Cygnet Health Care Limited

Cygnet Joyce Parker Hospital

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 caring?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this service.

We carried out this inspection in response to concerning information received through our monitoring processes.

We found the following areas of good practice:

- Staff involved children, young people and their families in risk assessment, risk management and care planning. Staff made sure the children and young people could access advocacy services when they needed to.
- Staff supported, informed and involved families or carers.
- Staff continually assessed the physical and mental health needs of all children and young people during their admission. They developed individual care plans, which the multidisciplinary team reviewed regularly and updated as needs changed. Young people reported staff used medication to sedate them less than in previous hospitals.
- The ward had enough nursing and medical staff, who knew the children and young people. Staff completed and kept up to date with their mandatory training.
- The provider's governance processes were effective in identifying when staff had not reported and completed incident reports accurately.

However:

- Young people did not always understand their restraint reduction risk management plans. This resulted in some feeling that staff did not care about them because they did not respond with immediate restraint techniques when the young people were attempting to harm themselves.
- Not all young people felt staff treated them with kindness and compassion. Young people felt their privacy and dignity was compromised because there were often more male support workers than females working on the ward.

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	See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Joyce Parker Hospital

Cygnet Joyce Parker Hospital is a location operated by Cygnet Healthcare Ltd. The hospital provides mental health care and treatment for children and young people aged between 12 and 18 years.

The location is registered to provide the following regulated activities:

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

The hospital opened on 15 October 2020 and has 4 wards:

Dragon ward - a mixed gender children and young people's low secure ward with 10 beds, which opened on 15 February 2021.

Mermaid ward - a mixed gender children and young people's psychiatric intensive care unit, this ward has 10 beds and opened on 3 November 2020.

Pixie ward is a mixed gender general children and young people's unit, this ward has 12 beds and opened on 15 February 2021.

Faun ward is a child and young female psychiatric intensive care unit, this ward has 8 beds and opened on 11 October 2022.

The hospital has been inspected 4 times since it opened. The last inspection was in January-February 2023. That was also a focused inspection which looked at the key questions of safe, caring and well-led. Following that inspection, the service was rated requires improvement for those 3 key questions. We issued requirement notices for regulatory breaches in the following areas: regulation 10 (Dignity and respect), regulation 12 (Safe care and treatment) and regulation 17 (Good governance).

We did not check if the service had made improvements following the inspection in January- February 2023 as the report was not published at the time of this inspection.

We received concerning information about Dragon ward, therefore this inspection only focussed on this specific ward. We inspected Dragon ward during the day and during the night. All the young people receiving treatment on Dragon ward were detained under the Mental Health Act 1983. There were 5 patients admitted to the ward when we began this inspection, 1 of whom was away on overnight home leave. A new young person was admitted to the ward during our inspection, bringing total patient numbers to 6.

The hospital had a registered manager and there was an Ofsted registered school on site.

What people who use the service say

We spoke with 4 young people using the service. We received a mixture of positive and negative feedback.

Summary of this inspection

A young person was very positive about the service. They told us that staff were kind, listened to them and were very supportive, understanding what worked best for them. They told us Dragon ward was the best, mainly because staff were kind, more caring, understood them well and supported them when they were distressed, without putting them straight into seclusion and without over sedating them. They told us the hospital was clean and tidy, there was plenty of good food and there were enough activities to get involved in.

Two young people told us they worried about the wellbeing of staff. All the young people we spoke with told us they observed staff falling asleep while carrying out their safe and supportive observations during the night. One told us this was rare, but another told us it had happened often. We looked at incident records and patient community meeting minutes. We also reviewed CCTV footage. We found that when young people reported staff had been asleep on duty, managers investigated their claims. We were not able to conclude that staff regularly fell asleep whilst on duty. There had been 1 proven recent incident and following investigation by hospital managers, the provider took action in line with their policy.

Two young people told us they would prefer to have more female staff working on the ward. One of them told us if their safe and supportive observations were carried out by male staff, they would need to tell staff when they needed to use the toilet, so a female escort could be found. The young person found this embarrassing.

A young person told us “Some staff are lovely, and I owe them a lot” but different staff delivered different responses, which the young person found inconsistent. They told us they believed some staff overreacted when young people physically pushed them, falling to the ground when the force used to push them didn’t warrant it.

Young people told us they understood their care plans and there were low levels of physical restraint and seclusion on Dragon ward. They told us that not being put into restraint on a regular basis was preferable for them. However, some young people interpreted the lack of physical restraint as an indication that staff did not care when they tried to hurt themselves.

A family member told us their relative was safer on Dragon ward than they had been in other hospitals. They were secluded less, physically restrained less, were no longer over-medicated and were subject to less rapid tranquilisation than in the other hospitals. They approved of all these things. Another family member told us they “find it hard to fault” Dragon ward but think some support workers would benefit from additional training to understand the nuances of language and impact, for example, of a glance away, a smile at the wrong moment or a misjudged greeting. They also told us support workers sometimes shared information about themselves, which the family member felt was unprofessional.

How we carried out this inspection

For this inspection we looked at specific key lines of enquiry in relation to the concerning information received. We have reported under 3 of the 5 key questions: safe, caring and well led. Because this inspection was focussed on specific concerns, our report does not include all the headings and information usually found in a comprehensive inspection report.

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

During the inspection visit, the inspection team:

Summary of this inspection

- visited Dragon ward and looked at the quality of the ward environment and observed how staff were caring for the children and young people;
- spoke with 4 young people who were using the service;
- spoke with 3 parents/ carers/ relatives of young people using the service;
- interviewed the ward manager and the hospital clinical manager;
- spoke with 16 other staff members; including nurses, healthcare support workers, doctors,

1. therapists, ancillary staff and the safety intervention lead;

- looked in detail at the care and treatment records of 3 young people;
- reviewed 12 incident records;
- reviewed closed circuit television footage (CCTV) of 12 incidents including a review of 8 incidents hospital staff had analysed;
- observed a shift handover and a multidisciplinary daily risk assessment meeting;
- spoke with the independent advocate;
- gathered feedback from 3 external commissioners and case managers;
- spoke with the local authority designated officer (LADO); and
- Looked at a range of policies, procedures and other documents relating to the running of the ward.

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that children and young people are supported to understand what underpins risk management plans aimed at reducing episodes of physical restraint.
- The service should ensure there are sufficient female support workers available on the ward to support patient preferences.
- The service should ensure staff are mindful of how their behaviour and language spoken may impact on children and young people.
- The service should ensure staff are effectively supported through investigations and disciplinary processes.
- The service should ensure learning is embedded with staff to enable accurate reporting of incidents.

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	Not inspected	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	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
Caring	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

Safe and clean care environments

Dragon ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. As the children and young people discovered new ways to damage property, the service responded quickly and developed new ways of removing and reducing the associated risks. Young people's access to risk items were individually assessed.

Staff could observe children and young people in all parts of the wards. The ward used (CCTV) cameras and mirrors to support staff with their physical observations.

The ward complied with guidance in relation to mixed gender accommodation. There were no shared rooms, no dormitories and each young person had access to their own ensuite bathroom. The ward had mixed sex lounge and recreational areas as well as a single sex lounge.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Staff reviewed ligature risks regularly and managed these with environmental and individual risk management plans. Ligature incidents on the ward were not associated with fixed ligature anchor points.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. We observed quick and effective response times when staff and patients activated the nurse call systems. The hospital provided staff and visitors with alarms for use when on the ward. An effective process was in place to make sure these were fully charged, checked and returned before leaving the building.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Children and young people had been involved in designing and decorating the ward.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning schedules were up to date and we observed good standards of routine cleaning taking place on the ward.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet, a clock and the temperature could be controlled. It was clean and was easily accessible from the main ward area.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The room was well ordered, and staff completed routine checks to make sure stock remained within its expiry date.

Staff checked, maintained, and cleaned equipment. All the equipment was in working order and was regularly calibrated in line with the manufacturers' guidelines.

Safe staffing

The ward had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The ward had enough nursing and support staff to keep children and young people safe. We reviewed staffing rotas, which showed there were enough staff of all grades on each shift.

The ward had low vacancy rates and reducing rates of bank and agency nurses. The agency nurses had been engaged on long term contracts and were well known to other staff and patients on the ward. The nursing establishment for the ward was 8 full time equivalent nurses. There were 2 vacancies when we carried out this inspection. Two nurses had been recruited to the ward and were due to take up their posts the following week. In the 2 months leading up to this inspection, no shifts were unfilled. During our inspection there was 1 shift where a nurse was not able to complete a planned shift. We saw that other nurses and managers across the hospital provided support to the night nurse and made sure they were able to take their scheduled breaks.

The ward had low rates of bank and agency healthcare assistants. The establishment for healthcare support workers was 28. Managers had over-recruited to the role, with 32 staff in place. A further 3 healthcare support workers had been recruited and were due to take up their posts within the next month. The ward also held a small bank of healthcare support workers who worked regular shifts on the ward to make sure they remained familiar with patients, staff and ward processes.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The bank and agency staff we spoke with had worked on the ward for more than 1 year.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff told us the induction was effective and had prepared them for their role.

The ward had low turnover rates. There had been no staff leavers in the 2 months leading up to this inspection. This was a significant improvement on the 14% turnover reported in the January 2022 inspection.

Managers supported staff who needed time off for ill health.

Levels of sickness were low and reducing. The provider reported sickness rates of 3% and 2.4% in the 2 months prior to our inspection.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The ward manager or nurse in charge could adjust staffing levels according to the needs of the children and young people. The rotas we reviewed showed that the actual numbers of staff deployed on each shift were reviewed and increased or decreased depending upon acuity. For example, when patient safe and supportive observations were increased, the number of staff increased to meet the change in patient need.

Children and young people had regular 1:1 sessions with their named nurse. They were also able to request additional 1:1 sessions whenever they need them. We crossed referenced documentation such as patient community meeting minutes and found when young people requested additional, ad hoc sessions staff provided them in a timely and responsive way.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. We heard and saw no examples of this happening.

The ward had enough staff on each shift to carry out any physical interventions safely. Each shift had “floating staff”, which made sure there were enough staff to support all activities.

Staff shared key information to keep children and young people safe when handing over their care to others. This included essential information for staff shift handovers and for discharge planning.

Medical staff

The ward had enough daytime and night-time medical cover. A doctor was always available to get to the ward quickly in an emergency.The provider policy for access to doctors in an emergency was that the on-call doctor was expected to be within a twenty-minute drive from the hospital. There was a doctor’s “on call suite” at the hospital for doctors to use when they were on-call if they were not within a 20 minute drive.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.The mandatory training programme was comprehensive and met the needs of patients and staff. The programme included physical intervention training, which had a compliance rate of 92%.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

Inspected but not rated

Child and adolescent mental health wards

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission/ arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff regularly reviewed risks in the multidisciplinary daily risk assessment meeting.

We reviewed 3 patient care records, all of which contained fully completed risk assessments.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff we spoke with knew the young people well and understood their risks. They were able to describe what might trigger distress for each young person on the ward and what de-escalation techniques worked best for them.

Staff identified and responded to any changes in risks to, or posed by, children and young people. We saw these were effectively recorded and communicated to staff.

Staff could observe children and young people in all areas of the ward staff followed procedures to minimise risks where they could not easily observe children and young people. These included the use of relational security, CCTV and suitably positioned mirrors to support staff with their observations. Each night shift had a floating staff member who checked upon each worker assigned to carry out safe and secure observations. The role made sure that staff were all alert and could take comfort breaks when they needed them. All the night staff we spoke with told us this was a valuable and supportive addition to the team. This reduced the likelihood of staff falling asleep whilst on young people's observations.

Staff followed the provider's policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. The young people we spoke with reflected that on the whole, this was better for them because they did not like being restrained and often found such interventions triggered distressing emotions.

Staff participated in the provider's restrictive interventions reduction programme.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Levels of restraint were low and the philosophy of the ward was to support children and young people to manage their distress in ways which were less harmful to themselves. However, whilst families and external professionals saw the benefit of reduced incidents of physical restraint, some of the young people interpreted this as a lack of care. We reviewed CCTV footage of restraint incidents which demonstrated staff attempting verbal de-escalation and utilising care planned strategies before resorting to physical interventions.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Levels of rapid tranquilisation used were low.

Safeguarding

Most staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse. The provider had a named nurse and doctor for child safeguarding and the ward had a safeguarding lead. Staff did not report all safeguarding concerns.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff told us the training was suitable for their needs and prepared them well.

Staff kept up to date with their safeguarding training. At the time of our inspection the training compliance rate was 100%.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Examples included young people's use of social media and their interpersonal relationships while on the ward.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We received feedback from the local authority designated officer and from 3 young people's case managers, all of whom were confident in ward staff's ability to identify and raise safeguarding concerns. We reviewed 1 young person's care records and identified 5 safeguarding incidents from their admission date. Staff had not reported 2 of these as safeguarding incidents. The provider's internal audit identified this and notifications had since been submitted. Senior leaders advised staff were now trained and understood how to recognise safeguarding incidents.

Staff followed clear procedures to keep children visiting the ward safe. The ward had a comfortable visitors' room which was located off the main ward area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw examples of staff raising concerns which were dealt with in line with the provider's processes.

There had been no recent instances of the ward being subject to any serious case reviews.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. This included bank and agency staff.

Staff completed accurate safe and supportive observation records on paper. These were uploaded to the electronic records system the following day.

Records were stored securely and only those who needed access could do so.

Medicines management

The ward used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

We reviewed medicine administration charts and inspected the clinic room which showed that staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. The young people who talked to us about their medicines, understood what they were taking and why any changes had been made to their prescribing regime.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The clinic room was well ordered and all stock we reviewed was stored correctly and was within its expiry date.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. A young person gave an account of not receiving their medicines correctly which we reviewed. We could see the provider had investigated this, made changes to the prescribing and provided a full apology to the young person and their parents.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. A young person told us they were not over medicated, as they had previously experienced.

Staff reviewed the effects of each child or young person's medication on their physical health according to National Institute for Health and Care Excellence guidance. Staff routinely measured and recorded physical health observations.

Track record on safety

Reporting incidents and learning from when things go wrong

The ward managed most patient safety incidents well. Staff did not always report incidents in line with the provider's policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff did not always report and record incidents in line with the provider's policy. All staff had access to the incident reporting system. We reviewed incident records against CCTV footage and found staff reported these accurately. The provider's CCTV audits identified occasions when staff did not record restraint incidents accurately. This included incorrect times that restraint lasted (longer than actual time); not recording all de-escalation strategies used; staff not accurately describing the incident and staff recording multiple incidents of restraint as 1 overall incident.

Inspected but not rated

Child and adolescent mental health wards

The provider's security lead updated the incident reports to ensure an accurate record. It was clearly detailed that these were retrospective entries. The security lead identified and delivered training needs for staff. We identified an incident resulting in harm to a young person that required medical attention at A&E. Staff rated the incident as no/negligible harm. We raised this with the provider who advised they would change the rating to minor harm and speak to staff to ensure learning. We reviewed an incident where staff recorded that a young person tied 1 ligature. In the young person's safe and supportive continuous observations record staff recorded the young person tied 2 ligatures.

There had been 52 incidents reported for the ward in February 2023 and 61 in March 2023. Of these, 79 were categorised as "no harm", 33 as "minor harm" and 1 as "moderate harm".

Staff reported serious incidents clearly and in line with the provider's policy.

There had been no "never events" on the ward.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. A parent and a young person gave an example of when this had happened. They told us staff had been open and honest about the issue and had made an apology.

Managers debriefed and supported staff after any serious incident. Staff told us these took place in a timely manner and were staggered when necessary, for example to allow staff who had been injured to attend a debrief after the event. Managers also provided debriefs to children and young people after incidents. Records showed that managers regularly asked the children and young people if they felt safe on the ward and if they needed 1:1 support to talk through how they were feeling.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations when required. We saw evidence of this in patient records and incident reporting forms, which was also corroborated by some young people.

Staff received feedback from investigation of incidents, both internal and external to the service. We were given examples relating to risks posed by social media, which were particularly relevant to some young people on the ward.

Staff met to discuss the feedback and look at improvements to patient care. Staff of all roles were included in this, including maintenance staff when relevant.

There was evidence that changes had been made as a result of feedback. Several examples we reviewed related to the specific risk behaviours some young people shared with each other and the changes the ward made to reduce the impact of this.

Is the service caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Inspected but not rated

Child and adolescent mental health wards

Not all the young people we spoke with felt that staff always treated them with compassion and kindness. We were told staff respected children and young people's privacy and dignity but some young people felt more female staff working on the ward would be an improvement. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people. We observed staff responding promptly, supporting young people to maintain dignity when they were distressed or upset, providing space, quiet time and discreetly keeping the area private. However, some young people felt that when they harmed themselves staff did not intervene quickly enough as staff would attempt verbal de-escalation when the young person believed a physical intervention would have been a more suitable response. The young people told us that the ward would be improved if more female staff were employed to work there. Young people found it uncomfortable and embarrassing if male staff were allocated to their continuous safe and supportive observations and they needed to use the bathroom. The young person needed to tell the male staff who would then find a female member of staff to swap with to provide this support.

Staff gave children and young people help, emotional support and advice when they needed it. We observed staff providing advice, practical help, and emotional support. We saw they did not always wait to be asked for help or wait for distress to be evident. Our discreet observations of the ward environment showed that the young people also freely approached staff and that staff responded positively and promptly. This included support workers and members of the multidisciplinary team who worked from offices on the ward.

Staff supported children and young people to understand and manage their own care, treatment or condition. Young people and staff gave examples of the coping strategies and distraction techniques the young people were supported to use, such as sour sweets, headphones and ice cubes.

Staff directed children and young people to other services and supported them to access those services if they needed help. This included engaging with acute and community health services, welfare benefits and accessing therapeutic and leisure activities.

Staff treated the children and young people well and behaved kindly. However, some young people expressed concerns about staff behaviour. A young person told us that staff often spoke to each other in a language that wasn't English, so they could not understand what was being said. They found this upsetting because they worried staff might be speaking about them. We did not observe this during our inspection. Some young people worried that if staff left them to support another young person, this meant staff cared more for the other person. Some felt distressed over words staff used and if staff laughed together.

Staff understood and respected the individual needs of each child or young person. They spoke well to us about the young people in their care. They were able to describe what support worked well for their patients. They spoke with compassion and commitment to supporting their patients, even when they had been threatened, verbally abused, and assaulted.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards children and young people. We reviewed examples of staff intervening to prevent harm when the young people were disrespectful and unkind to one another.

Staff followed policy to keep patient information confidential.

Child and adolescent mental health wards

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission.

Staff involved children and young people and gave them access to their care planning and risk assessments. The young people told us they had been involved in developing their care plans and risk assessments. The patient care records we reviewed clearly showed the young person's views and we saw that staff offered young people a copy of their individual care plans.

The patient care records we reviewed showed that staff made sure children and young people understood their care and treatment and found ways to communicate with children and young people who had communication difficulties. Our observations of the multidisciplinary daily risk assessment meeting showed that staff understood the specific communication needs of their patients.

Staff involved children and young people in decisions about the service, when appropriate. There were opportunities to be involved in staff recruitment and activities across the provider network, such as the "People's Council". Young people gave examples of a previous patient becoming involved in provider activities at a national level.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Weekly meetings were held on the ward where the children were encouraged to shared their views and to give feedback to staff. These were typed and stored so staff and patients could refer back to them if they wanted to.

Staff supported children and young people to make decisions on their care. The patient care records we reviewed showed that staff encouraged the young people to participate in care planning meetings, reviews and important decision about their care.

Staff made sure children and young people could access advocacy services. All the young people we spoke with knew the advocate and how to make contact with them. They told us the advocate was easy to reach and supported them when they wanted support. Staff displayed posters in communal ward areas which advertised the independent advocacy service. We observed the advocate on the ward during our inspection.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with 3 family members, all of whom told us they had been involved in their relative's admission and in developing their care plans. They received advance warning of important meetings, were able to attend virtually or in person and they always received a copy of the minutes, though these could sometimes be delayed. Each told us that ward staff kept them up to date with their relative's progress and any incidents. They told us the consultant psychiatrist was responsive and listened to them. A family were distressed that their relative had recently instructed ward staff that they were no longer permitted to involve them in their care, but

Inspected but not rated

Child and adolescent mental health wards

told us that before this, Dragon ward was, “the best communicator, without a doubt” and “they are the most competent team we have worked with so far”. They felt able to compare several different hospitals. Another family member told us that on Dragon ward, “generally communication is great and is better than the previous 2 hospitals”. Family members told us they felt their children were subject to less physical restraint and rapid tranquilisation on Dragon ward than during admissions to other hospitals, which they felt was better for their child.

Staff helped families to give feedback on the service. Families and guardians were encouraged to attend care planning meetings and reviews where they were encouraged to contribute.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

Staff spoken with told us senior managers were visible and supportive. Examples included managers completing walk arounds at night and offering support to staff allocated to young people’s continuous safe and supportive observations. A staff member told us this is the safest place they have worked and managers ensured all staff were trained.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff reported effective and supportive team working across all disciplines. Agency staff told us they felt as supported as permanent staff.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

We observed effective management of risk through daily ward risk meetings that fed into the daily senior management meeting. The ward manager was able to access information in relation to staff training and supervisions. The ward team were able to access information they required, and the service used an effective system for care records.

The provider’s governance processes identified that staff did not always record incidents accurately. The provider identified 6 incidents of inaccurate recording in the 8 CCTV audits we reviewed. The provider took action to ensure staff learned from this and improved their incident recording.

Engagement

Inspected but not rated

Child and adolescent mental health wards

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

We saw the provider worked in collaboration with external partners, for example, case managers and social workers to develop effective care plans for the children and young people. Managers were involved in the local CAMHS provider collaborative.