Huntercombe Young People Ltd

Huntercombe Hospital Maidenhead

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Following the inspection, we have suspended the rating of the service. We will monitor the hospital closely and will return in due course to see if the required improvements have been made.

On the 1 February 2022 we undertook an unannounced, focused inspection of Huntercombe Hospital Maidenhead to check whether the improvements that we told the hospital to make following our last inspection had been made.

The provider had made the following improvements:

- The provider had made improvements to the environment by increasing the number of communal spaces available on Kennet ward and refurbished the main dining room. The provider had also started building work on Severn and Thames ward to remodel them into four smaller wards. The provider had made a planning application to build a replacement ward for Tamar ward.
- The provider had updated their ligature point assessment, and staff would now use observation and CCTV to manage identified risks.
- The environment of the nasogastric feeding room had been improved. The room now had a wellbeing screen for the young people to watch music videos or television. The room now had air-conditioning to regulate the temperature and a new more comfortable seat was in place.
- Training in eating disorders was now mandatory on the PICU ward that offered care to young people with eating disorders as well as the specialist eating disorder ward. More staff had completed the full eating disorders training.
- Staff supporting young people to have nasogastric feeds who needed to be restrained to receive their essential feeds received appropriate supervision and debriefs.
- The number of therapy staff had been increased. For example, there was now two occupational therapists working across the hospital and each ward had a dedicated occupational assistant.
- The majority of staff had now received an appraisal.

However:

- Improvements had not yet been made to the environment on Tamar ward. However, planning permission had been submitted to provide a purpose-built new ward and externally monitored CCTV had been installed.
- Some young people complained that some staff had a poor attitude towards them. For example, telling the young people that their mental health issues were behavioural.

Following our inspection there was a serious incident at the hospital that resulted in the death of a young person. On the 2 and 3 of March 2022 we undertook an unannounced inspection to ensure young people cared for on the psychiatric intensive care unit (PICU) were safe. We did not look at the events surrounding the serious incident on this inspection as there was an ongoing police investigation. We will follow our usual policies and procedures relating to serious incidents following the police investigation.

At this inspection we found:

- The observation policy and the assessment of staff competencies were not always completed for all staff and the quality of the competencies assessments varied.
- All staff we spoke to could not accurately explain what was required of them in carrying out the different levels of observation young people could be placed on to keep them safe.

Summary of findings

- The provider had carried out audits but had not documented any action taken to address any issues identified. Therefore, the provider could not demonstrate that any of the improvements identified by the audits had been made.
- All staff we spoke to could not explain what other ways they might support young people and manage their risk other than the use of observations.
- Young people told us staff did not follow the observation policy in line with their care plans.
- Staff felt the wards were understaffed. However, we found that because managers often moved staff around wards there was confusion as to who was working on what shifts. Staff were unable to access a rota that accurately represented who is working on the ward over the following week.

However:

- We reviewed CCTV footage and saw that, on all the footage we reviewed, staff followed the observation policy.
- We reviewed incidents on CCTV and saw that, on all the footage we reviewed, staff used physical interventions appropriately.

Following our inspection, we served a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulations 12 (1)(2) (c), Safe care and treatment and with Regulation 17 (2) (a)(b) Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We told the provider that they need to ensure staff had the necessary training and competence to follow the observation policy, that staff must be assessed as competent before carrying out observations and that the assessment should be completed inline with the their policy. We also told them that they needed to have appropriate systems in place to ensure staff followed the observation policy correctly to ensure the safety of the young people admitted to the hospital.

We told the provider that they must become compliant with these regulations by 1 April 2022.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inspected but not rated	

Summary of findings

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Summary of this inspection

Background to Huntercombe Hospital Maidenhead

Huntercombe Hospital Maidenhead is a specialist child and adolescent mental health inpatient service (CAMHS). It is a 59-bed independent hospital, however, is currently only able to admit 50 patients due to conditions imposed on its registration by CQC. It provides specialist mental health services for adolescents and young people from 12 to 18 years of age. The hospital delivers specialised clinical care for young people requiring inpatient CAMHS, including psychiatric intensive care and eating disorders.

The hospital and its surrounding grounds are within a rural setting and are situated near a town with easy access to transport links and shops. Young people are supported in their education via the hospital school which is rated good by Ofsted. Where appropriate the young people have access to the hospital grounds and local community facilities.

The hospital consists of four wards:

- Kennet ward provides eating disorder services and has 20 beds.
- Tamar ward provides tier four CAMHS general adolescent services and has 10 beds.
- Thames ward has 14 beds and provides psychiatric intensive care services (PICU).
- Severn ward has 15 beds and provides psychiatric intensive care services (PICU).

Following the warning notice, served after the inspection in March 2021, the number of beds on Thames and Severn ward was capped at 10 on each. This was increased to 22 across both wards to ensure the hospital could work flexibly to provide care to young people during the process of reconfiguring the PICU wards.

What people who use the service say

We received mixed feedback from the young people we spoke to at Huntercombe Hospital Maidenhead during the inspection in February 2022. A number of young people told us that staff were caring and respectful, involved them in planning their care and followed their care plans.

However, some young people told us that they were not involved in planning their care and did not know what was in their care plans. Some young people told us that staff did not follow care plans and treated the young people unprofessionally, for example, laughing when using physical interventions and blaming the young people for their health conditions.

During the inspection in March 2022 we received mainly negative feedback from the young people we spoke to at Thames ward. Young people told us that staff did not follow the care plans in relation to their level of observations. They told us that if there was an incident the staff stopped doing intermittent observations. Staff in charge of shifts on wards asked new staff members to do observations before they understood how to do it. Staff had to ask the young person how to carry out their observations as they did not always understand what was expected of them in carrying out different levels of observations. Not all staff understood the young people's needs and made unhelpful comments about their mental health crises. Some young people said they felt that the hospital should be shut down. However, they also felt that there were some skilled staff and that there were some enjoyable activities for them to take part in.

Summary of this inspection

How we carried out this inspection

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

The inspection team on the 1 February 2022 comprised two inspectors and one specialist advisor who has expertise in the services inspected.

The inspection team on the 2 March 2022 consisted of two inspectors and on the 3 March 2022 consisted of one inspection manager and one inspector.

As these were not comprehensive inspections, we did not pursue all key lines of enquiry.

During the 1 of February 2022 we only focused on the issues identified in the Section 29 warning notice served following the last inspection and the requirement notices. We concentrated on looking at the key questions, are services safe, are services effective and are services caring.

During the inspection visit, the inspection team:

- Spoke with senior managers
- Spoke with eight young people using the service
- Spoke to 12 staff including nurses, support workers and a psychology assistant
- Looked at eight medication records
- Looked at four patient records

During the inspection on the 2 and 3 March 2022 we only focused on the issues identified following the serious incident. We concentrated on looking at the key question, are services safe.

During the inspection visit, the inspection team:

- Spoke with senior managers
- Spoke with five young people using the service
- Spoke to eight other staff including nurses and support workers
- Reviewed eight hours of CCTV footage
- Reviewed five incidents on CCTV
- Reviewed the observation competency checklist for six members of staff
- Reviewed the observation compliance audits for January and February
- Reviewed staff rotas

Areas for improvement

Please also see the section about breaches of Regulations and the Enforcement Action.

Action the service MUST take is necessary to comply with its legal obligations.

Summary of this inspection

Following the inspection on the 01 February 2022 we took the following action.

Action the service MUST take to improve:

- The service must ensure that the hospital environment is safe and fit for purpose. Regulation 15: Premises and equipment, (1)(c) and (e).
- The service must ensure that they continue to review incidents on CCTV that are not covered by the external provider, to ensure staff follow care plans and policies and document any action taken to address concerns identified. Regulation 17: Good Governance, (1)(a) and (b).

Action the service SHOULD take to improve:

- The service should ensure that they continue to work to improve the culture of the hospital and ensure that all interactions between staff and young people follow a positive approach. This includes appropriately support for young people during mealtimes.

Following the inspection on the 2 and 3 of March 2022 we took the following action.

We served a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulations 12 (1)(2) (c), Safe care and treatment and with Regulation 17 (2) (a)(b) Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that they must become compliant with these regulations by 01 April 2022.

Please also see the section about breaches of Regulations and the Enforcement Action.

Action the service MUST take to improve:

- The service must ensure that that all staff working with young people in the hospital are appropriately trained, assessed as competent to carry out all aspects of their role and understand how to follow the hospitals observation policy. Regulation 12 (1) and (2)(c)

- The service must ensure that all identified concerns from audits have a documented action plan that clearly identifies actions needed to make improvements and that those actions are taken. . Regulation 17 (2)(a) and (b).

- The service must ensure that there are always enough suitable qualified and competent staff on duty at all times. In addition, if must ensure that staff are always clear what staff are on duty on each shift and which shifts are unfilled (so these can be filled appropriately). The service must ensure that staff follow the agreed processes if they want to change their shifts. Regulation 18 (1).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inspected but not rated	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Child and adolescent mental health wards

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Well-led	Inspected but not rated

Are Child and adolescent mental health wards safe?

Inspected but not rated

Ratings have been suspended at this time.

Safe and clean care environments

Safety of the ward layout

When we visited in July 2021, we found that the provider did not ensure that the ward environments were suitable to meet the needs of young people. There were not sufficient communal spaces on Kennet ward for the young people to use. On Tamar ward there was no toilet on one of the female bedroom corridors, the corridors were very narrow, making it difficult for people to pass one another. We also identified problems with sound on Tamar ward, for example young people who became distressed could clearly be heard in other areas of the ward.

When we returned for the inspection in February 2022, we found that the hospital had increased the number of communal spaces available to the young people on Kennet ward. Severn and Thames wards were being remodelled to provide four smaller PICU wards. The dining room in the main hospital building had been refurbished with new seating and food service area.

Although the environment on Tamar ward remained the same, we were advised that a planning application had been submitted to provide a modern purpose-built general adolescence unit on the hospital site. In addition to the plans to build a new unit the provider had now installed CCTV that is monitored by an external organisation who can contact the ward when young people need support, on Tamar and Kennet wards.

When we visited in July 2021, we found that the ligature point assessment for Severn ward had ligature risks that had been identified but no mitigation put in place. On the inspection in February 2022 we saw that staff were to manage all ligature risks using observations and CCTV. We discussed with senior managers who told us there would be fewer ligature points on the wards following the remodelling programme and the externally monitored CCTV would be installed.

Maintenance, cleanliness and infection control

When we visited in July 2021, the room used for nasogastric feeding was hot and unpleasant. On this inspection the room used for nasogastric feeding had improved. The seat could easily accommodate three people. There was a mindfulness screen on which the young people could watch television, music videos or relaxing images and there was air conditioning in the room.

Inspected but not rated

Child and adolescent mental health wards

Safe staffing

The staff team had not received all the training they needed to keep the children and young people on the ward safe from avoidable harm.

Nursing Staff

When we inspected in February 2022 current vacancy rates at the hospitals for nurses was 60% and support workers was 42%. Managers told us that they filled any vacant shifts with bank and agency staff. However, staff reported being short staffed. We reviewed the January 2022 Daily Operational Meeting minutes. This meeting involves senior staff reviewing staffing across the hospital during the day to ensure there are safe levels of staffing across the ward. This showed that the hospital had reported being short staffed on four occasions. Twice the hospital was short two support workers on one ward and twice they did not have a second qualified nurse on one ward. When this happened, managers moved staff from other wards to cover the young peoples' leave and activities.

When we inspected in March 2022, senior managers were able to show us that the hospital was rarely short staffed. However, staff working on Thames ward were unsure of how many staff should be on each shift and were not able to view a rota that accurately showed them who was working on the ward over the week. Senior managers told us that agencies had arranged staff hours that did not follow the hospitals standard shift pattern. This meant it was very difficult for staff to safely plan shifts to meet the needs of the young people admitted to the hospital.

Mandatory training

When we inspected in July 2021, the mandatory training programme did not cover all the training the staff required to ensure they could meet the needs of the young people. Training in eating disorders was not mandatory for all staff working with young people. Staff working with the young people with eating disorders on Thames and Kennet ward did not receive sufficient training. Only 19% of eligible staff had attended the four-hour eating disorder teaching session delivered by the clinical psychologist and the head of therapies. Staff on Thames ward could not access training on supporting young people with eating disorders at mealtimes, despite having to offer this to young people in their care.

When we returned for this inspection in February 2022, we found that staff had received appropriate training in eating disorders for their role. The eLearning eating disorder training was now mandatory. At the time of this inspection 69% of staff on Kennet ward and 70% of staff on Thames ward had completed the training. The provider had commissioned training from an external training provider whose training conformed with the National Institute of Health and Care Excellence (NICE) guidance. At the time of this inspection 69% of staff on Kennet and 70% of staff on Thames ward had completed the face to face training. Staff on Thames ward were now able to access training on meal support. Senior managers told us that the number of staff, working on the wards, who had completed the training had recently gone down due to staff turnover and staff changing roles. Managers told us that all staff will have completed this training by the 11 March 2022.

When we inspected in March 2022, we found that staff did not fully understand the providers observation policy and therefore did not always undertake therapeutic observation correctly. We interviewed eight members of staff and none of the staff were able to describe all the different levels of observations correctly. All the staff we spoke with were unsure of the minimum length of time between intermittent observations. We reviewed six staff observation competency checklists, completed by staff to show they understood the observation policy. We found three records where staff had made at least two errors and therefore had not passed the assessment, but the assessing staff had passed them to carry out observations anyway. Not all staff had completed a competency check before carrying out observations, which was against the providers policy. Staff were unable to discuss other security strategies to keep the young people safe. For

example, staff had not had training in relational security. Relational security is the knowledge and understanding staff have of a young person and of the environment, and how this information can help to develop care plans to manage individual risk. However, the hospital had recognised this and was training staff in relational security while we were on site.

During the March 2022 inspection we found that the provider had not ensured they had oversight and assurance that the observation policy was being carried out correctly by staff. There was a regular spot check audit carried out by senior staff to ensure that the ward staff were following the observation policy correctly. We reviewed the checks completed in January and February 2022 and found that when issues were identified there was not any documented action taken to address the issue. For example, the audit check stated that staff need to be reminded to not leave young people on 1 – 1 observation, but there was no recorded action taken.

However, we reviewed eight hours of CCTV footage and five different incidents and saw staff followed the observation policy. For example, asking other staff to take over observations if they needed a break.

Track record on safety

When we inspected the service in July 2021, staff involved in restraining young people for nasogastric feeding on Thames ward told us they did not receive support, after having to undertake the procedure. They told us they felt under a lot of pressure with the number of young people they had to support in this way as well as providing care to the other young people on the ward.

When we returned for the inspection in February 2022, staff told us they felt they received the right level of support when having to give nasogastric feeds under restraint. Staff also told us that as there were less nasogastric feeds needed it no longer had an impact on providing care for the other young people on the ward.

Are Child and adolescent mental health wards effective?

Inspected but not rated

Ratings have been suspended at this time.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

When we inspected the service in July 2021 the provider did not ensure that there were enough suitably qualified and competent therapy staff to provide a range of therapeutic interventions to meet the needs of the young people. When we returned for this inspection the provider had increased the number of doctors on Kennet ward from one to 1.6. There were now two occupational therapists to cover the hospital and an occupational therapy assistant on each ward. There was now one psychologist working at the hospital and each ward had a psychology assistant.

Inspected but not rated

Child and adolescent mental health wards

When we inspected the service in July 2021, the managers did not support all staff through regular, constructive appraisals of their work. Forty percent of staff had received an appraisal in the last year, which is well below the provider's compliance target of 90%. During the inspection in February 2022 we found that the appraisal rate varied across the wards with the highest percentage being 92% and the lowest being 40% and the overall appraisal rate being 77%.

Are Child and adolescent mental health wards caring?

Inspected but not rated

Ratings have been suspended at this time.

Kindness, privacy, dignity, respect, compassion and support

When we visited in July 2021, the young people told us that staff did not always follow their care plans when supporting them at mealtimes as they had not read their care plans. Which could affect a young persons' recovery. When we returned in February 2022 for most young people told us that staff understood their care plans and followed them during mealtimes. However, some young people still told us that not all staff fully understood how to support them during mealtimes. Senior managers explain how meal support worked and we saw staff following this process during a meal.

In February 2022 some young people told us that not all staff acted professionally or communicated with them appropriately. They told us that some staff laughed at them when they needed physical interventions to control their behaviour and blamed them for their mental health conditions. We discussed this with the senior management team and agreed they would review 10 incidents on CCTV in the hospital and report on any actions they needed to take. We were advised that before the February 2022 inspection the provider had taken actions following two of the incidents reviewed which involved retraining for staff and a safeguarding referral. The provider is up grading all its CCTV facilities to be externally monitored so inappropriate practice would be flagged to the managers for review.

During the March 2022 inspection young people on Thames ward told us that staff did not understand their needs and did not follow their care plans. The young people told us that they needed to explain how to carry out observations to some new staff. Staff would not always carry out intermittent observations when there was an incident on the ward. They told us they did not feel safe at the hospital. However, they also felt that there were some skilled staff and that there were some enjoyable activities for them to take part in.

During both inspections the hospital director told us that they were committed to ensuring that staff focussed on providing the best possible care to the young people. If there was concerns about staff performance, they used the providers performance management policies and had started performance management with 103 staff which had led to 11 having their employment ending at the hospital.

Are Child and adolescent mental health wards well-led?

Inspected but not rated

Ratings have been suspended at this time.

Inspected but not rated

Child and adolescent mental health wards

Our findings from the other key questions demonstrated that governance processes did not operate effectively.

Senior managers were not aware that the observation competency checklists were not being marked in line with the providers policy or that identified actions from the observation audits had not been actioned.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes • The environment on Tamar ward remained unsuitable to meet the needs of young people admitted to the service.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Managers did not regularly review CCTV of incidents to ensure policy and procedures were being followed. • Concerns identified during audits did not always have a documented action plan. • Staff had not document what action they had taken to address concerns relating to the carrying out of observations.

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 • There was not an easy way for staff to identify who was working each shift and if that shift was fully staffed. • Staff did not always follow the agreed process when wanting to change their shifts.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

- Staff working with young people in the hospital were not always appropriately trained and assessed as to carry out all aspects of their role.
- Staff did not understand how to follow the hospitals observation policy.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	S29 Warning Notice **Regulation 12, (1) and (2)(c), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • Not all staff working with young people on Thames ward had the necessary training and competence to follow the observation policy. • Staff did not always undertake therapeutic observations appropriately and therefore put young people at risk of harm. **Regulation 17, (2) (a)(b), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • The provider did not have oversight and assurance that the observation policy and related practice was carried out appropriately by trained and competent staff. • The provider could not be assured that young people were receiving the level of observation needed at all times to mitigate risks relating to the health, safety and welfare of the young people on Thames ward.