Elysium Healthcare No.2 Limited

Potters Bar Clinic

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2969790449	Potters Bar Clinic	Child and Adolescent Mental Health Services	EN6 2SE

This report describes our judgement of the quality of care provided within this core service by Elysium Healthcare No.2 Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Elysium Healthcare No.2 Limited and these are brought together to inform our overall judgement of Elysium Healthcare No.2 Limited.

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

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

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

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

Summary of findings

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Overall summary

We did not rate this service because this was a focussed inspection.

- We were not assured that patient safety was a priority. Managers did not ensure that safeguarding processes and procedures were adhered to by staff. We found a number of occasions when staff had not reported incidents to external bodies as required. This included safeguarding concerns, and serious patient injury. Incident forms were not always completed accurately and had not been signed off by appropriate senior staff. Staff were unable to provide examples of lessons learned from incidents. Many young people self-harmed even when on constant observations with multiple staff observing them.
- Staff did not fully recognise risks associated with anticipated events and emergency situations. Five out of seven patients did not have an initial risk assessment completed within 48 hours of admission as per the provider's policy. We found that in some instances, staff had not completed a risk assessment for several weeks. Completed risk assessments were not updated by staff following incidents.
- Managers had not identified all potential ligature anchor points on the ward ligature risk assessments. The ligature risk assessments had the same mitigations regardless of the risk or location. For example, the mitigation for ligatures in patient bedrooms stated that there was CCTV. There was not CCTV in patient bedrooms.
- The leadership and governance did not always support the delivery of high quality person-centred care. We found repeated poor application of the safe and supportive observation and engagement policy. We found evidence of the emergency responder being allocated to carry out patient observations. If the alarms sounded, the staff member would either not attend, or they would leave their patient on enhanced observations unsupervised.
- There had been numerous and repeated occasions of staff shortages. Although the provider was able to staff wards at a level they had assessed as being safe, at times there were too few staff to meet all care needs of the patients.
- People were at risk of not receiving effective care and treatment. We found multiple instances where the provider did not follow their section 17 leave policy. We found gaps within the pre-leave risk assessment forms. Leave forms were not sufficiently detailed. Six out of 14 nurses and health care workers knew the location of the Mental Health Act administrators but not who they were.

However:

- The ward complied with guidance on eliminating mixed-sex accommodation.
- All staff received an induction to the service. Each staff member then had some time on their allocated ward, on a supernumerary basis. When bank and agency staff were used, we saw evidence of a bank and agency induction pack to familiarise themselves with the provider and ward.
- The multidisciplinary team provided a range of care and treatment in line with National Institute for Health and Care Excellence guidance. Staff used recognised rating scales to assess and record severity and patient outcomes.
- Four patients told us regular staff were respectful, caring and polite. We observed patients engaged with members of staff in a range of activities.
- Staff told us leaders were visible on the wards and all staff knew who the senior management team were. Most staff said they felt respected, supported and valued by their colleagues.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found:

- Staff did not always recognise or respond appropriately to abuse. We identified a number of occasions when incidents had not been reported to the local safeguarding authority, or other external bodies as required. This included statutory notifications to the Care Quality Commission to inform of safeguarding concerns, or notifications of serious injuries to patients.
- There was little evidence of staff learning from incidents, or actions taken to improve safety. Staff were unable to give examples of learning from incidents.
- We found repeated incidents of serious self-ham whilst patients were under a constant high level of observation by multiple staff. Incident forms were not always completed accurately, and had not been signed off by appropriate senior staff. Agency staff did not always have access to the incident reporting system and therefore were unable to record incidents first hand.
- Managers had not identified all potential ligature risks through the ward ligature risk assessments. We found multiple potential ligature anchor points which managers had not identified. For example, the fence in the gardens. The ligature risk assessments had the same mitigations regardless of the risk or location. For example, the mitigation for ligatures in patient bedrooms stated that there was CCTV. There was not CCTV in patient bedrooms.
- The wards did not always meet their safe staffing levels. We examined the rotas between 01 November 2018 and 20 February 2019. We found that the wards were below their safe staffing level 60 times in this period. Some staff told us that they rarely had breaks and if they did they were rarely on time. The wards had an emergency responder allocated each day who would respond to alarms throughout the hospital. However, we found on occasions, the emergency responder had been allocated to carry out patient observations. If alarms sounded, the staff member would either not attend, or they would leave their patient unsupervised.
- The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed. Five out of seven patients did not have an initial risk assessment

Summary of findings

completed within 48 hours of admission as per the providers' policy. We found that in some instances, staff had not completed a risk assessment for several weeks. Staff did not update risk assessments following individual incidents.

- Staff did not always follow the providers policy when allocated to undertake enhanced patient observations. We found significant gaps in observation recordings for some patients. Some observation records could not be located. Staff often undertook observations for longer periods than the policy stipulated. Records seen, and observations undertaken by the inspection team, showed that staff did not always observe patients as prescribed.

However:

- The wards complied with guidance on eliminating mixed-sex accommodation.
- Staff carried keys and personal call alarms issued by reception at the start of each shift. There were call button alarms located in each of the bedrooms.
- All staff received an induction to the service. Each staff member then had some time on their allocated ward, on a supernumerary basis. This enabled them to become familiar with the ward environment and the patients. When bank and agency staff were used, we saw evidence of a bank and agency induction pack to familiarise themselves with the provider and ward.

Are services effective?

We found:

- We found 59 active care plans between seven patients. We found 41 out of 59 care plans had the same review date. These care plans were all written across six dates spanning over two weeks. Care plans were not always personalised. Two care plans referred to the patient by their hospital number, and the wrong gender. Another care plan stated the wrong patient name.
- Seventy-five per cent of staff had had training in the Mental Health Act and Code of Practice at the time of our inspection. This was below the provider target compliance of 95%. Five out of 14 nurses and health care workers we spoke with did not have a good understanding of the Mental Health Act and were not aware of its principles.
- Staff were not sufficiently trained in issues relating to children and young people mental health issues.

Summary of findings

- We found multiple instances where the provider did not follow their section 17 leave policy. We found gaps within the pre-leave risk assessment forms. We found no names or grades of staff escorting patients on leave on either the patients' leave authorisation form or pre-leave risk assessment. We found no evidence of feedback gathered from the patients' parents or family, either during, or following leave. We found no clear patient views on how they felt their leave had gone. We found no clearly listed home addresses or contact numbers for patients on home leave.
- Staff monitored patients' physical health inconsistently. Routine physical health observations were carried out between one and 52 days apart.

However:

- The multidisciplinary team provided a range of care and treatment in line with National Institute for Health and Care Excellence guidance. Staff used recognised rating scales to assess and record severity and patient outcomes.
- Staff shared information about patients at effective handover meetings within the teams. This included Mental Health Act paperwork during morning meetings. Patient rights that needed to be explained were discussed and flagged to the nurse in charge.

Are services caring?

We found:

- There were times when patients did not feel well supported or cared for. We spoke with seven patients. Three patients told us they did not feel safe on the wards. One patient told us they did not feel listened to by staff. Six patients told us they knew how to raise a concern or complaint although they hadn't all got a response when they did. Two patients told us staff had been rude to them. One patient said staff didn't engage with them. Two patients told us staff had made negative comments about their weight.
- One patient told us they don't have debriefs after incidents. Another patient told us staff had not supported them after a recent serious incident.
- We observed a care programme approach meeting where a patient was able to offer a suggestion on how they would like to be supported during their periods of distress. However, neither consultant present responded to this suggestion.

Summary of findings

- Five out of eight carers told us there was a lack of communication from the hospital about their relative. Staff had not always made them aware of incidents happening at the hospital involving their relative. One carer told us that staff had not informed them when their relative was taken to hospital.

However:

- Four patients told us that regular staff were respectful, caring and polite.
- We observed patients engaged with members of staff throughout the inspection, in a range of activities.

Are services well-led?

We found:

- Leaders did not have a good understanding of the service they managed. We found conflicting and contradicting information between senior managers and staff working on the wards. For example, when patient records should be updated. We reviewed the providers' patient baseline risk assessment policy and the providers service specification document. We found evidence within these provider policies of contradicting information.
- Governance systems did not ensure that patients were kept safe. We found repeated poor application of the safe and supportive observation and engagement policy. We found evidence of incident forms not completed accurately. Senior staff with lead responsibility for safeguarding did not ensure that safeguarding processes and procedures were adhered to in all instances. We identified a number of occasions when incidents were not reported to external bodies as required.
- At times there were too few staff to meet all care needs of the patients. We found the staffing numbers and names were recorded in a number of places each day. We found these did not always match which made it difficult to confirm which staff were working which shifts. Between the 20 February 2018 and 20 February 2019, the provider reported a staff turnover of 64.2%. Between the 20 February 2018 and 20 February 2019, the provider reported an absence level of 7.4%.
- Some staff did not feel the provider gave consistent support after incidents and that managers delivered debriefs for 'significant' issues only. Staff told us they felt some level of stress in their roles.
- The senior management team maintained and had access to the risk register. Staff at ward level were not aware of the risk register, what it contained, or how to access it.

Summary of findings

- There was a lack of learning from significant incidents. One learning point the provider shared with us was around the safe management of leave. As a result, they had implemented a home leave feedback form. This had not been implemented at ward level, despite the significant incident occurring several weeks prior to the inspection taking place.

However:

- Staff told us leaders were visible on the wards and all staff knew who the senior management team were.
- Most staff said they felt respected, supported and valued by their colleagues.

Summary of findings

Information about the service

Potter Bar Clinic is an independent hospital that provides services to people who have needs related to their mental health. Patients may be detained under the Mental Health Act, or may be voluntarily staying at the hospital.

Potters Bar Clinic offers Child and Adolescent Mental Health Services (CAMHS) Tier 4 low secure services for young people aged 13 to 18 with a wide range of disorders and complex needs.

There are two CAMHS wards:

- Jasper ward is a mixed gender CAMHS Tier 4 ward with 11 beds on the ground floor.
- Opal ward is a mixed gender CAMHS Tier 4 ward with 7 beds on the ground floor.

There are two adult mental health wards at this location:

- Crystal is an acute female ward with 12 beds on the first floor.
- Ruby is an acute mixed ward with 20 beds on the first floor.

We did not inspect these wards.

We inspected the CAMHS wards as part of a focused responsive inspection. This was the first inspection of the Potters Bar Clinic CAMHS wards since they opened in December 2017.

The service offers education opportunities through its onsite school. This is Ofsted registered and had been inspected in March 2019, results of which were due to be published.

Potters Bar Clinic is registered to carry out the following legally regulated services/activities:

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

At the time of the inspection there was a registered manager in place who was the hospital director.

Our inspection team

The team that inspected the service comprised of a Care Quality Commission Inspection Manager, four Care Quality Commission inspectors, an assistant inspector, a Mental Health Act reviewer and a specialist advisor (nurse) with experience in the care and treatment of young people detained under the Mental Health Act.

Why we carried out this inspection

We carried out this unannounced inspection, following a number of significant concerns raised to the Care Quality Commission about the care and treatment of individuals detained within the CAMHS wards. We had also received concerns surrounding a death of a young person detained on a CAMHS ward.

How we carried out this inspection

We have reported on some of the key questions in safe, effective, caring, and well led. As this was a focused inspection, we looked at specific key lines of enquiries in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive report.

Summary of findings

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

During the inspection visit, the inspection team:

- visited both CAMHS wards and looked at the quality of the ward environments
- spoke with seven patients who were using the service
- spoke with the Hospital Director, who was also the registered manager
- spoke with 27 other staff members; including consultant psychiatrists, therapy leads, nurses, health care workers and acting and deputy ward managers
- received feedback about the service from the police
- attended and observed four multi-disciplinary meetings
- attended and observed one community meeting
- examined in detail, the care and treatment records of seven patients
- examined in detail, seven incident forms
- examined in detail, the observation records of 17 patients
- examined in detail, seven qualified staff files
- examined in detail, 17 patient medication records
- spoke with eight carers of patients who were using the service
- observed seven interactions using the short observational framework for inspection (SOFI). SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. The tool records the quality of engagement between staff and patients and is appropriate for people with learning disabilities)
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

- We spoke with seven patients across the two wards we visited. Four patients felt regular staff were respectful, caring and polite.
- Two patients felt staff had been rude to them. Two patients told us staff had made negative comments about their weight.
- Two patients felt there was not enough staff and one patient felt more permanent staff were needed. Patients told us they did not have regular one-to-one time with their named nurse.
- Three patients did not feel safe on the wards. One patient did not feel listened to by staff. One patient felt they got no time alone with staff so caused incidents as a way of getting attention. One patient felt staff did not engage regularly with them. One patient told us they did not have a debrief after incidents. Another patient told us that staff had not supported them after a recent serious incident.
- One patient told us night staff slept whilst on their observations and had been woken up by them snoring. One patient told us that on one occasion, they were able to self-harm because their observing staff were sleeping. One patient told us they should be observed every 15 minutes but they have been left for 30 minutes.
- Six patients told us they knew how to raise a concern or complaint although they hadn't all got a response from staff when they did.
- Three patients told us they had a care plan and were involved in writing it.
- Four patients told us they have had their section 17 leave (permission for patients to leave hospital under a Mental Health Act section) cancelled due to staff shortages. Two patients told us staff had not given them their section 17 leave forms. One patient told us the doctor renewed their section without consulting them.
- Five out of the eight carers told us there was a lack of communication from the hospital about their relative. Staff had not always made them aware of incidents happening at the hospital involving their relative. One carer told us that staff had not informed them when their relative was taken to hospital. One carer told us they felt completely out of the loop which they found very distressing.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure relatives and carers are kept informed of patient wellbeing, in particular feedback after incidents.
- The provider must ensure patient records are personalised and meet the needs of that individuals
- The provider must ensure staff communicate with patients effectively and ensure they treat patients with dignity and respect.
- The provider must adhere to their search policy and procedures.
- The provider must ensure the ligature risk assessments are accurate and contain mitigation for individual risks identified.
- The provider must ensure that staff undertake patient observations as prescribed and adhere to the hospital policy.
- The provider must adhere to the Mental Health Act Code of Conduct with regards to recording and reporting Section 17 leave.
- The provider must ensure they have a robust and effective oversight of their section 17 leave processes and documentation.
- The provider must share lessons learned from incidents with all staff.
- The provider must debrief patients after incidents.
- The provider must inform external bodies of incidents as required.
- The provider must ensure they follow their internal quality assurance processes.
- The provider must ensure all staff have access to systems used for care planning and incident reporting.
- The provider must ensure they have a good understanding of their services and information is descended and ascended appropriately.
- The provider must ensure they have appropriate governance systems to keep patients safe.
- The provider must ensure they monitor patients' physical health consistently.
- The provider must ensure they adhere to their training compliance targets.
- The provider must ensure staff have a good understanding of the Mental Health Act and Code of Practice.
- The provider must ensure they meet their safe staffing levels. These must be recorded coherently and consistently.
- The provider must ensure staff have the appropriate training and knowledge for the patient group.
- The provider must ensure that any restrictions to patients are kept to a minimum, are individually risk assessed, and care planned.

Action the provider SHOULD take to improve

- The provider should ensure medical equipment used for physical examinations is available in the clinic rooms at all times.
- The provider should ensure they respond to patients if they make a concern or complaint.
- The provider should ensure they review patient records individually, according to needs and wishes.

Elysium Healthcare No.2 Limited

Potters Bar Clinic

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Child and Adolescent Mental Health Services	Potters Bar Clinic

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.

- We reviewed section 17 leave of absence for patients detained under the Mental Health Act as part of our focused inspection. We looked at recent episodes of leave covering dates in January 2019 and February 2019.
- The responsible clinician discussed section 17 leave of absence with the patients in the ward rounds and at other times during the week, when the responsible clinician was visiting the ward. Leave was authorised by the responsible clinician. We checked 19 section 17 leave forms. We found multiple instances where the provider did not follow their section 17 leave policy.
- Seventy-five per cent of staff had had training in the Mental Health Act Code of Practice at the time of our inspection. This was below the provider target compliance of 95%. Five out of 14 nurses and health care workers we spoke with did not have a good understanding of the Mental Health Act or its principles.
- We reviewed 13 pre-leave risk assessment forms and identified gaps in recording.
- Four patients told us they have had their section 17 leave cancelled due to staff shortages. Two patients told us staff did not give them their section 17 leave forms. One patient told us the doctor renewed their section without consulting them.
- Six out of 14 nurses and health care workers knew the location of the Mental Health Act administrators but not who they were.
- Mental Health Act paperwork was discussed in morning meetings. Patient rights that needed to be explained were discussed and flagged to the nurse in charge.
- Consent to treatment forms were attached to medicine cards for all patients.
- Patients had easy access to information about independent mental health advocacy and the advocate visited the wards once a week.
- Staff requested an opinion from a second opinion appointed doctor when necessary.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All patients were detained under the Mental Health Act. No patients were subject to a Deprivation of Liberty Safeguards application or authorisation.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The layout of the wards enabled staff to observe all parts of the ward effectively. Staff were present in the main communal areas. However, we found blind spots on the access stairwell from the wards to the school entrance on the third floor. The provider mitigated these as the patients would be accompanied in these areas at all times.
- During the week, most patients attended the on-site school subject to their clinical presentation. The school area was located on the third floor of the hospital and was supervised by both ward and teaching staff.
- Each patient bedroom had a viewing panel to assist staff with observation. The viewing panel on one of the bedrooms we tested did not work and would not close. The patient's privacy and dignity could be compromised. CCTV covered the ward communal areas. CCTV was used for post-incident review and could only be viewed by the senior management team. Monitors were based off the ward on one of the wards we visited, however, the other ward had CCTV monitors in the staff office.
- Patient observation levels were based on the clinical decision made by the multidisciplinary team. The multidisciplinary team prescribed observation levels based on risk to keep individuals and other patients safe.
- We found potential ligature anchor points which staff had not identified on the wards' individual ligature risk assessment. A ligature point is a fixed or static object that a ligature could be secured to and used for self-harming purposes. The ligature risk assessments had the same mitigations regardless of the risk or location. For example, the mitigation for ligatures in patient bedrooms stated that there was CCTV. We asked staff about this who told us there was not CCTV in patient bedrooms.
- Patients could access an outside, secure garden on each ward with supervision.
- There was a restrictive practice in place. We found a water dispenser on one of the two wards with no free access to cups. This meant that patients had to ask for a drink whenever they wanted one.
- The ward complied with guidance on eliminating mixed-sex accommodation.
- Staff carried keys and personal call alarms issued by reception at the start of each shift. There were call button alarms located in each of the bedrooms on the wards. In addition to the ward's own staff who responded to alarms, one staff member on each ward was designated to be the safety officer who would respond to alarms on other wards.
- All ward areas needed painting. We found paint coming off the walls in certain areas of the wards. The windows in the ward areas were dirty and the skirting boards were scuffed. We found writing on the walls in multiple areas of the wards and one bedroom had 'cell' written above the door number. We found there were not enough dining chairs on one of the wards if all patients wanted to eat at the same time.
- We found out of date notices relating to school term and safeguarding officers on the walls within each ward.
- Both wards had seclusion rooms. However, neither of them had been used since June 2018.
- Both wards had a de-escalation room. However, staff told us they sometimes used patient bedrooms and the quiet rooms on each ward to deescalate patients. Quiet rooms doubled up as multi faith rooms. This would deprive others of using the quiet / multi-faith rooms at these times.
- Each ward had a clinic room. The clinic room on Opal Ward had no examination couch. Doctors undertook physical examinations in patient bedrooms. Not all equipment was kept in the clinic rooms. For example, the weighing scales were kept in the ward office. We found the medical equipment checklists were not completed. Medical equipment used by the doctors for physical examinations could not be located at the time of inspection.
- Clinic rooms were clean but untidy. Medication cabinets were tidy; however, store cabinets were cluttered. The fridge was not locked in the Jasper Ward clinic room

despite containing medication. Staff had recorded fridge and room temperatures regularly. A pharmacist visited wards weekly to check and audit medication charts as well as checking medication stock and expiry.

Safe staffing

- We examined the rotas of wards visited between 01 November 2018 and 20 February 2019. We found that the wards were below their safe staffing level 60 times in this period. Wards were below their safe staffing numbers by one on 44 occasions; short by two on 14 occasions, and short by three staff members on two occasions. We found the staffing numbers and names were recorded in a number of places each day. We found these did not always match which made it difficult to confirm which staff were working which shift.
- Between the 20 February 2018 and 20 February 2019, the provider reported a staff turnover of 64%.
- Between the 20 February 2018 and 20 February 2019, the provider reported an absence level of over 7%.
- There was not a substantive ward manager in post at the time of the inspection for either wards visited. One ward had a deputy ward manager who had been in post for five weeks. The second ward, the deputy ward manager was acting up as ward manager and had been in post since December 2018. The deputy ward manager and acting ward managers both said they could adjust the staffing levels when required to take account of changing observation levels.
- There were three qualified nurse vacancies and two healthcare worker vacancies across the wards at the time of inspection. However, there were two qualified nurses and four healthcare workers going through the new starter procedure, and had not started working on the wards. The provider had used agency and bank staff to cover these vacancies. Due to the high levels of patient observations required on the ward, agency staff were used frequently to add to the minimum staffing numbers. We saw that some bank and agency staff worked regularly within the service to help continuity of care.
- The provider had a number of processes they carried out to check agency staff were compliant to work within their service. Every member of agency staff had the right level of training the provider would expect. Agency providers sent through training records for every staff member who worked at the service.
- Some staff told us that they rarely had breaks and if they did they were rarely on time.
- All new staff received an induction to the service. This included a two-week hospital wide induction which covered various training including basic life support and management of violence and aggression. All new permanent staff also received a full weeks specific Child and Adolescent Mental Health training delivered externally within their two-week induction. Each staff member then had some time on their allocated ward, on a supernumerary basis. This enabled them to become familiar with the ward environment and the patients. The provider told us that staff received additional training in child mental health issues, including; adolescent mental health, working with families and carers, risk management, observation, patient engagement and suicide prevention. We requested data to show how many staff had completed the various modules. We found 23 out of 32 registered nurses and health care assistants had received training relating to child mental health issues. Staff personnel files did not contain information on training received. Staff training information was held in a central recording system managed by the training administrator for the service. The provider had recently approved training for eight staff with a local university to provide specific children and adolescent mental health training. We saw evidence of this for two qualified staff. The provider put on a specific week of children and adolescent mental health training for all regular and agency staff in summer 2018. However, there were a number of agency staff who commenced employment after this time.
- When bank and agency staff were used, we saw evidence of a bank and agency induction pack to familiarise themselves with the provider and ward.
- A staff member was present in the communal areas of the ward at all times.
- Patients told us they did not have regular one-to-one time with their named nurse. We looked at seven patient records in detail and found no evidence of patients having recorded one-to-one sessions with their named nurse.
- Four out of seven patients told us they had their section 17 leave (permission for patients to leave hospital under a Mental Health Act section) cancelled due to staff shortages. Two patients told us they were not given their section 17 leave forms.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The wards had an emergency responder allocated each day who would respond to alarms throughout the hospital. This meant that there were enough staff to carry out physical interventions safely. However, we found evidence of the emergency responder being allocated to carry out patient observations. This meant that if the alarms sounded, the staff member would not attend, or they would leave their patient unsupervised. Staff told us they were often allocated as an emergency responder and on constant patient observations.
- Medical staff were present in the hospital Monday to Friday during office hours. In addition, a permanent or locum doctor was resident on site for evening and night cover who could attend the ward quickly in an emergency. A consultant was always available on the phone for advice.
- We found 81.3% of staff were compliant with their mandatory training in December 2018. This was below the provider target compliance of 95%. This figure excluded staff who had worked with the provider for less than three months. In line with the providers' corporate policy they had a three month period to ensure all staff were compliant in all areas.
- We reviewed seven qualified staff files. Four of the nurses were registered mental health nurses, two were registered nurses with learning disabilities and one was a registered children's nurse. We found three out of seven nurses had child and adolescent mental health experience prior to employment. One out of the seven nurses had certificates for specific child and adolescent mental health training.

Assessing and managing risk to patients and staff

- The providers' risk assessment policies and procedures stated that all patients should have an admission risk assessment completed within 48 hours, and a care plan within 24 hours. We looked at seven care records. Five patients did not have an initial risk assessment completed within 48 hours of admission as per the providers' policy. One patient's initial risk assessment had been completed four weeks prior to admission by their previous placement who was also part of Elysium Healthcare. Staff completed one almost 19 weeks after admission. A further two were completed almost 23 weeks after admission and another completed almost 31 weeks after admission.
- Staff did not update patient risk assessments following incidents.
- The provider had a policy for enhanced observations which staff were expected to follow. We looked at 17 observation records. Staff did not adhere to the policy. We found five observation records were missing for a period of between one and 39 days. We found a further 14 gaps in records seen. Staff had not recorded any information for between 20 minutes and up to almost three hours. We saw multiple instances were staff were undertaking observations for longer than the policy stipulates. We found repeated incidents of self-harm which occurred when staff should have observed patients. Records seen, and observations undertaken by the inspection team, showed that staff did not always observe patients as prescribed.
- All staff completed an enhanced observation competency checklist which stated that the nurse in charge signed to confirm a staff member was competent in a number of areas including; reading and understanding the enhanced observation policy, and responsibilities regarding documentation and timing. We found two enhanced observation competency checklists completed and dated with future dates.
- Due to the nature of the environment, blanket restrictions were imposed. For example, young people did not have free access to their own mobile phones. However, we found evidence of staff applying blanket restrictions unnecessarily. Staff told us all patients were observed on a minimum of 15-minute observations, regardless of their clinical risk. We were told by staff at the inspection that as these were Child and Adolescent Mental Health wards that patients were always on 15 minute observations due to the acuity of the patient group and they would not feel confident leaving the patients for an hour.
- Staff searched patients routinely on return to the wards if they had been on unescorted leave or home leave. Staff did not always conduct searches in line with the providers' search policy. We found that on one occasion, one male member of staff searched a female patient. Policy stated that two staff should be present, and a female staff present when searching female patients.
- Staff adhered to best practice in implementing a smoke-free policy.

Safeguarding

- All staff had received and were up to date with training in safeguarding level three, adults and children. All staff were trained to this level as a minimum requirement

regardless of role or position. The senior management team were all trained in safeguarding level four adults and children. All staff we spoke with said they knew the safeguarding procedure and who to raise a safeguarding alert with. We spoke with the hospitals' safeguarding lead and a deputy lead who explained the safeguarding reporting procedure. However, we reviewed the providers safeguarding, serious incident and incident logs. We reported nine potential incidents to the provider on the day of the inspection when we found no evidence that staff had reported incidents to external bodies as required, including statutory notifications to the Care Quality Commission. For example, allegations of abuse or patient self-harm resulting in injury. When it was bought to the provider's attention, managers submitted notifications retrospectively. Three incidents we found had already had notifications submitted to the Care Quality Commission. Three notifications were sent within a week of the inspection. Two notifications were sent within two weeks of the inspection. One incident was reported to safeguarding but told that a safeguarding notification was not required. The final incident was reviewed on CCTV by the provider and did not occur the way the patient had told inspectors. All incidents were discussed on the final date of the inspection at the follow up visit.

- Internal staff reviewed safeguarding concerns before a decision was made to raise an alert with external bodies. There were incidents within the internal safeguarding log where it was not clear if staff had alerted external organisations as required, but were dealt with internally.
- During the period of 21 November 2018 and 21 February 2019 the provider recorded 254 incidents. During the period of 5 December 2018 to 14 February 2019 the provider recorded 15 serious incidents. During the period of November to December 2018 the provider recorded six safeguarding incidents.

Staff access to essential information

- The provider used a combination of paper and electronic records which all permanent staff could access. Some agency staff only had access to paper records if they were regular, or had not yet completed the providers' records training.

Medicines management

- We reviewed 10 patient medication records on Jasper Ward. We found seven out of 10 medication charts had not been printed clearly.
- We reviewed seven patient medication records on Opal Ward. We found two out of seven medication charts had not been printed clearly. We found that staff had not recorded patient allergies on one of the prescriptions. A further allergy was not legible.

Track record on safety

- We found repeated incidents of serious self-ham whilst patients were under a constant high level of observation of multiple staff.

Reporting incidents and learning from when things go wrong

- During the period of 5 December 2018 to 14 February 2019 the provider recorded 15 serious incidents. The provider recorded patients had attended accident and emergency three times for an overdose; three times for swallowing an object; two times for inserting an object; one time for food and fluid restriction; one time for self harm. The provider recorded police involvement two times, staff supplied contraband one time, patient on patient assault one time and a patient death one time. All of these required a notification to the Care Quality Commission. Of the 15 serious incidents, three had not been notified to the Care Quality Commission as expected.
- We reviewed seven incident forms in detail. Staff had not recorded in detail, in three of these forms, where physical restraint had been used. We found that none of these patients restrained had care plans in place around restrictive interventions. We also found missing and conflicting information about the restraints within the three incident forms.
- The provider's process for quality assurance of incident forms consisted of sign off by the person reporting the incident, a clinical / multidisciplinary team member and a health and safety officer. We found in two out of seven incidents, staff completed the record the day after the incident occurred. Staff recorded one incident two days after the incident. We were told by one senior management team member that the ward managers should sign the clinical / multidisciplinary team member section and a member of the senior

management team should sign the health and safety officer section. We were told by another of the senior management team the opposite. We found that all seven incident forms were signed by the same member of the senior management team who had signed off as the clinical / multidisciplinary team member and health and safety officer.

- Staff told us they knew what incidents to report and how to report them. However, agency staff did not always have access to the incident reporting system and therefore were unable to record incidents first hand.
- Fourteen staff were aware of lessons learned from incidents but were unable to tell us of any specific lessons learned as a result of incidents.
- The provider told us prior to the inspection that as a result of a serious incident occurring when a patient had returned from leave, that they had implemented a home leave feedback form. However, we saw no evidence of the newly implemented sheets during inspection.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at seven patient records in detail. We found that six out of seven patients received an initial mental health nursing assessment on admission.
- We found six out of seven patients received a physical health examination on admission. The one patient who didn't received a physical health examination on admission was a patient transferred internally from another clinic provided by Elysium. We found that staff monitored patients' physical health inconsistently. Routine physical health observations were carried out between one and 52 days apart.
- We found only two out of seven patients had an initial 72-hour care plan in place as per the providers' policy upon admission.
- We found 59 active care plans between seven patients. We found 41 out of 59 care plans had the same review date. These care plans were all written across six dates spanning over two weeks. The provider told us they held a planning week every three months which they blocked out to specifically update care plans. Staff told us they updated care plans and risk assessments formally within patient care programme approach meetings every six weeks, and informally at the weekly ward round.
- Two care plans referred to the patient by their hospital number, and the wrong gender. Another care plan stated the wrong patient name. Two of the seven patients did not have a management of risk behaviour care plan.
- We found four out of seven patients did not have a specific discharge care plan.
- We reviewed 10 patient positive behaviour support plans. We found positive behaviour support plans contained the details of what would make the patient upset and how they would prefer staff to support them during these times. Staff had recorded patient views, but there was no evidence of patients signing their plan or being given a copy. Staff told us conflicting timescales of when positive behaviour support plans had to be reviewed. We found staff had written six out of 10 positive behaviour support plans over 19 weeks previously. Staff had written one over a year ago. We found no positive behaviour support plans had a review date. Staff had not reviewed these since they had been written.

Best practice in treatment and care

- The multidisciplinary team provided a range of care and treatment in line with National Institute for Health and Care Excellence guidance. Examples we saw of these included dialectical behaviour therapy, art therapy and mindfulness.
- Staff ensured that patients had good access to physical healthcare, by attending appointments with healthcare professionals, or facilitating visits to the general hospital where required. Staff followed advice of healthcare professionals to ensure patients received the appropriate care following discharge from general hospitals.
- Staff assessed and met patients' needs for specialist nutrition and hydration. Staff could seek additional support from a partnering Elysium hospital.
- Staff used recognised rating scales to assess and record severity and patient outcomes. We saw evidence of patients having a Health of the Nation Outcome Scale for Children and Adolescents and a Children's Global Assessment Scale. Staff reviewed these regularly.

Skilled staff to deliver care

- The provider employed seven qualified nursing staff to work across the two wards. Three out of seven staff had experience of working with children with mental health issues. Of the seven staff, two had worked in the service for 6 weeks, two had worked in the service for between five and six months, three had worked in the service for between one and six and a half years.
- Five of the seven staff had recently been subject to investigations regarding conduct or performance.
- We reviewed all personnel files of the seven staff. One out of seven personnel files showed evidence of specific training staff received relating to child mental health issues. We requested training records from the provider. We found five of the seven staff had received training relating to child mental health issues.

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

- Seventy-five per cent of staff had had training in the Mental Health Act Code of Practice at the time of our

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

inspection. This was below the provider target compliance of 95%. This figure excluded staff who had been working with the provider for less than three months. In line with the providers' corporate policy they have a three month period to ensure all staff are compliant in all areas. Five out of 14 nurses and health care workers we spoke with did not have a good understanding of the Mental Health Act or were aware of its principles.

- We looked at 19 periods of section 17 leave. We found multiple instances where the provider did not follow their section 17 leave policy. We found six out of 19 periods of section 17 leave did not have a pre-leave risk assessment form completed by staff prior to leave being taken. We found four instances of section 17 leave having no electronic record of the leave. We found no evidence of feedback gathered from the patients' parents or family, either during, or following leave. We found no clear patient views on how they felt their leave had gone. Staff used standard statements such as answering patient views to leave as "yes". We found no names or grades of staff escorting patients on leave on either the patients' leave authorisation form or pre-leave risk assessment. We found no patients had a specific section 17 leave care plans. We found no clearly listed home addresses or contact numbers for patients on home leave. On several electronic records we found no evidence that the patient was aware of their leave conditions or any contingency plans should the patient not return from leave.
- We reviewed 13 pre-leave risk assessment forms and identified gaps in recording. We found seven out of 13 assessments had no time recorded for when the patient was due back from leave. We found nine out of 13 assessments had no time recorded for when the patient returned to the ward. We found two discrepancies between the time out recorded on the pre-leave risk assessment form and on the providers electronic recording system. We found two entries where the patient returned from leave between 15 and 50 minutes late as per the time due back on the pre-leave risk assessment form. There was no explanation post leave as to why the patient returned late.
- Four patients told us they have had their section 17 leave cancelled due to staff shortages. Two patients told us staff did not give them their section 17 leave forms. One patient told us the doctor renewed their section without consulting them.
- Six out of 14 nurses and health care workers knew the location of the Mental Health Act administrators but not who they were. Staff discussed Mental Health Act paperwork in morning meetings. Patient rights that needed to be explained by staff were discussed and flagged to the nurse in charge. Staff recorded that they had explained these within the patients care plan. We found evidence of staff revisiting these when the patient had not understood their rights.
- Staff attached consent to treatment forms to medicine cards for all patients.
- Patients had easy access to information about independent mental health advocacy and the advocate visited the wards once a week.
- Staff requested an opinion from a second opinion appointed doctor when necessary.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We spoke with seven patients. Three patients told us they did not feel safe. One patient told us "they sent me on leave even when I didn't feel safe". One patient told us they did not feel listened to.
- One patient told us they don't have debriefs after incidents. Another patient told us that staff had not supported them after a recent serious incident.
- Four patients told us regular staff were respectful, caring and polite. Two patients told us staff had been rude to them. Two patients told us there was not enough staff. One patient told us more permanent staff were needed. One patient said staff didn't engage with them. Two patients told us staff had made negative comments about their weight. One patient told us night staff slept whilst on their observations and had been woken up by them snoring. One patient told us they were on constant observations and they were able to self-harm because their staff were sleeping. One patient told us they should be observed every 15 minutes but they had been left for 30 minutes.
- Six patients told us they knew how to raise a concern or complaint although they hadn't all got a response when they did.
- We observed patients engaged with members of staff in a range of activities including card games, table tennis and an animal visit. Of the seven patient and staff interactions observed, six were positive. Staff engaged with patients and treated them with respect, we saw one interaction where staff were discussing a patient's discharge and celebrating their achievements. However, we witnessed one member of staff leave their post when supporting a patient who was on one to one observations. This member of staff also ignored the patient for most of the 30 minute observation period.
- We observed staff not carrying out or recording observations as per the enhanced observation policy. We observed incidents that were not recorded on the patients' observation record sheets.

The involvement of people in the care that they receive

- Three patients told us they had a care plan and were involved in writing it. We found all patients whose records we reviewed had been offered a copy of their care plan.
- We observed a care programme approach meeting where a patient was able to offer a suggestion on how they would like to be supported during their periods of distress. However, the two consultants present did not respond to the suggestions.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- The provider had not recruited staff with the necessary skills and experience to care for and manage those on the ward. We reviewed seven qualified staff files from the wards visited. Four of the nurses were registered mental health nurses, two were registered nurses with learning disabilities and one was a registered children's nurse. We found three out of seven nurses had child and adolescent mental health experience prior to employment at Elysium healthcare. Five out of seven staff had been subject to investigations due to inappropriate conduct or performance. Of the seven staff, two had worked in the service for 6 weeks, two had worked in the service for between five and six months, three had worked in the service for between one and six and a half years.
- Leaders did not have a good understanding of the service they managed. We found conflicting and contradicting information between senior managers and staff working on the wards. For example, when patient records should be updated.
- Staff told us leaders were visible on the wards and all staff knew who the senior management team were.
- Although the provider was able to staff wards at a level set in accordance with Quality Network for Inpatient Child and Adolescent Mental Health standards and they had assessed these as being safe, at times there were too few staff to meet all care needs of the patients in relation to carrying out prescribed observations.
- Leaders told us they had leadership development opportunities and felt able to progress within the organisation.

Culture

- Most staff said they felt respected, supported and valued by their colleagues.
- All staff told us they knew how to use the whistleblowing process. Most staff felt able to raise concerns without fear of victimisation. Two staff told us they would feel victimised if they raised concerns.
- Some staff did not feel the provider gave consistent support after incidents and that managers delivered debriefs for 'significant' issues only. One staff member told us that they had post-traumatic stress disorder as a result of working within the patient group. One staff member told us they had serious anxiety. However, all staff had access to support 24 hours per day via the company helpline. Most staff felt supported by their colleagues.
- Staff told us they felt some level of stress in their roles. One staff member told us they felt down and felt they were doing too much.

Governance

- Governance systems did not ensure that patients were kept safe. We observed and were told that clinical governance processes in the form of multidisciplinary meetings and ward rounds reviewed risk factors for each patient. We found no evidence of risks assessments being updated after these meetings.
- We reviewed the providers' patient baseline risk assessment policy and the providers service specification document. We found evidence within these provider policies of contradicting information. The patient baseline risk assessment policy states that all patients should have the admission baseline risk assessment completed within 48 hours by a member of the multidisciplinary team. The providers service specification document states that on admission all young people must have an initial risk assessment (including a risk assessment) and care plan completed in 24 hours.
- Staff held morning meetings daily. We observed a morning meeting. We found patient observation levels, staffing on the wards, patients' section 17 leave, incidents, admissions and discharges, patients detained under the Mental Health Act who needed their rights explained to them and the plan for the day were discussed by the team.
- We saw evidence of lessons learned posters in a folder on each ward and posters stuck on the back of toilet doors. However, five out of 14 nurses and health care workers were not aware of lessons learned from incidents and were unable to tell us of any lessons learned as a result of incidents.
- The provider told us prior to the inspection that as a result of a serious incident occurring after a patient had returned from leave that they had implemented a home leave feedback form. However, this had not been completed at ward level.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- We found repeated poor application of the safe and supportive observation and engagement policy. Many young people self-harmed even when on constant observations with multiple staff observing them.
- Senior staff with lead responsibility for safeguarding did not ensure that safeguarding processes and procedures were adhered to in all instances. Staff did not always report harm to young people under safeguarding, or shared with the appropriate authorities.
- During the period of 5 December 2018 to 14 February 2019 the provider recorded 15 notifiable serious incidents. On review all of these required a notification to the Care Quality Commission. Of the 15 serious incidents, three had not been notified to the Care Quality Commission as expected.
- Systems used for care planning did not incorporate a process for recording progress against identified goals.
- Senior managers did not ensure that all staff had access to systems used for care planning and incident reporting. Agency staff did not always have access to the incident reporting system and therefore were unable to record incidents first hand.
- The governance processes and systems for monitoring the uptake of mandatory training were effective. Induction training for agency and bank staff was completed over weekends for maximum attendance. New permanent staff completed a two week induction programme before working on a ward.
- We found evidence of incident forms not completed accurately. We found one entry on a serious untoward incident reporting form where a member of the staff had recorded their job title inaccurately. We found another incident form with a name of someone who doesn't work at the hospital recorded as responding to a serious incident.

Management of risk, issues and performance

- The senior management team maintained and had access to the risk register. Staff at ward level were not aware of the risk register or how to access it.

Information management

- Permanent staff told us they had access to the equipment and information technology needed to do their work. Agency staff did not always have access to the equipment and information required to do their work effectively.
- Team managers told us they had access to information to support them with their management roles. We saw evidence of the ward to board dashboard and InCharge dashboard. This included information on the performance of the service, staffing and patient care.
- We identified a number of occasions when incidents were not reported to external bodies as required, including statutory notifications to the Care Quality Commission. When it was bought to their attention managers submitted notifications retrospectively. Safeguarding concerns were reviewed internally before a decision was made to raise an alert with external bodies. There were incidents within the internal safeguarding log where it was not clear if staff had made alerts to external organisations as required, but were dealt with internally.

Engagement

- We spoke to eight carers. Five carers told us there was a lack of communication from the hospital about their relative. Staff had not always made them aware of incidents happening at the hospital involving their relative. One carer told us that staff had not informed them when their relative was taken to hospital. One carer told us they felt completely out of the loop which they found very distressing.
- Most staff told us they felt they had an opportunity to give feedback on the service and input into service development.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Relatives and carers were not kept informed of patient wellbeing.** **Patients care plans were not always individualised and person centred.** **This was a breach of regulation 9(3)(g)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Staff did not always communicate with patients effectively.** **Staff did not always conduct their searches in line with their policy and procedures.** **This was a breach of regulation 10(1)**

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 **The provider did not ensure physical healthcare checks were carried out and recorded on admission or routinely thereafter.** **This was a breach of Regulation 12(1) (2)(a)(b)**

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ligature risk assessments were not accurate. They did not contain mitigation for individual risks identified. Patient observations were not always carried out as prescribed. Staff did not always adhere to the hospital observation policy. Staff did not always adhere to the Mental Health Act Code of Conduct with regards to recording and reporting section 17 leave. Not all staff were aware of lessons learned from incidents. Patients were not always debriefed after incidents. This was a breach of regulation 12(2)(a)(b)

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 Not all notifiable incidents were reported to the Care Quality Commission or external bodies as required. The provider did not always follow their internal quality assurance process. Not all staff had access to the systems used for care planning and incident reporting. The provider did not always descend and ascend information appropriately. The provider did not have the appropriate governance systems in place to ensure patient safety.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not always meet their training compliance targets. Staff did not always have a good understanding of the Mental Health Act Code of Practice. The provider did not always ensure they met their minimum safe staffing levels. These were not always recorded coherently or consistently. Not all staff had the appropriate training and knowledge for the patient group. This was a breach of regulation 18(1)(2)(a)
	The provider did not ensure they had a robust and effective oversight of their section 17 leave processes and documentation. Staff did not monitor patients' physical health consistently. Blanket restrictions were put in place without individually risk assessing patients and risks were not identified in patient records. This was a breach of regulation 17(1)(2)(a)(b)(c)