Active Young People Limited

Ivetsey Bank Hospital

Inspection report

Ivetsey Bank
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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Ivetsey Bank hospital formerly known as Huntercombe Hospital Stafford is a child and adolescent mental health service for 37 male and female children and young people aged 12 to 18 years.

At an inspection in October 2021 this service was placed into special measures as we found the service to be inadequate overall. We inspected again in September 2022 and, we found improvements.

This was a focused inspection based on concerns that were raised with the CQC. We used the quality of life tool during this inspection. The quality of life tool was designed and is described on our website as being relevant for assessing the quality of a service for people with a learning disability and autistic people. This is now being trialled in settings where care is provided to a different population group.

The quality of life tool has not replaced our published methodology for assessing and evaluating the performance of registered providers, the Key Lines Of Enquiry remain in place under the 5 key questions as the focus of our inspections against the fundamental standards set out in the Health and Social Care Act 2008 regulations. The quality of life tool is being piloted for inspectors to assist them in emphasising good and poor care in line with our KLOES. We followed CQC guidance to make assessments and judgements on right support, right care, right culture'.

This inspection was a focussed inspection following patient safety concerns raised with us. The service will continue to remain in special measures.

Our rating of this location went down. We rated it as inadequate because:

- Staff did not always develop holistic positive behavioural support plans for those with a dual diagnosis, consisting of the young person's voice.
- Young people did not always receive care in their preferred manner.
- Staff did not always complete appropriate checks and records after young people had been injured after incidents.
- Staff did not always assess and manage risk well after incidents.
- Staff did not always label food safely and it was not always clear when food had been opened and when it should be consumed by.
- The service did not ensure all incident forms were an accurate description of incidents to identify and safeguard young people from the use of disproportionate force during incidents involving restraint.
- Not all areas of all ward were clean, and all furniture was not wipeable to meet infection control needs.
- The service governance processes did not always ensure that ward procedures ran smoothly. The processes in place did not always identify gaps in recording, gaps in patient checks and whether risk management plans had been updated after incidents had occurred.
- The service audit systems in place did not identify if all young people with a dual diagnosis had a positive behaviour support plan in place.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff actively involved patients in multidisciplinary meetings including ward rounds.

Summary of findings

- Staff worked as a team to de-escalate and support young people who were distressed using a range of methods including verbal de-escalation and distraction before using restraint.

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 	

Summary of findings

Contents

Summary of this inspection

Background to Ivetsey Bank Hospital

Ivetsey Bank Hospital Stafford is a child and adolescent mental health service provided by Active Young People Ltd. The provider took over the service on 28 February 2021 from the previous provider.

The service provides care for 37 male and female children and young people aged 12 to 18 years. The hospital admits informal and detained children and young people.

Ivetsey Bank Hospital consists of 3 wards; Hartley ward, Thorneycroft ward and Wedgewood ward.

Hartley ward is a psychiatric intensive care unit (PICU) providing 12 beds. The PICU unit offers care to children and young people suffering from mental health problems who require specialist and intensive treatment. There is an additional bed in the extra care area, which is attached to the ward, which can be utilised for young people who require long term segregation and was occupied at the time of our inspection.

Thorneycroft ward is a general child and adolescent mental health (CAMHS) acute assessment unit with 12 beds for young people aged 12 to 18 years. The children and young people treated there have a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm.

Wedgewood ward is a specialist eating disorder unit (EDU), which provides services for 12 children and young people. The children and young people treated here have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or other similar disorders.

Ivetsey Bank Hospital Stafford has a registered manager and is registered to provide the following regulated activities:

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

We most recently inspected the service in September 2022 and carried out a focussed follow up inspection. We rated the service as requires improvement overall, with key questions rated: safe, effective and well-led as requires improvement and caring and responsive as good.

At this inspection, we undertook an unannounced focussed inspection following concerns raised around patient safety of the following key questions:

- Are services safe?
- Are services caring?
- Are services well-led?

We visited the location on the 14 and 15 November 2022 during the day shift. Following the onsite inspection visits, we carried out remote interviews with staff members, carers and family members and further evidence gathering until 22 November 2022. We have taken enforcement action against the service following this inspection and we have requested immediate assurance from the provider.

Summary of this inspection

What people who use the service say

We spoke with 9 children and young people who use the service and 11 family members and carers.

Children and young people who use the service told us they felt the staff were kind and approachable, were kept up to date and involved in their treatment and were able to raise concerns if they had any. Three of the young people we spoke with told us they were encouraged to go to bed early during the weekdays and things were a bit more relaxed during the weekend. One patient who used the service told us they had access to the art room whenever they wanted.

All 11 family members and carers we spoke with felt they were kept informed with their loved one's treatment plan, but not all felt they had an active voice in the treatment plan.

Two family members felt sometimes a disproportionate amount of force was used during restraint.

Two family members raised concerns about possible head injuries during incidents where their loved ones banged their heads.

All family members knew how to raise a complaint or concern and the service fed back to them around actions taken.

One family member whose child recently moved from the service told us the service was unable to meet her child's needs and a delay in finding a suitable placement meant her child's treatment and recovery has been delayed. This was not due to a failure in the service but an issue with the space available at the service and alternative suitable services not being available.

How we carried out this inspection

During the inspection, the inspection team:

- visited all 3 wards and the extra care area, looked at the quality of the environments and observed how staff were caring for children and young people;
- spoke with 9 children and young people who were using the service;
- spoke with 11 family members and/or carers of children and young people using the service;
- spoke with the registered manager, a doctor, and ward managers for 2 wards;
- spoke with 14 other staff members including; nurses, support workers, music therapist and administrative staff.
- looked at 13 care and treatment records of children and young people;
- looked at 21 prescription cards;
- carried out observations on all 3 wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

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.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider 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 MUST take to improve:

- The service must ensure young people with a dual diagnosis of autism or a learning disability have an active detailed positive behaviour support plan in place that they are involved in. (Regulation 9)
- The service must ensure young people have access to psychology provision is available in their chosen style. (Regulation 9)
- The service must ensure staff clearly record injuries sustained during incidents on body maps. (Regulation 12)
- The service must ensure staff complete and record appropriate neurological checks after incidents where head injuries have been sustained. (Regulation 12)
- The service must ensure patient risk plans are detailed and updated after incidents. (Regulation 12)
- The service must ensure food consumed by patients is labelled correctly showing when it has been opened and when it should be consumed by. (Regulation 12)
- The service must ensure incident forms give an accurate description of incidents to identify and safeguard young people from the use of disproportionate force during incidents involving restraint. (Regulation 13)
- The service must ensure all areas of all wards are clean and furniture is wipeable to meet infection control needs. (Regulation 15)
- The service must operate effective systems or processes to ensure compliance with the requirements of the regulations. (Regulation 17)
- The service must ensure appropriate audit systems are in place to identify if post incident body maps are completed after injuries are sustained. (Regulation 17)
- The service must ensure appropriate audit systems are in place to identify if post incident neuro observations are completed after incidents of headbanging. (Regulation 17)
- The service must ensure appropriate audit systems are in place to identify if risk management plans have been updated after incidents. (Regulation 17)
- The service must ensure appropriate audit systems are in place to identify if all young people with a dual diagnosis have a positive behaviour support plan in place. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure that young people's belongings including clothes are stored effectively so it can easily be established who they belong to.
- The service should ensure family members and carers feel involved in the child or young person's care and treatment plan.
- The service should ensure medication audits are completed accurately and identify when out of date equipment is still in situ in the clinic rooms.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Not inspected	Requires Improvement	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Good	Inadequate	Inadequate

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Caring	Requires Improvement
Well-led	Inadequate

Are Child and adolescent mental health wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were 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. All wards had updated ligature risk assessments in place. Staff we spoke to were aware of the risks in ward areas and mitigation in place.

Staff could observe children and young people in all parts of the wards. Blind spots on the ward areas were mitigated using convex mirrors or placement of staff completing observations.

The ward complied with guidance and there was no mixed sex accommodation. All 3 wards had single sex bedroom corridors and separate bathrooms.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The service updated ligature risk assessments. Staff knew ligature points on the ward and knew the mitigations in place.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Not all ward areas were clean, well maintained, well-furnished and fit for purpose. Wedgewood ward had a footstool that had ripped and that could not be cleaned in line with infection control guidelines. The laundry room on Thorneycroft ward and Hartley ward was disorganised with piles of clothes on the washing machine that had not been labelled clearly. The storage room for additional patient items had piles of clothes that were not labelled clearly. This meant that there was an increased risk of soiled clothes not being cleaned safely and young people losing personal clothing items.

Staff made sure cleaning records were up-to-date. The cleaning records for all 3 wards were completed and the ward areas were generally clean. However, the records did not reflect what we found, and during our ward observations the

kitchen floor on Hartley ward was dirty and stained. The fridge on Hartley ward consisted of food not labelled correctly. The food in the fridge did not have labels on stating when they were opened and when they should be consumed by. Milkshakes that should be stored in a fridge were stored without labels outside the fridge. This meant there was an increased risk to patients having food that is not suitable and spoiled and could cause illness or be a risk to young people's health.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. The seclusion room was used for long term segregation at the time of inspection. Therefore, patients did not have access to seclusion facilities. The service recognised this was not an appropriate environment for long term segregation but had adapted the space to meet the young person's needs and maintain their dignity. This young person had access to a de-escalation room used as a lounge area, access to toilet and shower facilities and outdoor space.

Clinic room and equipment

Staff did not always check equipment. We found some clinical tests were out of date on all 3 wards which included urine test strips and blood vacuum bottles. Expired blood tubes should not be used for specimen collection. Expired tubes should be discarded because out-of-date tubes may have decreased vacuum (preventing a proper fill) or degraded additives. Underfill of the specimen collection tube could result in inaccurate test results. This increased the risk of inaccurate blood test results leading to incorrect or delay in treatment. This action was identified within the previous inspection carried out in September 2022 and has been included within the action plan developed by the service. The medication audits in place did not identify the out of date equipment in place.

Assessing and managing risk to children and young people and staff

Staff did not always use restraint and seclusion only after attempts at de-escalation had failed. Staff did not always assess and manage risks after incidents to children, young people and themselves well. However, the ward staff participated in the service's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool. However, staff did not review these regularly, including after any incident. 77% of the risk plans we viewed were not detailed and did not identify all areas of risk. There was no evidence these risk plans had been updated after incidents. Staff did not complete positive behaviour support plans for all young people with a diagnosis of autism (a positive behaviour support plan is a document created to help understand behaviour and support behaviour change in children and adults who have learning disabilities). We reviewed the records for 4 young people in long term segregation with a dual diagnosis of autism. Three of these young people had not had an active role in the development of their positive behaviour support plan. One of these had a blank template in place with no explanation of why it had not been completed or indication of when it will be completed. This did not meet the guidance within the Mental Health Act 1983: Code of Practice.

Management of patient risk

Staff did not always know about any risks to each child and young person and did not act to prevent or reduce risks. Risk management plans we reviewed were not updated regularly or after incidents. Eight out of the 13 risk management

plans had not been updated after incidents. Therefore, staff would only have the information given to them from the handover and would not have access to more detailed risk plans or strategies in place. This increased the risk of risk management plans and strategies not being followed and young people not receiving the right care and right support. Even though all staff attended a thorough and detailed handover before every shift, including a detailed handover on every child or young person and any incidents that had occurred on the ward this would only consist of detail within the last shift.

Use of restrictive interventions

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. We reviewed closed circuit television (CCTV) whilst on inspection as sexual safety concerns during restraint had been raised to us.

We saw that staff used de- escalation techniques when a child or young person became distressed or agitated, including verbal de- escalation, distraction techniques and swapping staff members. When staff had to use restraint, this was done in line with the services policy and procedures.

During observations on Thorneycroft ward we saw staff successfully work as a team and de-escalate a potential incident when a young person was distressed. Every ward clinic room had access to an ice machine that young people could use to self-regulate (ice can be used to self-soothe to help regulate disruptive emotions and benefit mental health).

We reviewed 8 incidents on CCTV and found 7 of these matched the account given on the incident record. However, one incident record did not match the footage viewed. This incident stated the young person had been physically aggressive towards staff before staff restrained the young person, however, the footage viewed did not show any physical aggression towards the staff members. Staff on the CCTV were viewed using a disproportionate amount of force when restraining the young person during de-escalation of an incident. Other staff present during this incident had not raised any concerns regarding this incident and although the service carries out random incident checks on CCTV on this occasion they had failed to identify and safeguard this young person from the use of disproportionate force during restraint. The service took immediate action to address this including suspending staff from shifts pending their investigation.

We also reviewed sexual safety concerns or complaints raised by children or young people after restraint. The service has received 12 complaints in the last 6 months, 2 have been around sexual safety raised by a young person. One of these was a historic complaint and the other is around the way staff spoke around a patient. The service had allocated an investigator to both complaints and the complaints process in place is being followed. This included the service giving the complainant feedback after the complaint had been investigated. Investigations included suspending staff until the complaint had been fully investigated, reviewing CCTV and interviewing staff and young people.

Staff followed The National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Records we reviewed showed staff completed appropriate physical health observations and monitored young people after administering rapid tranquilisation.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation (LTS). At the time of our inspection 4 young people were placed in LTS; 3 on Hartley ward and one on Thorneycroft. Two were in the seclusion suite and extra care suite respectively; 2 were segregated within

their child and adolescent mental health ward bedrooms. They were supported with extra staff and had access to outside space and other facilities. They could still participate in activities, including those outside of the hospital. Staff we spoke with understood how to manage the young people in LTS, so they were restricted as little as possible, but were also kept safe.

Safeguarding

Staff understood how to protect children and young people from abuse and worked well with other agencies or make appropriate referrals. Staff had training on how to recognise and report abuse. The provider had social worker who was the safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Staff adult safeguarding training compliance rates were at 95% and children's safeguarding rates were at 97%. This met the service compliance target rate of 80%.

Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns, they made appropriate referrals and informed all appropriate professionals.

During our review of CCTV, we found other staff present when a disproportionate amount of force was used to de-escalate an incident and the other staff failed to report or raise concerns.

Track record on safety

Staff recognised incidents but did not always and report them appropriately or complete appropriate post incident checks.

Staff knew what incidents to report and how to report them. All staff had access to the services incident reporting system to report an incident and incidents were discussed at every handover.

Staff did not raise concerns and reported incidents and near misses in line with service policy. Staff did not always complete body maps after incidents and restraint. Staff did not complete body maps after injuries had been sustained following an incident.

We reviewed 42 incidents in the last 2 months where children or young people had injured themselves after an incident or self-harm and there were no body maps in place. Children and young people on the wards had injuries and bruises from self-harm incidents but did not have body maps completed. This would make it difficult to establish if a wound was healing effectively, if further injuries had been sustained due to other incidents or if the patient required further medical attention. The service incident reporting policy in place guided staff to complete body maps, update the young person's observation levels and risk plans after incidents.

Staff did not always complete neurological observations (neurological observations are a collection of information on the function and integrity of a patient's central nervous system-the brain and spinal cord) after incidents involving head injuries. We reviewed 8 incidents where patients had banged their heads, but staff had not completed neurological observations to monitor the young person's health. This would make it difficult to establish the impact of the head injury and determine if the young person required further medical attention.

Inadequate

Child and adolescent mental health wards

Are Child and adolescent mental health wards caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity but did not always respect their preferences. 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. During observations on all wards staff were being responsive to the young people. We saw staff supporting young people who were beginning to feel unsettled and de-escalate situations by working as a team and with the young person.

Staff gave children and young people help, emotional support and advice when they needed it. We observed staff emotionally supporting young people when they were distressed and giving them time to respond. During observations we saw a young person crying. A staff member sat with them trying to get them to talk by talking gently to them. The person walked out, the staff member left them for about 90 seconds then followed them, the young person came back in and had stopped crying.

Staff supported children and young people to understand and manage their own care treatment or condition. The wards had 2 weekly multidisciplinary team meetings that patients and family members could attend. Wedgewood ward had templates that the young people could complete before attending the meeting where they could log their progress and log what they would like help with. Eight young people and their carers told us they had attended these meetings and were involved in treatment plans. However, 3 carers or family members felt even though they attended these meetings their views weren't listened to and communication could be better.

Children and young people said staff treated them well and behaved kindly. None of the children and young people we spoke to raised concerns about the way staff treated them. One carer raised concerns about the force used to restrain a young person and the injuries this caused. We reviewed these records and found the service had logged the incident and recorded injuries sustained. A patient told us they could use the art therapy room when ever they wanted to and there was an art therapist that visited the wards.

The service understood and respected the individual needs of each child or young person.

The service had initiatives in place on all wards such as an equalities board and the children and young people had created a handprint wall where young people who were discharged from the service left encouraging messages.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. All staff we spoke to knew how to raise concerns and felt confident in doing so.

Involvement in care

Inadequate

Child and adolescent mental health wards

Staff had meetings in place where young people and their families could give feedback on treatment but young people and family members were not always actively involved in care planning and risk assessment. Staff 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 showed young people around the ward as part of the admission process and informed them of school times mealtimes etc. Carers and parents were also encouraged to have a look around the ward and see the environment the young person will be in. Children and young people were encouraged to attend 2 weekly multidisciplinary meetings to discuss progress and treatment plans. One family member told us the hospital did not allow them to visit their child the first 2 weeks after admission. However, when we spoke to the service, they stated this is not the case but may be requested rarely for clinical reasons. The services admission policy promoted the least possible separation from family, carers, friends and community.

Staff did not always involve children and young people and gave them access to their care planning and risk assessments. Nine patient records we reviewed showed an active voice of the young person. However, 4 young people, 3 of who were on long term segregation did not have a positive behaviour support plan in place. The service was not guaranteeing autistic young people choices and independence in their care. The service did not have an on-site lead psychologist to support these young people to have an active voice in this plan. Three health care assistants we spoke with told us they do not have access to patient notes and only had the information given to them at handover. The handover documents we viewed gave a detailed account on every young person including current risks, incidents and their general wellbeing.

Staff involved children and young people in decisions about the service, when appropriate. Each ward had weekly community meetings and 'you said, we did' boards were in place, showing actions and changes the service had made following feedback. Actions from the previous week were also discussed at meetings to ensure they were addressed.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Children and young people were encouraged to give feedback at the weekly community meetings where they were also reminded about the complaints policy and access to advocacy support.

The service did not have the right staff supporting children and young people to make decisions on their care. There was no psychologist on site to support the young people complete the risk formulation part of the positive behaviour support plans. The service had assistant psychologists on site who provided the remote psychologist with this information. This was an issue highlighted at the last inspection and at this inspection we found there was still no on-site psychologist. The manager of the service told us they were reviewing the remote lead psychology service and were hoping to recruit on-site support. The service was not guaranteeing autistic young people choices and independence in their care.

Staff made sure children and young people could access advocacy services. Every ward displayed how young people could access advocacy services and this was discussed weekly at the ward community meetings.

Involvement of families and carers

Carers and family members did not always feel staff involved them appropriately.

Inadequate

Child and adolescent mental health wards

Staff informed families or carers but did always involve them. All families or carers were invited to attend multidisciplinary meetings to discuss treatment plans but not all felt their views were listened to. Three carers or family members we spoke to felt even though they attended these meetings their views weren't listened to and communication could be better. Two family members raised concerns around possible injuries caused during incidents involving head banging. One family member whose child is no longer at the service felt the service could not meet their child's needs and several incidents occurred due to a suitable placement not being found.

Staff helped families to give feedback on the service. All families and carers we spoke to knew how to make a complaint and were given feedback after issues had been investigated.

Are Child and adolescent mental health wards well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, however they had lost oversight of the safe care of patients through not properly auditing processes to check post incident support was carried out correctly. 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. All staff and young people knew who the manager of the service was and told us the manager had an active presence on the wards.

Vision and Strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Six staff we spoke to knew the hospitals vision and strategy and knew where they were displayed.

Culture

All staff we spoke to felt respected, supported and valued. Staff told us there were programmes in place to assist their progress. **They could raise any concerns without fear.** The service had a freedom to speak up guardian in post and staff told us they knew how to access this service (freedom to speak up guardians support workers to speak up when they feel that they are unable to do so by other routes).

Governance

Our findings from the other key questions did not demonstrate that governance processes operated effectively at a hospital level and that performance and risk were not managed well.

There were high levels of risk across the service and the governance response was not adequate to meet the needs of patients. Staff reported incident into the incident reporting system, but managers did not always review them proportionately and make appropriate decisions to notify stakeholders.

Inadequate

Child and adolescent mental health wards

When reviewing records, we requested further information regarding incidents where we found the service had not notified CQC of all reportable incidents. There was an increased risk of staff not recognising the seriousness of all incidents and therefore not informing relevant stake holders, families or carers in line with their policy. This meant the service was not always open and transparent about incidents.

There was not a clear process in place around identifying if staff had effectively completed body maps after injuries had been sustained following an incident.

The governance processes in place did not identify if staff had completed neuro observations after incidents where young person had sustained a head injury. The governance processes in place did not escalate if staff had updated a young person's risk plan after an incident.

The service had monthly clinical governance meetings where incidents data and trends were discussed. However, these discussions did not include post incident documentation or checks including neurological observations or body map completion.

The monthly medication audit process in place did not identify if there was any out of date clinical equipment in the clinic rooms.

Annual appraisal rates were at 93%. Staff received regular clinical and management supervision, with compliance at 91%. The manager had oversight to ensure these were completed. These were above the service target of 80%.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care.

The care records program was not working effectively due to a national program issue and the service had put a plan in place to temporarily support the staff team until the system was fixed.

However, appropriate and accurate information was not effectively processed, challenged and acted on therefore risk management plans in place did not reflect patient needs. Staff were not updating the information and risk management plans after incidents and not completing post incident checks in line with the service policy.

Engagement

Managers engaged actively with 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. Despite the service having monthly meetings in place with local commissioners and being offered regular oversight and support from partners, the service was unable to identify gaps in records and observations**.**

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 HSCA (RA) Regulations 2014 Premises and equipment Not all areas of all wards are clean and furniture was not always wipeable to meet infection control needs.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not ensure young people with a dual diagnosis of autism or a learning disability had an active detailed positive behaviour support plan in place that they were involved in The service did not ensure young people had access to psychology provision available in their chosen style.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not operate effective systems or processes to ensure compliance with the requirements of the regulations. The service did not ensure appropriate audit systems were in place to identify if post incident body maps were completed after injuries were sustained. The service did not ensure appropriate audit systems were in place to identify if post incident neuro observations were completed after incidents of headbanging. The service did not ensure appropriate audit systems were in place to identify if risk management plans had been updated after incidents. The service did not ensure appropriate audit systems were in place to identify if all young people with a dual diagnosis had a positive behaviour support plan in place.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure staff clearly recorded injuries sustained during incidents on body maps. The service did not ensure staff completed and recorded appropriate neurological checks after incidents where head injuries had been sustained. The service did not ensure patient risk plans were detailed and updated after incidents. The service did not ensure food in patient areas was labelled correctly showing when it has been opened and when it should be consumed by.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure incident forms gave an accurate description of incidents to identify and safeguard young people from the use of disproportionate force during incidents involving restraint.