Priory Hospital Blandford

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Inadequate**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker

Chief Inspector of Hospitals

Overall summary

We rated Priory Hospital Blandford as inadequate because:

- CQC took enforcement action and issued a warning notice due to concerns about the safety of young people at the hospital. Staff did not have a detailed understanding of the specialist nature of a learning disability CAMHS service. Staff did not comprehensively assess the risks of the young people accessing the service. We reviewed risk documentation for seven young people on the wards and found inadequate assessment and documentation of risk in all records. Staff and young people said that they felt unsafe on the wards and that there had been patient on patient assaults and bullying, and assaults on staff. Many staff did not have the experience and skills to manage the complex presentation and needs of the young people on the ward.
- Pre-admission assessment was not comprehensive enough to ensure all information about risks and needs of young people was available to staff. Following admission, staff did not always complete initial assessments in a timely manner and the assessments lacked detail meaning information around young person's needs could get missed. Care plans were not young people centred; nursing staff had not written them in the young person's voice. There was a lack of young people's views and discussion recorded in the plans, so it became unclear how staff devised the plans with young people.
- The hospital had found it difficult to recruit permanent staff and there was therefore a heavy reliance on agency workers many of whom had little knowledge or experience of working with young people who had learning disabilities and autism and complex needs. This also impacted on the continuity of care being delivered. Not all agency staff received appropriate training or regular supervision.
- The garden for Oak Ward was not safe and hazards in the garden were impacting on the behaviours of young people and the response by staff. There were loose bricks and nails that young people had made attempts to use as weapons or could use to harm themselves; staff had restrained young people to prevent potentially dangerous situations occurring.
- Incidents showed inappropriately high use of physical restraint as an intervention. There had been 138 restraints out of 250 incidents involving eight different young people over a three-and-a-half-month period. Staff did not report all incidents, particularly around physical assault and racial abuse and the quality of reports were poor. This meant that incidents could be missed and therefore not escalated to external bodies such as safeguarding or CQC.
- Staff did not follow procedures for monitoring young people in long term segregation (LTS) as set out in the Mental Health Act 1983: Code of Practice. Records showed that medical staff did not always prescribe and administer medicines in accordance with agreed treatment plans. Staff had continued to give a young

Summary of findings

person medication beyond an agreed date to stop the medication because the prescribing doctor had not discontinued the prescription. Arrangements were not in place to ensure this could not happen. This meant that medication could be being given unlawfully.

- Young people said that communication with them was poor. There was poor and disconnected communication around planning care and treatment from staff to young people. Staff did not plan discharge effectively and there was limited evidence of discharge planning in the care records. The hospital had not planned effectively for the transfer of a young person to an adult hospital for a young person approaching their 18th birthday.
- The hospital did not, at the time of the inspection, have the ability to provide safe and effective support to young people with an eating disorder, this was due to delays in support from a dietician. At the time of the inspection the service did not have an occupational therapist. This meant that young people did not have assistance coping with the effects of their disability on various activities and occupations. The hospital had previously arranged for a sensory trained occupational therapist from another Priory hospital, but this had stopped.
- Some young people told us that the staff did not treat them well and did not behave in a caring manner towards them. Young people spoke about not being involved with care planning or their treatment. Young people said that there was limited activity on the wards and that they often got bored. Young people said that the food was poor quality. Families we spoke with said that they found the service disorganised.
- At the time of the inspection the hospital was not well-led. The leadership team did not have a clear understanding of the issues on the wards. Staff did not feel supported by the leadership team. Staff said they did not feel safe, listened to or supported by managers.
- The governance arrangements were not robust and did not provide assurance or provide information or support improvement to the quality of the service or protect young people from avoidable harm. Quality walk rounds, and audits of records had not addressed issues with safe and effective record keeping or helped young people feel safer on the wards.

However:

- Staff had assessed the environment for ligature risks and rated the risks to identify if action needed to be taken to reduce, mitigate or remove the risk. The hospital complied with guidance on same sex accommodation, was visibly clean and staff were able to observe all parts of the ward.
- Staff followed procedures to monitor physical health after the administration of rapid tranquilisation. Staff monitored young people's physical health at agreed intervals and responded to changing physical health concerns. Staff used recognised rating scales such as Health of the Nation Outcome Scales Child and Adolescent (HONOSCA) and the Children's Global Assessment Scale (CGAS).
- Young people's medicines were stored safely, and staff followed procedures to monitor physical health after the administration of rapid tranquilisation.
- Staff demonstrated a knowledge of the Mental Capacity Act and Gillick Competency.
- The hospital had committed to only admitting a low number of young people on opening and to building the number of young people slowly as staff were recruited and their ability to meet complex needs developed.
- The education area was well equipped and staffed by teachers that helped young people keep up to date with school work.
- The new hospital director told us they were keen to provide increased support and supervision to the staff team. They had brought in 'Treat Tuesday' to boost morale, buying the staff team doughnuts for example. The provider had a risk register and business continuity plan in place which helped them manage risks. The hospital had set up a 'your say forum' for staff to feedback.

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 	Child and adolescent mental health wards have been rated as inadequate due to concerns around risk management, assessment and safety. Young people had a negative experience at the hospital and felt unsafe.

Summary of findings

Contents

Inadequate

Priory Hospital Blandford

Services we looked at
Child and adolescent mental health wards

Summary of this inspection

Background to Priory Hospital Blandford

Priory Hospital Blandford is a Tier 4 (inpatient) child and adolescent mental health learning disability hospital for young people up to the age of 18 who have a learning disability or autism diagnosis as well as a mental health problem. The service has two wards, Oak and Ash and is registered to provide treatment to young people detained under the Mental Health Act and treatment for disease disorder or injury.

The hospital opened in September 2018. There has recently been a change in senior leadership in the hospital as there were concerns with the previous leadership.

This is the first time the hospital has been inspected and so is the first time it has received a rating.

Our inspection team

The inspection comprised two inspectors, one Mental Health Act reviewer and one specialist advisor with specific experience of working in child and adolescent mental health. A CQC pharmacist also inspected medicines management at the hospital as part of the inspection although this took place a few days after the main inspection, but this was still within the inspection window.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

During the inspection visit, the inspection team:

- spoke with the hospital director and the registered manager
- interviewed the clinical services manager
- facilitated a focus group with staff
- observed a flash meeting, a multidisciplinary team meeting and a Care Programme Approach meeting (CPA)
- reviewed seven sets of care records and all prescription charts
- spoke with three carers/family members of young people staying in the hospital
- spoke with four young people
- undertook seven interviews of nursing staff and nine support workers
- interviewed the social worker, occupational therapy assistant and Mental Health Act administrator and
- spoke with the head of quality.

Summary of this inspection

What people who use the service say

Some young people did not feel safe on the wards at Priory Hospital Blandford. They told us the staff did not treat them well and did not behave well towards them. Young people were not complimentary of their treatment. One young person felt that the hospital had not helped them, and staff had left them alone to look after themselves. Young people said that staff stayed in the office and they could hear staff talking about their care. Another felt staff were not interested in them. Young people used phrases such as feeling degraded, that staff were not caring, that there was no compassion and that they felt distressed at their treatment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Staff did not comprehensively assess the risks of the young people accessing the service. We reviewed risk documentation for seven young people on the wards and found inadequate assessment and documentation of risk in all records. Staff did not create sufficiently detailed risk management plans to help manage risks such as self-harm and violence on the wards.
- There was a high number of assaults on staff. The hospital was failing to adequately assess and manage young people's risks. Wards were unsafe for young people and staff. Staff and young people said that they felt unsafe on the wards and that there had been patient on patient assaults and bullying, and assaults on staff.
- The garden for Oak Ward was not safe and hazards in the garden were impacting on the behaviours of young people and the response by staff. There were loose bricks and nails that young people had made attempts to use as weapons or could use to harm themselves, so staff had restrained young people to prevent potentially dangerous situations occurring.
- The hospital had found it difficult to recruit permanent staff and there was therefore a heavy reliance on agency workers many of whom had little knowledge or experience of working with young people who had learning disabilities and autism and complex needs. At the time of the inspection, the hospital had just two registered nurses and two that were waiting to start.
- Pre-admission assessments were not comprehensive enough to ensure all information about risks and needs of young people was available to staff. Staff screened referral forms prior to accepting young people onto the ward, however, young people had been admitted with needs that could not be adequately met.
- Incidents showed inappropriately high use of physical restraint as an intervention. There had been 138 restraints out of 250 incidents involving eight different young people over a three-and-a-half-month period. Information from the restraint thematic review conducted by CQC outside of this inspection showed an average of 16 restraints per month for every 10 occupied beds in a CAMHS inpatient service.

Summary of this inspection

- Staff did not follow procedures for monitoring young people in long term segregation (LTS) as set out in the Mental Health Act 1983: Code of Practice. Reviews did not happen as prescribed and it was not clear who had conducted them.
- Records showed that medical staff did not always prescribe and administer medicines in accordance with agreed treatment plans. PRN care plans lacked detail to support staff around the administration of these medicines, this especially related to young people prescribed multiple sedatives.
- Staff did not report all incidents that occurred on the wards. Staff used an electronic record system to record higher level incidents. Lower level incidents including staff assault and racism had become normalised which meant that staff no longer considered them reportable.

However:

- Staff had assessed the environment for ligature risks and rated the risks to identify if action needed to be taken to reduce, mitigate or remove the risk. The hospital was visibly clean, and staff were able to observe all parts of the ward.
- Staff received mandatory training in essential areas of practice such as in basic life support, prevention and management of violence and aggression and breakaway.
- The hospital had a policy on observations that staff followed. Staff used observations to engage with young people and to observe and assess their mental health.
- Staff received mandatory training in safeguarding and demonstrated an awareness of how to raise a safeguarding alert.
- Young people's medicines were stored safely, and staff followed procedures to monitor physical health after the administration of rapid tranquilisation.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- Young people said that communication was poor between staff members and young people. We found that there was poor and disconnected communication around planning care and treatment for young people. Young people and their families

did not feel well informed about changes in care and decisions had been made individually, outside of the team. Poor communication had increased anxiety for young people and their families.

- Staff did not always complete initial assessments in a timely manner. Assessments lacked detail meaning information around young person's needs could get missed.
- Care plans did not address risks or focus on recovery, they lacked detail and staff did not always follow them. Care plans were instructional in nature, nursing staff had not written them in the young person's voice. There was a lack of young people's views and discussion recorded in the plans, so it became unclear how staff devised the plans. Although positive behavioural support plans were in place, staff lacked the skills to manage the risks and the complex needs of the young people, so the plans could not be followed appropriately.
- The hospital did not at the time of the inspection provide safe and effective support to young people with concern around their eating. There was evidence of a young person losing weight due to a lengthy delay in treatment. There was no dietician or occupational therapist.
- Not all staff received regular supervision. Night agency staff told us that they had gone several months without being supervised.
- At the time of the inspection the service did not have an occupational therapist. This meant that young people did not have assistance coping with the effects of their disability on various activities and occupations. The hospital had previously arranged for a sensory trained occupational therapist from another Priory hospital, but this had stopped.

However:

- Staff provided a number of treatments in line with National Institute for Health and Care Excellence (NICE) guidance. This included a mixture of medication and talking therapies such as those provided by a clinical psychologist, family therapist and speech and language therapist. However, young people told us there was a general lack of general therapeutic activities to keep them occupied.
- Staff monitored young people's physical health at agreed intervals and responded to changing physical health concerns.
- Staff used recognised rating scales such as Health of the Nation Outcome Scales Child and Adolescent (HONOSCA) and the Children's Global Assessment Scale (CGAS) to show positive outcomes for the young people who use the service.

Summary of this inspection

- The service had a multi-disciplinary team in place, the team inducted new staff and there was opportunity for some professional development.
- Staff demonstrated a knowledge of the Mental Capacity Act and Gillick Competency.

Are services caring?

Inadequate

We rated caring as **requires improvement** because:

- Some young people did not feel safe on the wards. Young people said that the staff did not treat them well and did not behave well towards them. Young people used phrases such as feeling degraded, that they were not caring, that there was no compassion and that they felt distressed at their treatment.
- Young people spoke about not being involved with care planning or their treatment. There was confusion about the plan for one young person that had resulted in them and their family not being clear about the next step in the young person's journey.
- Families we spoke with gave feedback that the service was disorganised and 'appalling' and that different staff told them different things.

However:

- Young people had been involved in the recruitment of staff by sitting on an interview panel. There was a tuck shop staffed by the young people.
- Young people had been provided with information about the hospital on admission and staff involved them in a community meeting to identify preferred activities.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Staff did not plan discharge effectively and there was limited evidence of discharge planning in the care records. For example, the discharge planning in a 'keeping connected' care plan was not present and in another there was inadequate planning or explanation around discharge.
- The hospital had not planned effectively for the transfer of a young person approaching their 18th birthday to an adult hospital. The young person would transition to adult services on this date and staff had not prepared for a transfer in good time.

Summary of this inspection

- Young people expressed that there was limited activity on the wards and that they often got bored. Two young people complained about the lack of activity and that the groups were poor quality.
- Young people said that the food was poor quality. The hospital had responded to this to help young people feedback to the chef about food choices.
- Young people said that they could hear staff talking about treatment in the staff office. This meant that confidentiality of young people could be breached.

However:

- The hospital had committed to only admitting a low number of young people on opening and to building the number of young people slowly as staff were recruited and their ability to meet complex needs developed.
- Staff ensured young people's beds were kept free when they went out on leave. Staff told us that young people were only moved between wards if it was clinically necessary.
- The education area was well equipped and staffed by teachers that helped young people keep up to date with school work.
- Staff provided young people with information essential to their care, for example information on medication or leaflets on how to make a complaint.
- There was the opportunity for young people to access spiritual support if they desired.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The staff had not been supported to develop the experience and skills to manage the complex presentation of the young people on the ward. Specialist training had not equipped staff with the skills to work effectively with managing risk, restraint, assessment or care planning.
- At the time of the inspection the hospital was not well-led. The leadership did not have a clear understanding of the issues on the wards with a clear disconnect between staff and managers. Not all staff were aware of hospital values.

Summary of this inspection

- The ward staff did not feel supported by the leadership team, they said they did not feel safe, listened to or supported by managers following incidents. They felt that concerns raised around staffing and support around care for specific young people were not listened to.
- The governance arrangements were not robust and did not provide assurance or provide information or support improvement to the quality of the service or protect young people from avoidable harm. The arrangements in place to review concerns had not triggered the senior management team to address safety issues such as high levels of staff assault and restraint.
- Quality walk rounds, and audits of records had not addressed issues with safe and effective record keeping or helped young people feel safer on the wards. The reviewing of the care notes by the Head of Quality aimed at auditing quality of care plans and their content had not improved their completion or depth but had found a lack of individualisation.

However:

- The new hospital director told us that she was keen to provide increased support and supervision to the staff team. The previous leadership of the hospital had created an unstable staffing team. The new hospital director had been brought in because she had experience of working within the Priory and because of her background in CAMHS.
- The hospital director had brought in 'Treat Tuesday' to boost morale within the team and increase staff feeling valued, for example buying staff doughnuts. Staff demonstrated awareness of the whistleblowing process.
- The hospital had set up a learning and outcomes group to review and share learning on incidents and complaints. The hospital had set up a 'your say forum' for staff to feedback.
- The provider had a risk register and business continuity plan in place.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff received some training in the Mental Health Act and demonstrated awareness of sections and requirements of the Act. The MHA Administrator had systems in place to deal with the requirements of the MHA and all legal documentation was in good order.

The hospital had policies and procedures in place for the MHA and there was access to these for staff working on the wards. Flash cards with MHA information on had been made for support workers.

Staff explained young people's rights under Section 132 of the act, this occurred with there was a change in treatment or every three months. There was access to an Independent Mental Health Advocate.

Staff had continued to give a young person medication beyond an agreed date to stop the medication because the prescribing doctor had not discontinued the prescription. Arrangements were not in place to ensure this could not happen. This meant that medication could be being given unlawfully.

Staff did not follow procedures for monitoring young people in long term segregation (LTS) as set out in the Mental Health Act 1983: Code of Practice. The site had a high dependency area that staff had used for LTS for two young people since the hospital had opened.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act applies to young people aged 16 or over. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the young person where possible in the decision making regarding their care. However, we did not see any documentation of these decisions.

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- Staff had assessed the environment for ligature risks and rated the risks to identify if action needed to be taken to reduce, mitigate or remove the risk. The assessment was redone every six months. The hospital was fitted with anti-ligature fittings such as collapsible bathroom doors and curtain rails. Staff further mitigated the risks by observing young people and the ward. The provider had committed to convert all bedrooms to a safer standard, for example changing the window glass. Three rooms within the hospital met the safer rooms specifications and there was a plan to convert all rooms to by the end of 2019. There was a high dependency area that was used for long term segregation, this was in use at the time of the inspection.
- The garden for Oak Ward was not safe. There had been incidents where young people had been able to lift the bricks out of the patio which could be used to harm staff, other young people or themselves. Staff had told us that young people found nails in the garden and had also used wood chip to self-harm. We reviewed incidents and found that staff had used restraint to prevent items being picked up in the garden, they had also used restraint to retrieve items taken from the garden. The issues in the garden were impacting on the behaviour of young people and therefore the response from the team. The hospital manager was aware of the risks presented by the garden and had planned to address them. However, there was no timeline for completion at the time of the inspection. The immediate risks presented by the garden were included as one of the issues in the warning notice that CQC served immediately following the inspection.
- The wards layouts allowed staff to easily observe the ward areas, there were convex mirrors to help staff observe harder to see areas and round corners more easily.
- The ward complied with guidance on same sex accommodation. Young people had access to their own ensuite bathroom.
- Staff had access to alarms to call for assistance and to summon help in an emergency. There were call points around the hospital. Due to some young people's sensitivity to noise the alarms did not sound out loud. Staff received a message on a pager to direct them to where help was needed.
- The hospital was visibly clean, furnishings were clean and well maintained. Cleaners worked daily to keep the hospital presentable and clean and signed records to confirm when areas were cleaned. However, young people told us that the toilets were often dirty; we did not find this at the inspection.
- Staff adhered to infection control principles, the hospital displayed handwashing signs. Clinical waste bags and sharps boxes helped staff dispose of clinical items appropriately.
- Staff had access to resuscitation equipment and emergency drugs and were trained in their use. Staff checked equipment to ensure that it worked.

- The hospital had well equipped clinic rooms and staff kept them clean and tidy. Equipment was well maintained and checked regularly.

Safe staffing

- Hospital managers had found it difficult to recruit permanent staff, therefore there was a heavy reliance on agency workers which had a risk of impacting on continuity of care. There was a 63% vacancy rate for registered nurses at the time of the inspection; the hospital had just two registered nurses and two that were waiting to start. The registered manager had found it easier to recruit support workers and as a result, there was only 1.5 WTE vacancies for the hospital. There were vacancies for an occupational therapist, ward manager and an occupational therapy assistant. There was a recruitment plan in place.
- Because of the high vacancies the hospital had recruited ad-hoc agency and agency staff on block booked contracts. They worked with the agencies to review these contracts month by month. Two of the seven agency nurses booked had been recruited from a specialist child and adolescent mental health agency. However, due to the increased observations and risks on the ward there had been ad-hoc agency staff used. The night shift at the time of the inspection had only agency nurses working on Oak Ward and only one substantive staff member in the team on Ash. Staff told us, and we found, that some shifts were run exclusively on agency staff.
- Agency staff had a local induction and observation competency assessment prior to working on the wards. However, permanent staff said that they did not find the agency workers had the necessary skills and competency and that they spent a lot of time inducting new and ad-hoc agency staff onto the ward.
- The hospital staffing numbers varied according to risk on the wards. There was a staffing ladder in place that was used to increase the number of staff if required. For example, if a young person required one to one observation. Staff worked long days, but the hospital was consistently meeting the minimum staffing required for the wards. There was one incident over the previous three months recorded that highlighted an understaffed shift.
- A registered nurse was available on the ward throughout the day and night. Young people said there were enough staff for them to take leave and have one to ones. However, they said that staff often stayed in the ward office.
- There were enough staff to perform physical interventions such as restraint. However, staff expressed concern that if there was more than one restraint taking place at any given time then then they were unable to provide care for the other young people on the ward and that they needed additional resources. Staff said that this increased anxiety for the young people on the wards.
- A ward doctor was available 24 hours a day and there was a consultant psychiatrist on call to summon further specialist mental health expertise if needed.
- Staff received mandatory training in essential areas of practice such as in basic life support, prevention and management of violence and aggression and breakaway. Two staff members received immediate life support training. Seventy-five per cent of staff had completed basic life support training and there was a plan in place to provide more staff with this training.

Assessing and managing risk to young people and staff

- Due to the number of concerns with assessment of management of risk to young people, CQC issued a warning notice that included this as one of the issues requiring immediate improvements to the care of young people. The warning notice included initial assessment, risk assessment and management of risk that had failed to keep young people and staff safe on the ward. There was a high number of assaults on staff and a high use of restraint.
- Staff did not comprehensively assess the risks of the young people accessing the service. We reviewed risk documentation for seven young people on the wards and found inadequate assessment and documentation of risk in all records. The Priory group policy for management of disturbed/violent behaviour stated; 'A comprehensive risk assessment must be carried out to manage violence and aggression. The process of assessing risk comprises a number of elements, including direct assessment by medical and nursing colleagues – both separately and together, collection of

background information and accessing and utilising other sources of information'. The risk assessments lacked detail or formulation of risk information. For example, care records showed there was only ticking and rating of risks with no explanation of what the risks were. One record out of seven had a formulation of risk but this was brief.

- We reviewed initial referrals into the service and found that risks highlighted on referral had not been transferred or explained in the risk assessment. Measures had not been put in place to manage identified risks. For example, a young person had risks such as auditory and visual hallucinations, self-harm by cutting, intrusive thoughts, suicidal ideas and poor diet identified. However, these were not reflected in their risk assessment which would have given staff the opportunity to be more aware and able to manage the risks more effectively.
- During inspection, staff and young people told us that they felt unsafe on the wards and that there had been patient on patient assaults and bullying, and assaults on staff. One young person was scared to attend education due to not feeling safe. We requested incident information for the previous three months and on top of patient on patient assault and bullying, there had been 23 officially documented assaults on staff. However, incident detail showed that there were far higher staff assaults recorded, at least a further 49 incidents on top of the 23 reported classified staff assaults out of 250 recorded incidents. Staff reported that they did not always record low level physical assault or racial abuse as it a had become a normal part of their working day and that nothing had changed when they had recorded it. This made it increasingly difficult to find the true picture of the safety of the wards and that the situation escalated to management was not accurate. One staff member told us that it was a matter of time before a serious injury to a staff member.
- Staff were not managing the risk and violence of the young people on the wards effectively. Staff did not create sufficiently detailed risk management plans to help manage risks such as self-harm and violence on the wards. The risk management plans we reviewed were missing in some cases, vague and lacked detail of how to manage risk or to recognise a change in risk.
- Following the inspection, the head of quality stated that risk assessment and management plans should have contained information around young people's triggers, for example a situation that might cause a young person to self-harm, and more explanation of risk factors in the formulation. This is reflected in National Institute for Health and Care Excellence (NICE) guidance on violence and aggression. While the Nursing and Midwifery (NMC) Council Code of Practice states nurses should 'identify any risks or problems that have arisen, and the steps taken to deal with them, so that colleagues who use the records have all the information they need'.
- Positive behavioural support (PBS) plans were not used effectively to manage risks and there was a high level of incidents of assault and restraint. Young people had PBS plans in place to help staff work towards managing behaviour and incorporated an element of risk management. However, due to the high amount of assault and restraint, these were not used effectively to manage young people's risk and challenging behaviour and clinical documentation did not reflect that staff were using PBS in the management of violence and aggression.
- Pre-admission assessments were not comprehensive enough to ensure all information about risks and needs of young people was available to staff. Staff screened referral forms prior to accepting young people onto the ward, however, staff admitted young people that were not appropriate. For example, initial assessment had not identified an eating risk in one young person and staff felt that had they known this risk then they would not have accepted the referral. Because of accepting the referral there was a delay in the care of this young person that had proved detrimental to the young person's health.
- The daily 'flash meeting' allowed the multidisciplinary team to review risks on the wards, incidents, leave and visits, however, the meeting proved to be ineffectual in its ability to manage risk. Young people had their risk rated, and then staff rated the risks of the ward. For example, if the ward was a red risk then the team considered getting extra staff or how best utilise the current staff to bring down the risk on the wards. However, staff said there continued to be an environment where staff felt that they were reactive to incidents rather than providing effective care.

Inadequate

Child and adolescent mental health wards

- The hospital had a policy on observations that staff followed. Staff used observations to engage with young people and to observe and assess their mental health. They changed observations according to risk, for example, using one to one observation if there was an increased risk to self. An external company called Care Protect monitored cameras placed in communal areas and rooms. Staff asked Care Protect to monitor bedroom cameras if they felt there was an increased risk to the young person. Staff sought consent of young people for cameras being turned on in their bedroom. Care Protect fed back areas of good practice and areas of poor practice and safeguarding concerns that required extra review.
- Staff conducted searches on young people on admission but individually assessed the need for searches thereafter. There was a banned item list which included pictures of items so that young people and families or carers knew what they could bring on the wards. There was a searching policy in place and staff needed to complete a competency assessment prior to searching young people as part of their practice.
- The hospital recently had brought in 'safewards' to help reduce restrictive practice on the wards by training staff in using soft words, de-escalation, positive words as well as key aspects concerning relational security and positive behavioural support plans, but this had not been embedded at the time of the inspection. Safewards is an evidence based clinical model that introduces a number of interventions that increase safety and reduce coercion, improves relationship between staff and patients, resulting in fewer incidents, making wards more peaceful places. Staff were open to reducing restrictive practices and gave an example of individual restrictions rather than blanket restrictions.
- Incidents showed high use of physical restraint as an intervention. There had been 138 restraints out of 250 incidents involving eight different young people, over a three-and-a-half-month period. Information from the restraint thematic review conducted by CQC outside of this inspection showed an average of 16 restraints per month for every 10 occupied beds in a CAMHS inpatient service. However, the numbers submitted by the hospital did not reflect the true picture, with multiple restraints reported on one form or incidents that had not be classified as physical intervention used. For example, we reviewed one incident that had been classified as a single restraint but showed that a young person was restrained eight times. The hospital director acknowledged variable levels of restraint with some young people more likely to need restraint than others.
- Staff received training in the prevention and management of violence and aggression (PMVA) and all said that restraint was part of their practice, this did not include the use of prone restraint. Young people told us that they found restraint a distressing experience and that they had not received any de-brief after. Staff confirmed that they tried to offer de-brief following a physical intervention, but it was often not possible due to the acuity of the ward.
- Staff did not follow procedures for monitoring young people in long term segregation (LTS) as set out in the Mental Health Act 1983: Code of Practice. The site had a high dependency area that staff had used for LTS for two young people since the hospital had opened. Daily doctor reviews had not always taken place, there were gaps at the weekend and records showed that the reviewer had not signed the review documentation. It was therefore unclear who had been involved in the review. Weekly reviews did not include an IMHA and there had not been reviews by a senior professional or an external hospital. This was brought to the attention of the hospital director at the time of the inspection.

Safeguarding

- Staff received mandatory training in safeguarding and demonstrated an awareness of how to raise a safeguarding alert. The social worker was the designated safeguarding officer for the site, who took the lead on any safeguarding matters and kept a log of safeguarding issues.

Staff access to essential information

- Staff used an electronic records system to store essential care information. A secondary file of paper records was also in place. However, agency staff told us that they did not always have login details to allow them access to essential clinical documentation. This meant that staff could not always access risk information, care plans or document the progress of young people receiving care on the wards.

Medicines management

Inadequate

Child and adolescent mental health wards

- Staff stored medicines securely in locked cupboards and fridges were only accessible to authorised staff. Fridge temperature records showed that medicines were being kept at appropriate temperatures. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely and were regularly checked.
- Records showed that medical staff did not always prescribe and administer medicines in accordance with agreed treatment plans. As required medication (PRN) care plans lacked detail to support staff around the administration of these medicines, especially for young people prescribed multiple sedatives. They did not contain information to direct staff to look at the positive behavioural support (PBS) plan before administration of PRN medicines. We observed third line medicines (medicines given after two previous medications had failed to have an effect) recorded as administered without the second line medicine having been administered nor any record of the decision-making process. Staff not recording the decision-making meant that those working with the young people did not necessarily have the information needed to effectively deal with risk in the future.
- Staff monitored physical health following the administration of rapid tranquilisation. Where a young person refused physical observations, staff documented the refusal and completed incident forms following the administration of the medication.

Track record on safety

- The hospital had 18 serious incidents that they had notified to CQC from opening and prior to the inspection. The main issues reported were self-harm, aggression and inappropriate behaviour.

Reporting incidents and learning from when things go wrong

- Staff did not report all incidents. Staff used an electronic record system to record higher level incidents. Lower level incidents including staff assault and racism had become normal which meant that they did not consider them reportable. This meant risk issues and opportunities for lessons to be learnt had been missed. The hospital manager had placed low level incident reporting on the risk register in November 2018 and had seen a small improvement since then.
- Learning from incidents was not robust enough to prevent repeated incidents occurring. Staff had reported 250 incidents in the three-month period prior to the inspection. The most common occurrences were self-harm and violence. Staff documented immediate learning and supported each other following incidents. However, they said that senior managers did not get involved with de-briefs and there was a lack of wider learning within the team. They did not feel that they had support or feedback following incidents. A 'flash' meeting took place each morning with the wider multidisciplinary team that reviewed the previous days incidents, the governance surrounding the incidents and if they needed to take further steps to report to safeguarding for example.
- Staff understood the need to be open and honest when a mistake occurred and fulfilled the requirements under the duty of candour.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- Staff did not always complete initial assessments in a timely manner and the assessments lacked detail, meaning information around young person's needs could get missed. We reviewed seven sets of care records for the young people on the ward and found nursing assessments not completed until up to 13 days after admission. The assessments lacked detail around areas such as young people's goals and expectations and adherence to care plans.
- On admission, there was assessment of young people's physical health by the admitting doctor.
- Young people had care plans to help staff work towards effectively supporting them in their stay in hospital. However, the care plans did not address risks or focus

on recovery, they lacked detail and staff did not always follow them. Each young person had a keeping safe, keeping well, keeping connected and keeping healthy care plan. There was a large variation in the depth and quality of these care plans. For example, there was a lack of prompting to deal with specific self-harming behaviours with the interventions focussing on offering 1:1 and PRN medication. However, on reviewing progress notes for young people there was often a deficit in staff offering and providing young people with 1:1 time. Staff did however ensure that care plans were up to date.

- Young people's care plans were not patient centred, nursing staff had not written them to reflect the young people's voice. There was a lack of young people's views and discussion recorded in the plans, so it became unclear how staff devised the plans. There were instances in three out of seven records showing no recorded input at all by young people. Despite this there was one particularly in depth set of records that included prompts to help the young person before and after an incident, included positive activities to support the young person and had explained the importance of medication.

Best practice in treatment and care

- Staff provided treatments in line with National Institute for Health and Care Excellence (NICE) guidance. This included a mixture of medication and talking therapies such as those provided by clinical psychology and family therapy, there was a speech and language therapist. However, young people told us there was a general lack of activity to keep them occupied. This work included individually tailored positive behavioural support plans (PBS) with the young person and the psychologist. PBS is 'a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge'. While we found that young people's PBS plans had been created, not all staff followed these plans or were able to identify triggers or strategies to manage challenging behaviour.
- Staff monitored young people's physical health and responded to changing physical health concerns. This included monitoring blood pressure, weight, temperature and pulse.
- Staff did not, at the time of the inspection, have the ability to provide effective support to young people with concern around their eating. Staff had arranged for dietician support to develop meal plans for young people with an eating disorder or concern. However, due to there not being a dietician on site, a delay in dietician support had meant that a young person on the ward had lost weight which was avoidable. On review of the care records it became apparent that the monitoring of food and fluid was not consistent, there were gaps in the recording which made it unclear as to whether young people were following their meal plan.
- At the time of the inspection the service did not have an occupational therapist. The hospital had previously arranged for a sensory trained occupational therapist from another Priory hospital, but this had stopped. There was no formal arrangement in place with another Priory hospital, so it was not clear how young people would access essential occupational therapy support.
- Staff used recognised rating scales such as Health of the Nation Outcome Scales Child and Adolescent (HONOSCA) and the Children's Global Assessment Scale (CGAS) to show positive outcomes for the young people who use the service. These scales rate severity and outcomes for young people and their general functioning. The psychologist used routine outcome measures as part of practice.
- Staff audited care records and managers used quality walk rounds to look at the safety and suitability of the environment and service user experience for example, however there was no clear action plans to address issues. At the time of the inspection we reviewed walk round documentation and found that issues that had been raised on the inspection, for example around young people not feeling safe had also been raised to staff.

Skilled staff to deliver care

- The service did not have a complete multidisciplinary team due to not having an occupational therapist and there was a lack of staff with specialist skills in working with young people with a learning disability. The lack of occupational therapy meant that young people did not have assistance coping with the effects of their disability on various activities and occupations. The

multidisciplinary team comprised a consultant psychiatrist, nurses and support workers, a social worker, psychologist, speech and language therapist, family therapist and an occupational therapy assistant.

- The team appropriately inducted new staff into the service to ensure that they were aware of young people and the processes on the wards. Temporary staff received an induction on their first shift.
- Managers provided individual supervision for the staff working on the wards, however there were variable rates of completion. Group supervision and reflective practice was also offered. Data provided by the hospital director showed an upward trend in the number of staff receiving supervision over three months from 68% to 85% of staff. However, during our night visit to the hospital, staff had said that they did not receive supervision. One staff member had gone six months with no formal supervision.
- There were continuous professional development opportunities for staff. Money for specialist training was available. The hospital had provided some focussed training for staff including understanding autism and learning disabilities, and positive behavioural support. However, not all permanent staff had completed this training and not all agency workers had not been offered the opportunity to attend.
- Managers had dealt with staff concerns swiftly. We saw evidence of action taken when problems arose.

Multi-disciplinary and inter-agency team work

- Staff held multi-disciplinary meetings to discuss treatment progress in young people. This included using Care Programme Approach (CPA) meetings to move forward with care. We observed multi-disciplinary meetings of staff working with young people. There was evidence of interagency working with social services around safeguarding concerns and for planning care with looked after children.
- Young people said that communication was poor between staff members and young people. There was poor and disconnected communication around planning care and treatment for young people. Young people and their families did not feel well informed about changes in care and decisions had been made individually, outside of the team. Poor communication had increased anxiety for young people and their families and there had been a delay in care for one young person. Another issue had arisen where discharge was delayed due to the poor timing of safeguarding and discharge meetings which meant an effective plan was not made in good time. Staff had not included the CAMHS community team and as a result, commissioners had to pay for a bed for longer than necessary.
- Staff did an effective verbal handover shift to shift so that the staff coming in received information that was up to date and relevant to the care of young people.

Adherence to the MHA and the MHA Code of Practice

- Staff received some training in the Mental Health Act and demonstrated awareness of sections and requirements of the Act.
- The MHA Administrator had systems in place to deal with the requirements of the MHA and all legal documentation was in good order.
- The hospital had policies and procedures in place for the MHA and there was access to these for staff working on the wards. Flash cards with MHA information on had been made for support workers.
- Staff explained young people's rights under Section 132 of the act, this occurred with there was a change in treatment or every three months. There was access to an Independent Mental Health Advocate.
- Staff had continued to give a young person medication beyond an agreed date to stop the medication because the prescribing doctor had not discontinued the prescription. Arrangements were not in place to ensure this could not happen. This meant that medication could be being given unlawfully.

Good practice in applying the MCA

- The Mental Capacity Act applies to young people aged 16 or over. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of

Inadequate

Child and adolescent mental health wards

Gillick and used this to include the young person where possible in the decision making regarding their care. However, we did not see any documentation of these decisions.

Are child and adolescent mental health wards caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

- Young people told us that the staff and leadership did not treat them well and did not behave well towards them. Young people were not complimentary of their treatment. One young person felt that the hospital had not at all helped them, that staff had left them alone to look after themselves. Another felt staff were not interested in them. Young people used phrases such as feeling degraded, they were not caring, that there was no compassion and that they felt distressed at their treatment. Young people said that staff stayed in the office and they could hear staff talking about care.

Involvement in care

- Staff provided young people with information about the running of the hospital on admission, this included timetables for activities and education and an orientation to the ward areas and their bedrooms.
- Young people spoke about not being involved with care planning or their treatment. There was confusion about the plan for one young person that had resulted in them and their family not being clear about the next step in the young person's journey. Young people expressed concerns such as not knowing who their key nurse was and that they had not received a choice of treatments or had 1:1 time. We witnessed an incident where poor communication had caused distress and confusion for a young person on one of the wards.
- Young people had been involved in the recruitment of staff by sitting on an interview panel. They were involved in a community meeting to feedback and make suggestions, about outdoor activities for example. However, these had not happened every week as planned.
- Young people were involved with staffing a tuck shop once weekly, this was an opportunity to sell items to staff and other young people in the hospital.
- Young people had access to an advocate that visited the ward each week.
- Generally, feedback from families was that the service was disorganised and 'appalling' and that different staff told them different things. We spoke to three dissatisfied families who complained about the communication and involvement in their loved one's care. They told us that the service lacked consistency.

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

Requires improvement

Access and discharge

- The service had committed to opening the service with a low number of young people and not filling all the bed at once to ensure that it could build on their experience of working with young people as well as attempting to get the necessary number of staff in to work in the service.
- Staff ensured young people's beds were kept free when they went out on leave, this meant that they were free to come back to a bed that was not occupied by another admission.
- Staff told us that young people were only moved between wards if it was clinically necessary. There were arrangements in place to transfer to a psychiatric intensive care unit (PICU) if a young person needed a higher level of care. Staff supported young people if they needed transferring to an alternative care setting.
- Staff did not plan discharge effectively and there was limited evidence of discharge planning in the care records. For example, the discharge planning in a 'keeping connected' care plan was not present and in another there was inadequate planning or explanation around discharge. Poor communication with one family had meant there were inconsistent messages passed to them from the team. This had led to confusion about

whether the young person was staying at the hospital or not. The discharge plan that had been agreed for this young people was not being followed by the hospital. The result of this was that the young person and their family believed that they were in a place where the young person could be discharged but felt the hospital had misled them.

- The hospital had not planned effectively for the transfer of a young person approaching their 18th birthday. The young person would transition to adult services on this date. At the time of the inspection there was no plan in place for this transition resulting in uncertainty for the young person involved.

The facilities promote recovery, comfort, dignity and confidentiality

- Young people had their own bedrooms that they were free to personalise, for example with their own posters. There was a secure area for young people to safely store their possessions.
- There was a lack of specialist activity for a specialist learning disability CAMHS service. Young people expressed that there was limited activity on the wards and that they often got bored. Two young people complained about the lack of activity and that the groups were poor quality. Staff felt that they could not plan activities because they had to be too reactive to incidents on the ward. However, there was an activity timetable in place to provide structure to their day during school term times and holidays.
- The education area was well equipped and staffed by teachers that helped young people keep up to date with school work.
- There were a range of rooms and facilities within the hospital. There was a family room and quiet areas for young people to meet staff.
- Staff ensured young people had access to a mobile phone. The hospital had created a policy to ensure boundaries around phone use and there was fair and safe use that protected young people's privacy and confidentiality.
- Young people had access to an outside space on each ward. Staff told us that they considered the gardens an extension to the wards and tried to ensure that young people got outside of the ward area rather than staying inside all day.
- Young people said that the food was of poor quality This had been fed back to the chef to help improve quality and food choices.

Young peoples' engagement with the wider community

- Staff ensured that young people had access to the local community, young people picked what trips out they would like, and staff tried their best to facilitate them. Young people went out for walks in the local area and staff said their aim was to get young people out most days providing they had leave.

Meeting the needs of all people who use the service

- The hospital did not have an adapted bedroom or bathroom for people with a physical disability, but the hospital director said they were able to put in additional support if needed, for example by increasing staffing numbers to help support young people. The hospital was wheelchair accessible.
- Staff provided young people with information essential to their care, for example information on medication or leaflets on how to make a complaint. This included information in easy read format. There was opportunity to provide information in different languages and access to an interpreter if there were communication difficulties. We saw evidence of the use of individual communication such as sign language which had been shared with the nursing teams.
- The hospital chef was able to provide diet choices according to cultural and religious preferences.
- Staff were able to arrange access to spiritual support if they needed it. For example, they had links with local religious leaders.

Listening to and learning from concerns and complaints

- Young people and their families had lodged complaints with the hospital. Hospital managers had responded to families and young people with the outcome. Information received prior to the inspection showed

that the service had two complaints since opening. There had been further complaints made that required a response and investigation. These had focussed on the care and treatment of young people. There had been complaints from the local community due to occasional noise from the site. The hospital director was trying to work to resolve this issue and the learning from this had been shared with the staff team.

- Young people stated that they knew how to make a complaint and one had lodged a complaint, another said that they had little faith in the system and lacked the confidence to complain.

Are child and adolescent mental health wards well-led?

Inadequate

Leadership

- The hospital director and registered manager had experience working for the provider. However, the leadership had not ensured the all staff were equipped with the experience and skills to manage the complex presentation of the young people on the ward. Specialist training did not equip staff to work effectively with managing risk, restraint, assessment or care planning.
- At the time of the inspection the hospital was not well-led. The leadership team did not have a clear understanding of the issues on the wards with a clear disconnect between staff and managers. The inspection found that the wards were not safely managed.
- Previous leadership had resulted in an unstable staffing team and poor safety on the ward. A new hospital director had been brought in by the Priory who had experience of working within the company, particularly in CAMHS. The new hospital director told us that she was keen to provide increased support and supervision to the staff team.

Vision and strategy

- Permanent staff were aware of the values of the hospital; however, agency staff were not able to share what they were. This meant that there were a high number of staff that were not signed up to the hospital's values.

Culture

- Staff did not feel supported by the leadership team. Staff said they did not feel safe, listened to or supported by management following incidents. They felt that concerns raised around staffing and support around care for specific young people were not listened to. They stated that morale was variable, and although it had started to improve that it continued to be low. However, night staff saw little wrong with the hospital apart from a lack of supervision. They said it was not uncommon for them to come on shift and head straight into a restraint.
- Staff demonstrated awareness of the whistleblowing process. Staff had used the whistleblowing process and managers had taken this seriously and were dealing with this at the time of the inspection.
- The hospital director had brought in 'Treat Tuesday' to boost morale within the team and increase staff feeling value but it was too early to say whether this was making staff feel better. There was an employee of the month scheme in place, this was done to help boost staff morale.

Governance

- The governance arrangements were not robust and did not provide assurance or provide information or support improvement to the quality of the service or protect young people from avoidable harm. The hospital followed the providers clinical governance policy and held a clinical governance committee. This covered several areas essential to the safe running of the hospital. However, the arrangements in place to review concerns had not triggered the senior management team to successfully address safety issues such as high levels of staff assault and restraint.
- The hospital had set up a learning and outcomes group to review and share learning on incidents and complaints, this was however in its infancy and had only occurred once.
- Quality walk rounds, and audits of records had not addressed issues with safe and effective record keeping

or helped young people feel safer on the wards. The reviewing of the care notes aimed at auditing quality of care plans and their content had not improved their completion and depth but had found a lack of individualisation. However, the completion of records was placed on the risk register and was being worked on by the team and the head of quality. A quality walk round two weeks prior to the inspection had found young people not feeling safe on either ward, inspectors raised this at the time of the inspection and it was not clear what had been done to resolve this problem.

Management of risk, issues and performance

- The provider had a risk register and business continuity plan in place to record and escalate risks. This meant that the delivery of care and treatment could continue in case of an unexpected event, for example flooding or power failure. Areas of concern raised on the inspection were on the risk register, for example high vacancies, poor documentation and low-level incident reporting. The risk register had been updated with actions over a number of months and risks had been rated.
- The site had mitigation controls on their risk register to help them mitigate risks. NHS England completed a service review to help feedback on contractual requirements as well as Quality Network for Inpatient CAMHS and CQC standards. The previous review had highlighted areas of risk around admission assessment, MDT care planning and CPA process and physical health but had found them to be good around areas including serious incidents and safeguarding for example.

Information management

- The hospital stored care records securely on an electronic records system. This required staff to have a log in to add progress notes and to create and adapt care plans and assessments. We spoke to agency workers that had worked at the hospital for a period that had never been given a log in for the records system despite management assuring that they provided temporary logins fortnightly.

Engagement

- The hospital had set up a 'your say forum' for staff to feedback on the service and to share ideas for development and on their experience.

Learning, continuous improvement and innovation

- The hospital was part of the Quality Network for Inpatient CAMHS (QNIC). At the time of the inspection they were waiting for a full assessment to see if they had done the work to become accredited.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is effective and safe assessment and management of young people's risk. (Regulation 12).
- The provider must ensure challenging behaviour is managed effectively and that staff assault is reduced. (Regulation 12).
- The provider must review and plan to reduce the high levels of restraint. (Regulation 12).
- The provider must ensure that all young people are assessed prior to admission to review if the hospital can meet their needs. (Regulation 12).
- The provider must ensure that care planning is person centred and involves the young people. (Regulation 9).
- The provider must comply with the requirements of Mental Health Act 1983 requirements for young people in long term segregation. (Regulation 12).
- The provider must ensure that all incidents are recorded and appropriately reviewed with staff given support and de-brief following the incident. (Regulation 12).
- The provider must ensure that communication amongst the multidisciplinary team is effective along with communication with young people and their families. (Regulation 9)
- The provider must ensure that young people admitted with an eating disorder receive timely input and follow up from an appropriate professional. (Regulation 14).
- The provider must ensure that staff plan for discharge of young people. (Regulation 9)
- The provider must review the governance arrangements for their safety and effectiveness. (Regulation 17).

Action the provider SHOULD take to improve

- The provider should ensure that young people are provided with a good level of activity.
- The provider should ensure that all staff receive supervision.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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 CQC took enforcement action and issued a warning notice due to concerns about the safety of young people at the hospital. Staff did not have a detailed understanding of the specialist nature of a learning disability CAMHS service. Staff did not comprehensively assess the risks of the young people accessing the service. We reviewed risk documentation on the wards and found inadequate assessment and documentation of risk in all records. Staff and young people said that they felt unsafe on the wards and that there had been patient on patient assaults and bullying, and assaults on staff. Many staff did not have the experience and skills to manage the complex presentation and needs of the young people on the ward. This was a breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.