Potters Bar Clinic

Quality Report

Potters Bar Clinic
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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

Are services safe?	
Are services effective?	
Are services well-led?	

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.

Overall summary

We did not rate this service because this was a focused inspection. We inspected this service because at our last inspection in February 2019, we had concerns about this provider. Following the inspection in February 2019, we

Summary of findings

took action to prevent further admissions to the wards for children and young people at this service. We also told the provider to submit information to the Care Quality Commission over a number of months to show what action they had taken about the concerns we raised.

- We were not assured that staffing levels were at a safe level to manage the children and young people on the wards. There was a high number of agency and bank staff used at the service and we were not assured they had received the appropriate levels of specific training in child and adolescent mental health issues.
- We were not assured that agency staff received regular supervision.

However:

- We were assured that the provider had made improvements in ensuring permanent staff received regular supervision.
- We saw improvements in how staff recorded risk assessments for patients who used section 17 leave. The provider had embedded a new system for staff to assess how patients felt before leaving the ward on leave, and what contingencies were in place should the leave break down.
- We were assured that the provider had improved how staff updated patients' risk assessments following incidents. This included an alert system in the electronic record so that staff cold see, at a glance, what the risk behaviours were of patients in their care.
- We were assured the provider had improved how they monitored and evaluated incidents. Three independent senior managers reviewed all incident forms and senior manager took action where necessary to investigate incidents and make recommendations to improve practice. Where required, the provider had consistently notified external agencies about incidents.
- The provider had taken action to update and improve ligature risk assessments and mitigation for risk.Staff working on the wards, knew how to identify ligature risks in each area of the wards, and knew how to mitigate risks in their day to day work with patients.
- The provider had completed a review of how enhanced observations of patients was carried out by frontline staff. We saw an improvement in how staff completed enhanced observation records.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Page

Background to Potters Bar Clinic 6

Our inspection team 6

Why we carried out this inspection 6

How we carried out this inspection 7

The five questions we ask about services and what we found 8

Detailed findings from this inspection

Mental Health Act responsibilities 11

Mental Capacity Act and Deprivation of Liberty Safeguards 11

Overview of ratings 11

Outstanding practice 16

Areas for improvement 16

Action we have told the provider to take 17

Potters Bar Clinic

Services we looked at:
Child and adolescent mental health wards;

Summary of this inspection

Background to Potters Bar Clinic

Potters 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 years 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 seven beds on the ground floor.

At the time of our inspection Opal ward was closed for refurbishment. All patients resided on Jasper ward.

There are two adult mental health wards at this location:

Crystal is an acute female ward with 11 beds on the second floor.

Ruby is an acute male ward with 12 beds on the first floor.

We did not inspect these wards.

Potters Bar Clinic is registered to carry out the following legally regulated 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 an inspection manager and three inspectors.

Why we carried out this inspection

We inspected the CAMHS wards as part of a focused inspection to follow up on enforcement action we took against the provider following an inspection in February 2019. Following that inspection, we applied conditions on the provider in March 2019 to prevent further admissions to the CAMHS wards due to breaches in the following regulations:

Regulation 12, Health and Social Care Act 2008, (Regulated Activities) 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 Practice 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.

Regulation 17, Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, Good governance.

- Not all notifiable incidents were reported to CQC 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.

Summary of this inspection

- The provider did not always descend and ascend information appropriately.
- The provider did not have the appropriate governance in place to ensure patient safety.

How we carried out this inspection

We have reported on the conditions we imposed on the provider in March 2019, following our inspection in February 2019. We have reported in the following domains:

- Safe
- Effective
- Well-led

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?

- Staffing levels remained a concern. There was a high use of agency staff. although most formed a core group who worked at the hospital regularly and received training specific to the patient group. We sampled a two-week period of staffing rotas and found 74.5% of shifts were filled by agency or bank staff. Fifteen out of 39 shifts were under planned staffing numbers with one shift five staff below planned staffing. We found that two shifts in this two-week period could not meet the enhanced observation levels of patients.
- Staff reported mixed views on staffing levels. Some reported it had improved and others reported shortages, particularly at weekends and sited public transport difficulties with getting into work. Some patient activity, including a risk assessed non urgent visit to A&E could not be facilitated due to staffing issues.
- We had concerns about the staff understanding of the providers' policy on enhanced observation and how this was carried out in practice. This may have been because the policy was slightly unclear and inspectors raised this with the provider during the inspection.

However:

- The provider had made significant improvements with their ligature risk assessments. Senior managers had developed new ligature risk assessments which included every room on the wards, each ligature risk within the room and the mitigation for each risk. All staff we spoke with knew what a ligature point was and where to find the risk assessment.
- Mandatory training compliance for permanent staff as of 14th June 2019 ranged between 63% and 100%. Two courses within the mandatory training were below 75%.
- The provider had made significant improvements in completion and review of patients' risk assessments. In the majority of incidents staff had updated the patients' risk assessment within a week, to include details of the last incident. All incident forms had been reviewed and verified by three independent senior managers. We saw that lessons learned posters were placed on the staff bathroom walls and

Summary of this inspection

updated following new incident outcomes. Posters were also in the folders in the ward offices and were discussed at team meetings and handovers This was a significant improvement since our last inspection.

- We saw significant improvement in the quality of staff recording of patients on enhanced observations.
- The provider had made some improvements to the way in which restrictions were recognised and reviewed. Staff had developed, in collaboration with patients, an audit tool which listed all potential restrictive practices. This ranged from access to mobile phones and the internet, to times for meals, access to bedrooms and access to hand towels.
- The provider had made improvements in investigating allegations of poor practice, and investigations of complaints. We saw evidence of investigations carried out by senior managers following complaints from patients.

Are services effective?

- The provider employed agency staff whose training records showed compliance with core basic training. Agency staff were expected to attend additional training from the provider, such as safeguarding. Throughout the inspection process the provider was unable to provide compliance rates for which agency staff had attended training. Compliance rates for the specific training in child and adolescent mental health for agency staff were low at 25%.
- Throughout the inspection process the provider did not provide compliance rates for agency supervision. We were not assured that the high numbers of agency staff used were supervised on a regular basis.

However:

- The provider had made significant improvements in the risk assessment and recording of section 17 leave. We saw evidence that staff completed detailed risk assessments, which included types of leave, conditions and the duration of leave and instructions for staff to follow when a patient returned from leave. The provider had developed a pre-leave risk assessment which senior staff on the ward completed with patients before they left the ward on planned leave.
- There was significant improvement in the eight pre-leave risk assessments reviewed. Staff had completed the documents in full with thorough detail of reasons for leave, risks associated with leave and reflected the patients voice.

Summary of this inspection

- The provider had delivered specific training in child and adolescent mental health for permanent and some agency staff. Permanent staff compliance with this training was 90%. All permanent staff spoken with, reported attending specific training on adolescent mental health.
- The provider had made significant improvements in permanent staff compliance with supervision. Permanent staff compliance with supervision in May 2019 was 81% and as of 18 June 2019 was ongoing at 60%. Staff reported that they received regular supervision.

Are services well-led?

- We were assured that the provider had reviewed its scheme of delegation for approving incidents and ensuring that policy was adhered to. Senior managers had oversight of all incidents and all incident forms had been reviewed by three independent senior managers.
- Where incidents required notification to external bodies, senior managers had completed these on all occasions.
- We reviewed 14 incident forms and saw that all incidents had been robustly investigated. Appropriate actions were taken by senior managers where staff conduct, skills or knowledge fell below expectations.
- We saw evidence of learning from the outcome of incidents and this was effectively updated and cascaded to staff.

Detailed findings from this inspection

Mental Health Act responsibilities

The provider had made significant improvements in the risk assessment and recording of section 17 leave. We saw evidence that staff completed detailed risk assessments, which included types of leave, conditions and a duration of leave and instructions for staff to follow when a patient returned from leave. This was considerably improved since our last inspection. We saw evidence where staff completed plans for patients on extended leave and contingency plans should the leave break down. Staff spoken with knew the process for recording and facilitating leave.

The provider had developed a pre-leave risk assessment which senior staff on the war completed with patients before they left the ward on planned leave. Particular questions had been devised which staff asked and discussed with patients to assess if the patient was safe to leave the ward.

We reviewed 8 pre-leave risk assessments. Staff had completed the documents in full with thorough detail of reasons for leave, risks associated with leave and reflected the patients voice. Staff signed to authorise leave and ensure the staff who was escort had also signed. The new process had been embedded with staff and staff understood the need to complete the forms. Staff knew what was expected of them when completing the form and could tell us the need to complete it and the importance of completing it in full.

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

This was a focused, unannounced inspection. We have not rated this service.

Child and adolescent mental health wards

Safe	
Effective	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- At the inspection held in February 2019 we found multiple potential ligature anchor points which managers had not identified on the wards individual ligature risk assessment. The ligature risk assessments had the same mitigations regardless of the risk or location. At this inspection, we saw significant improvement in ligature risk assessments. The ligature risk assessments were seen on Jasper ward. They incorporated all rooms, bedrooms and individual mitigation risk for each room. All of the 11 staff that we spoke with knew what a ligature was and what the ligature audit was. All were able to describe what they look out for and all said they had signed to say they had read the ligature risk assessments. The provider had developed a competency check and required staff to sign to say they understood issues relating to ligature risks. Staff compliance was at 100% for permanent staff and 91% for agency staff.

Safe staffing

- At the inspection held in February 2019 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.
- Staffing levels had improved since the last inspection. However, we were not assured that staffing levels were consistently at a safe level to manage the children and young people on the wards. We reviewed the staff rotas over the fourteen days prior to the inspection. Agency fill rates were at 75%.There were six out of 14 occasions on Jasper days and nights, and three occasions on Opal days and nights where staff numbers were lower than planned. There were 38% of shifts that were under planned staffing numbers across days and nights. However, staffing numbers met the needs of enhanced observations except on two occasions.
- Of the staff that we spoke with, three reported that staffing levels had improved but said there were still times when staffing could be low. Two staff reported being unable to take breaks. One staff member said that there were no gaps in staffing.
- All patients that we spoke with reported low staffing. All patients reported there was not enough staff and reported times when staff left their enhanced observations. We heard of one incident when a patient could not be facilitated to attend A&E for a non-urgent wound repair, following the recommendation of two doctors after an incident the day before. This was due to there not being staff on duty who knew the patient well enough to mitigate an absconsion risk. This was confirmed in the daily record and by staff we spoke with.
- Some staff said that train and bus travel was problematic for staff to access to get into work, particularly during weekends. The Registered Manager reported that as of 1st July 2019 there would be increased pay rates. Flexible working agreements were also in place in line with policy.
- The provider was working with a recruitment service to source more agency staff. The provider was implementing a starting bonus for bank staff. An E-roster system was starting on 1st July 2019 and shifts would no longer be planned on the existing paper system. Two staff had recently transferred from agency to permanent staff.

Assessing and managing risk to patients and staff

- At the inspection held in February 2019 we observed staff frequently 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. We found 14 gaps were recorded in the 17 patient observation records we reviewed. We found 12 gaps of between 20 minutes and

two hours 45 minutes. We found one gap of eight hours and 30 minutes where "hospital visit" was the last recorded observation before the next recording. We found one gap of nine hours and 20 minutes with no explanation.

- We reviewed the observations sheets of all patients over the eight weeks prior to this inspection and saw significant improvement week on week on how staff recorded enhanced observations of patients. During this inspection, observation sheets were sampled for all nine patients over a one-week period prior to the start of the inspection. No gaps were found in the records. Records reviewed showed staff completed a recording at the right time as recommended by the clinical team for example at five-minute or 15-minute intervals. We saw an improvement in the quality of what staff recorded. Staff included detail about what patients were doing and recorded thorough observations about breathing and movement when the patient was sleeping. However, we found the times between observations did not always follow the recommendations of the enhanced observation policy. Staff we spoke with, reported different explanations for each level of observation, and some records recorded how frequently to observe the patients, but this did not tally with what the explanation in the policy.
- At the inspection held in February 2019 we found multiple instances where staff applied blanket restrictions directly after serious incidents. At the time of inspection, we found that staff had developed, in collaboration with patients, an audit tool which listed all potential restrictive practices. This ranged from access to mobile phones and the internet, to times for meals, access to bedrooms and access to hand towels. A restrictive practice group, which included patients, regularly reviewed items on the audit and views were sought from all involved how to best implements or remove restrictions on the wards.
- Despite the development of a restrictive practice group we found some evidence of restrictive practice and blanket restrictions in place. During the inspection we reviewed the use of blanket restrictions. We reviewed one incident where a patient was aggressive as a result of a nurse saying that patients could not go to their room after their meal. There was no evidence of this in a care plan. On Jasper ward, there were no cups by water cooler. Ward managers could not define the restrictions rationale. Staff reported that it would be individually risk assessed. We reviewed the blanket restrictions audit tool which said that patients could have water bottles, but they were not seen on the ward. Patients spoken with reported that water bottles were not allowed. A registered nurse reported that three patients had limited access to toilet paper. We did not see evidence of this in care plans and it was not confirmed by any of the patients. Use of the ward phone appeared to be only agreed at certain times of the day. This may have been partly due to school hours and patients calling those they shouldn't. Legal/professional calls could be made at any time of the day. Documents reviewed evidenced that the provider was reviewing the protocol for phone usage. Nationally the low secure network were reviewing patients' use of mobile phones and the provider was awaiting guidance on this issue.

Safeguarding

- At the inspection held in February 2019 we found the 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, including statutory notifications to the Care Quality Commission. At the time of this inspection, we saw significant improvement in this area. We sampled 14 incident forms and found that all had been reviewed and authorised by three independent senior managers in line with the provider's scheme of delegation. All of the incident forms were robust and detailed and contained actions as a result of investigation. Examples of actions included staff training, where skills and knowledge fell below expectations. We saw evidence that the provider had notified external bodies of all reportable incidents.

Reporting incidents and learning from when things go wrong

- At the inspection held in February 2019 we reviewed patient risk assessments. We saw that they were not consistently reviewed and updated following incidents. During this inspection we sampled 14 incident forms. We found significant improvement in risk assessments. Risk assessments were updated after each incident, however, not immediately, but mostly within a week.

This included an alert in the front of patients' records showing the risk behaviours. Most staff reported that qualified nurses made changes to risk assessments. The Health Care Assistants reported seeing the changes.

- Staff reported knowing how to complete incident forms and managers reviewed incident forms and frequently sought clarification from staff on incidents. Managers provided support to staff who had been involved in incidents.
- We saw that lessons learned posters were placed on the staff bathroom walls and updated following new incident outcomes. Posters were also in the folders in the ward offices and were discussed at team meetings and handovers. This was a significant improvement since our last inspection.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Skilled staff to deliver care

- At the inspection held in February 2019, 75% of staff had received training in the Mental Health Act and Code of Practice. 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's mental health issues. At the time of this inspection the provider had addressed training in the Mental Health Act 1983. The compliance rate was at 80%.
- We reviewed training records at the time of this inspection. There was 90% compliance for permanent staff who had completed CAMHs specific training. Three staff remaining were booked onto future dates. Most permanent staff spoken with confirmed attendance at CAMHs specific training and mandatory training. Some agency staff confirmed that they had received CAMHS specific training and all were able to describe the content.
- There was 25% compliance for agency staff who had completed CAMHs specific training. Training was delivered on 1st and 2nd May 2019 and was the first batch of CAMHs specific training to be delivered to agency staff. The Registered Manager reported further dates had been arranged, but since the training lead had left and a new one started (who was on leave at the time of inspection) she could not access the database to report on dates planned for future training. The Registered Manager reported further dates had been arranged. At the end of the inspection we were given three dates planned in July to deliver further CAMHS training.. Staff reported a change in restrictive practice training.
- The provider had made significant improvements in permanent staff compliance with supervision. The provider no longer included staff meetings within compliance rates. All records completed by staff for May 2019 and June 2019 were reviewed. Staff compliance with supervision in May 2019 was 81% and as of 18 June 2019 was ongoing at 60%. Staff reported that they received regular supervision.
- At the time of inspection, the provider did not have a compliance figure for agency staff compliance with supervision. We were not assured that the high numbers of agency staff were supervised on a regular basis.

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

- At the inspection held in February 2019 we found inconsistencies and gaps in the documentation and recording of section 17 leave, At the time of this inspection, we reviewed 11 section 17 leave risk assessments and found that all 11 were in place. All assessments were complete with specific detail about particular risks and safeguarding risks. All assessments were in date and identified the type of leave and the expiry date. The conditions of leave were present, and the number of escorts required were present. Instructions for staff during leave were present along with Instructions about what to do on return from leave, including potential searches. This was considerably improved since our last inspection. We saw evidence where staff completed plans for patients on extended leave and contingency plans should the leave break down. Staff spoken with knew the process for recording and facilitating leave. We also saw section 17 leave

forms where leave had been revoked and the reasons why. There was detail around extended home leave and contingency plans if needed for action to take if leave broke down.

- At the inspection held in February 2019 we reviewed 13 pre-leave risk assessment forms and identified gaps in recording. At the time of this inspection the provider had developed a pre-leave risk assessment to be completed by staff, with the patients, before leaving the ward. Particular questions had been devised which staff asked and discussed with patients to assess if the patient was safe to leave the ward. All staff knew the expectation on them to complete the section 17 pre-leave risk assessment and were clear on what level of detail was needed on the form. In the 11 weeks leading up to the inspection improvements had been seen in quality of documentation and the detail recorded. We sampled eight pre-leave risk assessments. All were completed in full, with thorough detail of the reasons for leave, risks associated with leave and reflected the patients voice. Staff signed to authorise leave and ensured that the staff who was escort had also signed. The new process had been embedded with staff and staff understood the need to complete the forms.

Are child and adolescent mental health wards well-led?

Management of risk, issues and performance

- At the inspection held in February 2019 we found that senior staff with lead responsibility for safeguarding did not ensure that safeguarding processes and procedures were adhered to in all instances. Harm to young people was not always reported under safeguarding or shared with the appropriate authorities. We identified a number of occasions when incidents were not reported to external bodies as required, including statutory notifications to the Care Quality Commission. Incident forms were not signed off by three independent senior managers and lessons learned from incidents were not effectively cascaded to staff. During this inspection we found investigation reporting had much improved. Staff knew how to report incidents and the provider had reported all notifiable incidents to the relevant external bodies. All 14 incident forms sampled were reviewed and authorised by three independent senior managers in line with the provider's scheme of delegation.
- The quality and detail of Investigations had improved. Managers ensured that they were well recorded and sent through to CQC with notifications. On this inspection, we saw evidence of investigations carried out by senior managers, following complaints from patients. This included allegations of staff sleeping on duty and allegations of staff inappropriate behaviour. In some cases, we saw action was taken against staff where allegations were upheld. We saw evidence that senior managers took action where staff conduct fell below expectations. This included further training for staff, suspension of agency staff, reviews of CCTV, contact with external agencies such as police and safeguarding agencies and next of kin. Where incidents required notification to external bodies, senior managers had completed these on all occasions. There was evidence of CCTV being reviewed by staff, police review of CCTV, speaking to staff, not booking agency staff and sending staff onto training. Managers regularly sought clarification from staff on incidents and staff who had been involved in incidents were well supported by managers.
- We saw that lessons learned posters were placed on the staff bathroom walls and updated following new incident outcomes. Posters were also in the folders in the ward offices and were discussed at team meetings and handovers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that agency staff have specialist training levels in child and adolescent mental health issues.
- The provider must ensure agency staff receive regular supervision.
- The provider must ensure there are suitable levels of staff on duty to meet the needs of the patients.
- The provider must ensure that staff know how to carry out enhanced observations of patients in line with the policy.
- The provider must ensure compliance with all mandatory training courses, including administration of medication level one and infection control level two.

Action the provider SHOULD take to improve

- The provider should continue to review blanket restrictions within the service and ensure that any restriction is individualised and documented in a care plan.
- The provider should continue to ensure compliance with Mental Health Act training.

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 • The provider did not ensure staff compliance with all mandatory training courses, including administration of medication level one and infection control level two.

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 The provider did not ensure sufficient numbers of staff met the needs of patients. The provider did not ensure agency staff received training in specialist child and adolescent mental health issues. The provider did not ensure agency staff received regular supervision. This was a breach of Regulation 12 (1)