015. There had been no additional specialist training recorded during 2016 to the date of our inspection.
- Managers reported delays in being able to address performance issues around staff due to a lack of time to investigate concerns and the absence ward managers to manage capability and disciplinary processes.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team (MDT) meetings to review a young person's progress were held weekly on each ward. However, a young person could expect to be seen every two weeks on Wedgewood ward.

- The structure and frequency of MDT meetings was common to all three wards. We observed an MDT discussion on Wedgewood ward and found it to be well organised and inclusive of a range of professional opinions. The young people provided some written feedback about progress in the previous two weeks before attending and the professionals provided a report in advance. These reports are then loaded onto carenotes (the electronic patient record) for reference during the discussion. Staff recorded the conclusions and action points on carenotes for future review. The young person's parents were able to join this discussion from home via a conference call arrangement and feedback on recent home leave. The young person was allowed time to express their views to the meeting if they wanted to. In their focus group, the young people on Wedgewood expressed a concern that staff at these meetings focused on issues of medication and weight gain and did not address their other needs for activity and psychological therapy.
- Twice a day at the end/beginning of a shift, the incoming nursing staff received a handover from the previous shift. There was no common system for staff from other professions to receive an update on young people and care on a ward when they first attended for duty.
- Within the Huntercombe group, there was an effective system for discussing referrals and patient movement between their six hospitals specialising in child and adolescent mental health services. A central referrals team, based at Stafford, managed the beds and admissions across the six hospitals in close liaison with NHS England.
- Managers at the hospital did not register the young people with a local GP practice during their stay. This presented difficulties for the hospital doctors to make specialist referrals to local hospital services and accessing local specialist community services.
- In the weeks prior to inspection, we received a series of written concerns about the lack of transparency and patient safety at the unit from the head of Safeguarding for Staffordshire County Council. They reported a lack of communication from the hospital about the welfare and placement of young people required by the Children's Act. Visiting social workers following up on safeguarding concerns had found difficulty in assessing evidence in the form of CCTV and patient notes held on carenotes. Their concerns were great enough to call a strategy meeting led by the local authority area manager on the 09 May 2016 to which the CQC, local police and NHS England were invited. That meeting concluded that there was significant concern that the local authority safeguarding team and Local Authority Designated Officer would call regular further meetings to monitor progress in improving the quality, quantity and frequency of reporting potential safeguarding incidents. Hospital managers also agreed to arrange for easier access to evidence for visiting social workers following up concerns as child protection enquiries under Section 47 Children's Act.
- NHS England, the commissioning body, for CAMHS inpatient care also reported that hospital staff had not routinely informed them of the use of restrictive practices, restraint and rapid tranquilisation, as required by their oversight agreement with the hospital.

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

- Training on the Mental Health Act (MHA) at the hospital was limited to registered nurses, medical staff, the Mental Health Act Administrator and business manager. This group totalled 40 staff in 2015; only 12 of the 40 staff had received their annual update. There was no record of any MHA training at all in 2016.
- Staff, including the MHA administrator, told us they have not had specific training on the revised MHA Code of Practice that came into effect 01 April 2015. However, we did see a copy of the revised Code of Practice in a ward office.
- Training records evidenced that only 30% of qualified nursing and medical staff had received training since the introduction of the new Mental Health Act Code of Practice in April 2015. Support workers and allied health professionals working on the wards had not received any training or updates in the Mental Health Act.
- Staff failed to recognise the inappropriateness of using long-term segregation to manage a young person's non-aggressive behaviours. Our previous inspection report detailed the failure of staff to apply the required

safeguards during a series of restrictive interventions. There was a failure by clinical staff to understand and apply the principles of the Mental Health Act and the Code of Practice.

- We reviewed the statutory treatment forms required after three months of compulsory treatment to evidence if a detained patient is consenting to (Form T2) or refusing to comply with treatment (Form T3). If they are refusing, a second opinion from another psychiatrist is required to check and approve the prescribed medicines.
- On Hartley ward, we found a number of errors in the recording and authorising of treatment. One of the young people had a T2 issued dated 2 May 2016, however, medication on the T2 had been crossed through and dated 10 May 2016. Medical staff had not completed a new T2 recording no evidence of continued consent regarding this change. A second patient had one regular medication (diazepam) crossed out on a T2 form issued 25 February 2016; the crossing out was dated 10 May 2016. However, medical staff still prescribed and nursing staff had administered diazepam even though there was no current evidence of consent. On Thorneycroft ward, all T2 and T3 forms were complete and in order. On Wedgewood, we found two statutory treatment forms (T2 and T3) together in one patient file. This provided contradictory information to any nurse dispensing medicines about their authority to require the young person to comply. The responsible clinician explained this was an oversight and removed the T3 during our visit.
- Staff explained rights to young people detained under the Mental Health Act (MHA) at infrequent intervals and failed to meet the monthly frequency required. For one detained patient, we were unable to locate evidence that staff had ever explained their rights to them during their admission.
- The MHA administrator normally worked at another Huntercombe hospital but had been seconded to Stafford for a period of three months before our inspection. Hospital managers had appointed a full time MHA administrator who had yet to commence working at the hospital. The MHA administrator did not hold formal qualifications for the role and had not received specific training on the revised MHA Code of Practice, which came into effect 01 April 2015. She was unaware of any planned training.
- Management had failed to revise key clinical policies related to restrictive interventions in line with the revised Mental Health Act code of practice issued in April 2015. Policies on visiting, locked doors and supportive observations were last reviewed in May 2013. Managers had last reviewed the rapid tranquillisation policy in January 2015. They had updated policies on seclusion and long-term segregation in line with the new code of practice in July 2015.
- Detention paperwork was available for inspection on all wards. However, in two files on Wedgewood ward, we were unable to locate the Approved Mental Health Professional (AMHP) reports. In one file, the original medical recommendations were not present and in another, the transfer forms were not present. Record of admission forms (known as H3) was unavailable in each of the records that we looked at.
- Hospital staff had completed audits to check the MHA was correctly applied. The MHA administrator informed us that a recent audit showed that staff were not explaining to young people their rights on a frequent basis. As a result, staff were to read young people their rights every four weeks on all of the units and future compliance monitored.
- Mental health advocacy was available a voluntary sector organisation, for all detained young people. The support of a locally commissioned advocacy service was also available to young people normally resident in Staffordshire.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act training was available as an online module; as of 19 May 2016, 48% of staff had completed the module. There was a specific e-learning module on the Deprivation of Liberty Safeguards (DoLS) which all clinical staff were required to complete annually. In 2015, 100 out of 185 staff (54%) had completed this training.
- The hospital managers had made no DOLS applications in the six months from December 2015 to May 2016.

Inadequate

Child and adolescent mental health wards

- There was a policy on MCA including DoLS that staff could access.
- There were no arrangements in place to monitor adherence to the MCA within the hospital.
- On Wedgewood ward, we found that medical staff were assessing the ability of young people under 16 to consent to treatment using a test for mental capacity. This was an inappropriate use of the Mental Capacity Act, which does not apply to under 16 year olds in this circumstance. Staff on the ward, including medical staff, did not recognise the difference between establishing evidence of mental capacity and the concept of Gillick competency. This is a legal test to decide whether a child younger than 16 years is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Children must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.
- The issue of competence/capacity was particularly relevant to young people on Wedgewood and Thorneycroft wards where young people were most likely to be admitted on an informal basis. On Wedgewood ward, seven out of 16 young people were under the age of 16 years old as were two out of 12 young people on Thorneycroft. Medical staff on Wedgewood ward had asked parents to sign parental consent forms authorizing naso-gastric feeding of their children in advance at the point of admission. This was not appropriate and undermined the need to assess the potentially changing competency of the young person or the requirements of the Mental Health Act.

Are child and adolescent mental health wards caring?

Inadequate

Kindness, dignity, respect and support

- In our visits to the hospital, we saw staff failing to be respondsive to the needs of the young people because they were already committed to other tasks. On Hartley ward, we observed that young people had to wait for periods of up to 15 minutes for a staff member to become available to open a toilet for their use.
- All five of the young people that we talked to on Hartley ward complained about how some staff treated them. Young people told us staff frequently used restraint and did not always speak to them in attempt to de-escalate the situation. They stated this was very much dependant on which staff were involved at the time. Young people described experiencing staff observing different rules for different young people that seemed arbitrary. One patient who experienced regular restraint told us that staff who knew them really well went straight for restraint, at times causing bruising. This patient went onto tell us that restraint could really hurt them and that this dependeding on which staff were involved.
- A patient spoke to us about staff having given them an intramuscular injection of a sedating medicine under restraint with four or five staff present. They thought that had been an excessive number of staff and not justified by any threat they may have displayed. The patient described no one checking for bruising or injury after restraint and not receiving a debrief after the event.

The involvement of people in the care they receive

- On admission, young people were given an induction to the wards and some information on ward routines and the clinical team.
- Care plans showed little direct involvement of young people in their development and review. There was an opportunity for young people to discuss their views about progress and treatment with a nurse before review meetings.
- Wedgewood multi-disciplinary meetings were held weekly, however young people were seen on a fortnightly basis. Young people expressed they would like to see their doctor on a weekly basis. One patient told us where young people do not want to attend the meeting the doctor will meet them outside of this meeting. Where a patient lacked the capacity to instruct an advocate, the staff would discuss the patient at a multi-disciplinary meeting and a referral would be made if it were deemed beneficial.

Inadequate

Child and adolescent mental health wards

- There was information related to advocacy services on all of the wards. From a series of strategy meetings held by the local safeguarding team, it was clear that advocacy was not regularly accessed to provide support to young people following incidents of actual and potential abuse. From the 23 May 2016, the unit was to have a single independent advocacy service providing Independent Mental Health Advocacy (IMHA) and generic advocacy support to the young people. We saw posters in the patient areas promoting the new service. One patient told us she had received a letter from the hospital confirming the change in the provision of the advocacy services. Staff made referrals to the advocacy or young people could self-refer. Young people we spoke to during inspection were aware of the advocacy service.
- We discussed the involvement of carers with eight parents in a series of telephone interviews. We also heard from another parent whose child was discharged in April 2016. She had wanted to highlight problems of a lack of knowledge of staff on the two acute wards about how to manage her child's eating disorder. She felt that staff demonstrated a lack of compassion toward her child's problems and made negative comments about her self-harm. Three of the eight parents we spoke to by phone also identified concerns about staff behaviours being punitive. They reported that staff would threaten a loss of leave or other privilege in response to distress. All but one of the eight carers told us of difficulties with communication with ward teams or individual medical staff with calls not being returned and no regular updates offered. Many of the young people at the hospital were from out of area. The meant that many parents were not able to visit due to having limited time to travel. They were concerned about the limits staff imposed on the use of mobile telephones and the internet to communicate with their children was too restrictive.
- Each ward held community meetings for young people to discuss and raise issues and views. We observed a community meeting on Hartley ward 16 May 2016 that was attended by four young people and 11 staff. The occupational therapist on the ward led the meeting. The young people in attendance were free to come and go and this was the first meeting held in this format. The agenda followed the key headings safe, effective, caring, responsive and well-led. Young people engaged well in discussion and all ideas were listened to lots. Suggestions and agreed actions were recorded for review at future meetings. Ward staff had also introduced a similar format for community meetings onto Thorneycroft ward in April. On Wedgewood ward, daily community meetings for young people and a weekly meeting with professionals on the ward is an established practice. A young person chaired the meetings and written feedback given to queries raised.
- Managers told us that young people had previously been included in interview panels for senior staff or a focus group to ask questions of candidates. However, this was not the current practice. The recruitment of staff nurses and support workers was managed centrally and did not involve any young people in the process.
- There was no use of advance decisions from the young people to inform care at the time of inspection.

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

Inadequate

Access and discharge

- Average bed occupancy over the 6 months (01 Sept 2015 to 29 Feb 2016) was 92.3 % for Hartley, 876.5% for Wedgewood and 85% for Thorneycroft ward.
- All the beds at the hospital were managed as part of the national CAMHS network overseen by commissioners at NHS England in the West Midlands. This meant that young people were admitted to the hospital from across England.
- The overall decision to admit was made by the consultant psychiatrist following a full discussion within the MDT and after the needs of the other young people was considered. Young people were admitted to the hospital during the day but if an urgent admission was needed, this could be facilitated out of hours. The hospital was also able to accept unplanned admissions and there was policy to support senior nurses managing this process. As part of the contract with NHS England, all unplanned admissions underwent a multi-agency review within five working days.

- There was some limited movement of young people between Hartley ward and Thorneycroft reflecting changes in the presentation of the young people involved. As a patient improved from their initial admission to the intensive care unit, they could be stepped down to Thorneycroft, the general acute ward. If a young person on Thorneycroft was becoming more disturbed and if their risks increased, a move would be organised to Hartley ward or to another psychiatric intensive care unit (PICU) elsewhere if beds were not available.
- Discharges were organised in advance with the support of social work staff and the multi-disciplinary team in liaison with commissioners and home health and social services. Discharge occurred at an appropriate time and was planned during the care programme approach (CPA) process.
- In the six months between the 1 September 2015 and 29 February 2016, there were eight delayed discharges from the hospital.
- We were told of five delayed transfers of care from Hartley ward and three from Thorneycroft. The most frequent reason was delays resulting from young people awaiting transfer into adult services as they turned 18 years old and the availability of step down beds for young people leaving the PICU.

The facilities promote recovery, comfort, dignity and confidentiality

- Continuing access to education was available through an onsite teaching facility. Teaching staff offered the young people and children on Wedgewood and Thorneycroft wards four hours of education each day from Monday to Friday. Young people on Hartley ward could also access education but compliance was low due to their acutely distressed mental state. During our inspection period, some regular classes had been suspended to allow for revision and participation in examinations. There was a full range of rooms and equipment to support treatment and care (clinic room to examine young people, activity, education and therapy rooms).
- On Wedgewood and Hartley wards, we identified that there were numerous concerns about the privacy and dignity of the young people on these wards. In the double bed rooms, we found there was no partition between the young people to maintain their privacy and dignity. We also found it was possible to see into patient bedrooms when in the garden area. There was no reflective film on the windows or vanity board in place to protect privacy. Access to the administrative offices housed in the same building as Wedgewood ward was only available through the ward itself. This meant visitors and staff wishing access this suite of offices had to walk through the ward social areas or directly by patient bedrooms.
- There were no suitable arrangements for visitors to meet young people on Thorneycroft or Hartley ward. On these two wards, there were blanket bans on visits by parents onto the wards. This was contrary to the guidance given in the Mental Health Act Code of Practice. The rationale of management was that it was necessary to protect the privacy and dignity of other young people on the wards. Relatives found this lack of access concerning. They wished to view their child's living arrangements for assurance about their safety. Staff allocated visitors to Hartley or Thorneycroft wards space in one of two meeting rooms. These rooms had to be booked in advance and parents reported they were not always available at convenient times to regular visitors due to competition with other visitors. One parent told us that often the only options were to sit a public area or in their car during visiting. The hospital had provided a list of local places of interest and activities to facilitate visits. Both young people and their parents told us that there was often too little time, or restrictions, such as a staff escort, that made these options impracticable.
- On Hartley ward, staff did not allow young people to have mobile phones. Young people complained that they had to make calls in public areas of the ward using a portable phone supplied by ward staff. A further complaint was that the battery on this phone regularly ran out during the course of an evening or mid conversation. On the other two wards, mobile phones with limited functionality were allowed with strict limits on their use. The hospital did not have skype or equivalent facilities available for young people to maintain contact with family and friends.
- From Hartley ward, there was direct access to outside space. A securely fenced garden area was available with some room for ball games and recreation. Based on the

first floor Thorneycroft ward had no direct access to outside and had no dedicated outside space. The garden used by Hartley ward was accessible but only by prior agreement to ensure that the space was not in use by Hartley young people. For Wedgewood ward, the outside area was in front of the hospital and as such, there was no privacy for the young people. There was no access to the outside space available directly from the ward and any young person wishing to go outside would need staff to open two locked doors for them. This was excessively restrictive for a ward where the majority of young people were informal. We also saw that staff had left the storage shed, housing garden tools open and accessible to young people. We raised this with the ward manager during our visit for immediate attention.

- Young people that we spoke to told us that the food was ok and that they had a limited choice of meals on a four weekly menu cycle. Young people told us they only had puddings at weekends. They also told us that staff only recently allowed them access to a snack box every other day and this had now increased to daily access. This had been changed as a result of complaints to the hospital manager and access to treats had previously been restricted to weekends
- Young people on Hartley ward we spoke to told us they had limited access to drinks and snacks on as staff kept the kitchen locked. They were not allowed access unless a member of staff directly supervised them.
- Young people were able to personalise their bedrooms. Some young people had been able to decorate walls with posters and other decoration.
- Possessions that staff considered a ligature risk or contraband items were stored securely on Hartley and Thorneycroft wards. Following an episode of self-harm, staff could decide to strip a young person's bedroom clear of all personal items to reduce any ongoing risk of further harm. If that happened, personal belongings would only be returned as staff assessed risk as having reduced and in discussion with the young person. Some young people told us they felt this was a punitive action on behalf of staff and applied inconsistently.
- Activities on the wards were limited. The young people on Hartley ward complained of having to make their own entertainment and staff having a low tolerance for playing music or sharing.

Meeting the needs of all people who use the service

- There was level access to Hartley ward and through it to the garden areas. At the time of our inspection, an elevator that allows wheelchair access to Thorneycroft ward on the first floor was not in use.
- We saw information displayed within the patient areas regarding complaints, safeguarding and the Care Quality Commission (CQC). A list of solicitors specialising in mental health was also available to the young people.
- Ward staff could arrange for interpreters and/or signers to attend the hospital to support a young person's communications needs as required.
- There was a choice of food available to young people on all three wards. Catering staff could accommodate personal choice, religious requirements or ethnic preferences for food. However, on Wedgewood ward, staff could limit the range of personal choice around diets where clinical need required specific nutritional supplements. The newly appointed dietician was working with kitchen and clinical staff to improve the range of choices available and presentation of food, including controlling portion sizes, to make meals more attractive to young people.
- There was space for young people to worship within the hospital in both buildings with religious texts available to support prayer and reflection.

Listening to and learning from concerns and complaints

- The hospital managers' received 35 formal complaints in the year beginning 01 Mar 2015 to 29 February 2016. Nine complaints were from Hartley ward mangers had partially upheld one regarding the overall quality of care; five were ongoing, including two complaints about the use of restraint. Four complaints related to care on Wedgewood ward and all were still ongoing at the time of our inspection. Two of these related to lack of permanent staff on the ward and the other two were about staff behaviour. The majority of complaints related to Thorneycroft ward (22) and seven of these

had been upheld. Of those upheld, four related to inappropriate staff behaviour. Fourteen complaints were ongoing; and of those, 12 related to inappropriate staff behaviour.

- The young people we spoke to on Hartley ward knew how to make a complaint.
- In the absence of regular staff meetings on the wards, there was no mechanism for investigating managers to share the outcome of complaints and any findings with staff.

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Are child and adolescent mental health wards well-led?

Inadequate

Vision and values

- There was no clear knowledge amongst staff of the Huntercombe Group's values about patient care.
- We saw no ward based objectives or mission statement that reflected these values.
- Staff knew the name of and had met the hospital director; the lead consultant psychiatrist and director for quality and safety were new in post from April 2016 and were not known on all of the wards.

Good governance

- The hospital director had not registered as a registered manager with the CQC at the time of inspection as required. A registered manager is a legal requirement of the Health and Social Care Act (2008). The hospital director had failed to advance an application despite giving assurances to CQC inspectors in February 2016.
- Overall, we found that management systems were not effective in the hospital. Staff were not receiving mandatory training and supervision of staff was at very low levels. We could not determine overall levels of supervision as records were incomplete.
- Shifts were not covered by a sufficient number of staff of the right grades and experience
- Due to high levels of lone working, qualified staff could not maximise shift-time on direct care activities and they were caught up in immediate clinical duties and emergency responses.
- Although staff reported incidents, management systems and personnel did not allow for any effective review and staff learning from incidents, complaints and service user feedback. As outlined in our previous inspection report, we found that safeguarding, MHA and MCA procedures were not being consistently followed.
- The hospital was in the process of making changes to the existing care approach that had destabilised existing systems and staff teams. The hospital director had come into post in October 2015 and was leading this programme of change. The proposed aims of the restructure were to:
  - develop clinical leadership inside the hospital;
  - improve quality and clinical effectiveness;
  - strengthen unit management and nursing structure on the wards;
  - re-focus and improve therapy structures
  - reshape business support functions.
- Ward leadership was poor with only one ward manager having any experience at the hospital. Wedgewood ward had not had a manager actively in post since 2015. The ward manager for Thorneycroft ward had come into post in April 2016 and was covering Hartley ward. An additional (third) ward manager had been appointed in January 2016 but was not expected to come into post until June 2016. A lead post for quality and safety had been created to support the hospital director and the post holder had started in April 2016.
- A nurse development post had been created to support identified gaps in nurse training and competencies. The post holder was to start work at the end of May 2016. A new lead consultant psychiatrist had come into post in April 2016 taking responsibility for the PICU. Two further new consultant appointments were due to take up posts in June 2016. In the social work department at the hospital, a new senior social worker had been appointed in April 2016 to support a recently qualified social worker who was working alone and unsupervised. The number of recent appointments meant there was no established senior management team within the hospital to support and evaluate the wide ranging changes that had been introduced to the model of care and working practices since November 2015.
- Staff participation in clinical audit was limited to a few areas and only consistent on Thorneycroft ward.

- Staff did not have the ability to add items to the providers risk register at a local level and overall felt there concerns about clinical safety had not been addressed by managers. In the latest copy of the local risk register submitted (January 2016) these concerns did not feature. The three most highly rated risks were:
- a risk of harm to patients and staff due to staff training and refreshers not being up to date.
- a risk to business sustainability due to the ward environments not meeting expectations of commissioners.
- a possible change back to CAMHS being locally commissioned having a major impact on occupancy and funding processes.

Leadership, morale and staff engagement

- The hospital director and other managers received support from a central human resources team for the Huntercombe Group. Sickness and absence wereas monitored centrally through an electronic staff record. Advice was available on case management through a weekly visit by the HR lead to the hospital. There were no active cases of bullying or harassment raised by staff.
- One staff member had felt that whistleblowing was required in April 2016 leading to a responsive CQC inspection to examine concerns about patient safety. Subsequently two further staff members have come forward direct to the CQC during our inspection period to express concerns and advised that management were not acting to address serious safety and staffing issues. The reasons given by staff that chose to come to the CQC directly with concerns were that they were fearful of victimisation by management at the hospital and, despite previously raising concerns, they had felt ignored. We saw correspondence from senior clinical staff to the Group Chief Executive raising concerns about patient safety in April 2016. This aligned to the findings of the organisation's own quality assurance framework from March 2016 that identified significant failings in safety and governance systems. We did not see evidence of the group executive taking any robust action to remedy these issues before the CQC's first inspection at the end of April 2016 to investigate whistleblowing concerns.
- Staff reported generally low morale throughout the hospital. This was particularly true of permanent staff on Hartley ward who felt their ward team had been disbanded without reason and at very short notice.
- Qualified nursing staff on the wards had the opportunity to pursue leadership development through a locally run Royal College of Nursing programme.
- We heard from staff within each of the ward teams about difficulties in maintaining effective team working following the movement of staff between teams and a shortfall in qualified staff. We heard dissatisfaction from staff nurses on Hartley ward about the breakup of their team and increasing use of agency nurses to fill shifts. They felt this had destabilised an effective team that had worked well with young people and restraints had increased as a result.
- The therapy department had been subject to a restructure in November 2015. In the focus group we held with ten therapy staff the results of this restructure had been negative leading to staff leaving and the removal of the therapy lead post. This had meant that there were no clear lines of responsibility to or communication with the hospital senior managers. It also meant that new therapy staff had not received any dedicated induction programme and supervision networks falling apart. As a whole despite managers justifying the restructure as enhancing the role of therapy within the hospital the staff felt the outcome had been to diminish it. They felt that MDT meetings were too medically focused and their professional opinions not counted.
- Hospital managers recognised their duty of candour to be open and transparent and give an explanation to young people and their families when something went wrong. There was no ongoing record held to evidence when the duty of candour had been required or met. One young person did show us a letter from the hospital director in response to a complaint apologising for inappropriate staff behaviour whilst others reported that they had no feedback or explanation given to their concerns.
- As part of a Huntercombe group wide initiative, managers offered staff an opportunity to give feedback

on services and input into service development through a Conversation Into Action programme. Unfortunately, many staff across professional boundaries felt too intimidated to speak frankly about their concerns.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that entry to the hospital is controlled and patient safety maintained by following a process of security checks on visitors, staff and young people at the point they enter and leave the hospital.
- The provider must ensure the security of medicines and clinical equipment is controlled with a dedicated key rather than allow access though overrides and universal keys.
- The provider must ensure that the staff use the proper legal authority to assess the ability of young people to consent to treatment and the ability of young people under 16 to have the capacity to consent recognised.
- The provider must bring policies into line with the revised Mental Health Act Code of Practice to ensure staff are following best practice and protecting young people when using restrictive practices.
- The provider must ensure that staff are skilled in and have adequate knowledge of local safeguarding procedures.
- The provider must ensure that emergency equipment is ready and safe to use through regular checks and testing.
- The provider must ensure that ward environments are compliant with standards relating to mixed gender accommodation.
- The provider must ensure that staffing levels are sufficient to enable safe, effective and high quality care.
- The provider must ensure that mandatory training levels are addressed in order for staff to gain the skills and knowledge required to care for the patient group.
- The provider must ensure that supervision and appraisal of staff is addressed and are carried out at intervals in accordance with the organisation's own policy and . Tthat there is system for the induction of all new staff and support/preceptorship for newly qualified professional staff in line with requirements of their professional regulator.
- The provider must ensure that specialist training for naso-gastric tube feeding is delivered to all applicable staff
- The provider must ensure that care plans and risk assessments are completed and regularly reviewed, holistic, patient centred and recovery focussed
- The provider must ensure that Ccare records aremust be maintained securely, accurate, complete and contemporaneous.
- The provider must ensure that an annual environmental risk assessment is carried out and mitigation of risks identified
- The provider must ensure that clinical policies are reviewed and updated in line with national policy and guidance e.g. NICE on rapid tranquillisation
- The provider must ensure there is learning from incident reports and that lessons are shared across the hospital and organisation
- The provider must ensure the management of aggression and use of restrictive practices are in line with the least restrictive principle, monitored and subject to a reduction strategy.
- The provider must ensure the integrity of the fire alarm system to maintain the safety of people at the hospital.
- Hospital managers must meet their obligations under the Children Act and bring reporting procedures to the standards outlined in the Local Safeguarding Children Board.
- The provider must ensure that out of hours medical cover for the hospital includes access to psychiatric specialists at all times.

Outstanding practice and areas for improvement

- The provider must provide physical health care monitoring (on admission and following restraint) and to meet the specific needs of eating disorder patients as routine practice on all wards.
- The provider must provide sufficient, appropriate and coordinated therapeutic activities and access to psychological therapies must be available on all wards
- The provider must improve the arrangements for protecting the privacy and dignity of young people in shared bedrooms and shared facilities on the wards.
- The involvement of carers and family in young person's care must be improved and communication maintained between multi-disciplinary meetings.

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Action the provider SHOULD take to improve

- The provider should ensure that the rights of informal young people to leave the ward at will are clearly displayed
- The provider should improve visiting facilities to allow more flexibility for visitors to see the young people in private and include the option of visits onto the wards.
- The provider should work to develop transparency and positive engagement with external stakeholders.
- The provider should introduce a common method for handovers /communications between shifts and MDT meetings on all wards.
- The provider should involve and listen to young people's views and experiences of care in service 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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The ability of young people under 16 to consent to treatment was being assessed using the Mental Capacity Act, which does not apply to that age group in this circumstance. Staff had varying degrees of knowledge of the MCA and in there was very poor understanding of Gillick Competency This is a breach of regulation 11 (1) & (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 There was no effective system or processes to ensure quality and safety of services were assessed and monitored. There was no regular assessment of risk to the health, safety and welfare of service users e.g. ligature risks or plans to mitigate or for the ongoing monitoring of these risks. Clinical policies were not in line with the Mental Health Act Code of Practice. Staff were not familiar with or trained in the current guidance and the safeguards recommended to protect patients. Care records were not kept securely. Records were incomplete, with care plans and risk assessments out of date. Systems for lessons to be learnt and implemented from incidents were not robust and staff meetings did not take place.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 Staff offered to visitors keys to clinical areas and failed to conduct ID checks. Each building had a separate system for monitoring visitors that were not co-ordinated. This was a breach of Regulation 15 (1) (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 18 HSCA (RA) Regulations 2014 Staffing The number of qualified nurses on duty regularly fell below the local minimum standard. This lack of leadership on the ward was evident in the high level of restraints and incidents. Staff had not received mandatory training or supervision to develop skills and knowledge to provide safe care. There was a lack of specialist training essential to the care of patients on the eating disorders unit in naso-gastric tube feeding. This was a breach of Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 (Registration) Regulations 2009 Registered manager condition The provider did not have a registered manager in place as required.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 The dignity and privacy of young people was compromised by the lack of space available to make private phone calls and the use of shared bedrooms. This was a breach of Regulation 10 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 Care and treatment did not reflect the needs and preferences of the young people. There was no consistent evidence that care was assessed and care planning took place in collaboration with young people. This was a breach of Regulation 9 (1) (a) (b) (c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 least restrictive principle was not applied to risk care planning and there was no evidence of any attempt to balance rights against risk. Risk assessments did not include arrangements to respond appropriately and in good time to young peoples' changing needs. Emergency equipment was not regularly checked for completeness and readiness for use. Staff were not aware of where it was stored and were not up to date in training for its use. Staff had not secured the clinic rooms and safety of the stored medicines. Clinical policies were out of date and not in line with NICE guidance

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 12 (2) (a) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 The privacy of young people was not protected in shared sleeping areas or in the requirement for staff to supervise all access to toilets on Hartley ward. This was a breach of Regulation 10 (2) (a)