Care Quality Commission

Essex Partnership University NHS Foundation Trust

Child and adolescent mental health wards

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)
R1LZ9	Rochford Hospital	Poplar Ward	SS4 1RB
R1LX1	The St Aubyn Centre	Larkwood Ward	CO4 5HG
R1LX1	The St Aubyn Centre	Longview Ward	CO4 5HG

This report describes our judgement of the quality of care provided within this core service by Essex Partnership University NHS Foundation Trust. 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 Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of Essex Partnership University NHS Foundation Trust.

Summary of findings

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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Summary of findings

Overall summary

We found the following issues that the trust needs to improve:

- All wards had blind spots so staff could not observe all areas of the wards at all times to keep patients safe.
- The service used high levels of bank and agency staff to maintain safe staffing numbers. There were frequent staffing issues on Larkwood and Longview wards and qualified staff were not visible on the wards. Staff sometimes cancelled activities due to staffing shortages and informal patients could not always to leave the wards when they wished to.
- The seclusion room on Larkwood ward did not meet the standards laid out in the Mental Health Act Code of Practice.
- Seclusion paperwork was incomplete and staff did not consistently debrief patients following seclusion.
- We found gaps in observation records on Larkwood and Longview ward so were not reassured that patients were safe.
- Two patients had no risk assessment in place after three days of admission.
- Not all patients felt safe on the ward.
- There were blanket restrictions across the service.
- Staff were not routinely documenting if patients had capacity or competence issues on consent paperwork.
- There were inconsistent practices across the wards for documenting consent to treatment. Capacity paperwork was not fully completed.
- Care plans were not always holistic, recovery focused or personalised. Two patients on Longview ward did not have any care plans in place after three days of admission.
- Compliance with mandatory training was below 75% on Larkwood and Longview ward.
- Compliance with supervision was poor on Larkwood ward and on Longview ward at 41% and 48% respectively.Staff did not consistently change practice following lessons learnt.
- We identified lapses in management on Larkwood and Longview wards. We were concerned at the lack of management oversight on these wards.

However, we also found the following areas of good practice:

- The ward areas were clean and tidy and free from clutter. The clinic rooms were visibly clean, tidy and had enough space to prepare medications. Emergency resuscitation equipment available and staff checked the clinic regularly.
- Staff completed routine physical health observations.
- Consent to treatment forms and current medication forms were kept together so staff could check patients' consent for medicines.
- Families and carers were involved with their relatives care and treatment.
- The advocate visited the wards weekly and patients and staff knew how to access this service.
- Staff understood the complaint process and how to assist patients should they wish to complain. Most patients told us that they knew how to complain.
- Staff participated in a variety of clinical audits around medication and care plans.
- Staff told us that they received feedback following investigation in handovers and team meetings if they attended.
- Poplar ward was compliant with mandatory training, appraisal and supervision.

Summary of findings

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

Are services safe?

We found the following issues that the trust needs to improve:

- All wards had blind spots so staff could not observe all areas of the wards at all times to keep patients safe.
- The service used high levels of bank and agency staff to maintain safe staffing numbers.
- Larkwood and Longview wards were not always able to staff the wards to their required numbers.
- On Larkwood and Longview wards, the ligature risk assessments did not have time frames or action plans to fully mitigate risk.
- Larkwood ward seclusion room did not meet the standards laid out in the Mental Health Act Code of Practice.
- Seclusion paperwork was incomplete. Staff did not consistently debrief patients following seclusion.
- We found gaps in observation records on Larkwood and Longview ward so were not reassured that patients were safe.
- Poplar ward were reporting and documenting incidents of long term segregation as seclusion episodes.
- There were frequent staffing issues on Larkwood and Longview wards and qualified staff were not visible on the wards.
- Two patients had no risk assessment in place after three days of admission.
- Not all patients felt safe on the ward.
- Leave was sometimes cancelled due to staffing issues. Staff and patients confirmed this.
- There were blanket restrictions across the service.

However, we found the following areas of good practice:

- The ward areas were clean and tidy and free from clutter.
- The clinic rooms were visibly clean, tidy and had enough space to prepare medications.
- Staff completed routine physical health observations.
- Emergency resuscitation equipment was held in the clinic room and staff checked this regularly.

Are services effective?

We found the following issues that the trust needs to improve:

- Two patients' consent to treatment paperwork was missing that could not be located by staff.
- Staff were not routinely documenting if patients had capacity or competence issues on consent paperwork.

Summary of findings

- When patients lacked capacity to consent, there was no assessment documentation to show how staff had reached this decision.
- There were different practices in place across the wards to document if patients gave consent or were unable.
- Informal patients told us that they were not always permitted to leave the wards. Staff and two carers confirmed this. Poplar ward had no signage up to explain rights to informal patients.
- Two patients on Larkwood ward did not have the appropriate authorities in place to allow the administration of medicines for rapid tranquillisation by the intra muscular route.

However, we found the following areas of good practice:

- We saw detailed ward round entries on Poplar ward where consent was reviewed and updated weekly.
- Consent to treatment forms and current medication forms were kept together so staff could check patients' consent for medicines.

Are services caring?

We found the following issues that the trust needs to improve:

- Care plans were not always holistic, recovery focused or personalised.
- There was little evidence of patient involvement in some care plans on Larkwood and Longview wards.
- Staff did not provide regular 1:1 sessions with patients to discuss care and treatment on Larkwood and Longview wards.
- Staff did not routinely give patients a copy of their care plans.
- Two patients on Longview ward did not have any care plans in place after three days of admission.
- Patients were not invited to attend their care and treatment reviews on Larkwood and Longview wards.
- Regular community meetings were not taking place on Larkwood and Longview wards.
- Not all staff that worked on the wards understood individual patient's needs.

However, we found the following areas of good practice:

- Families and carers were involved with their relatives care and treatment.
- Weekly community meetings were taking place on Poplar ward.
- The advocate visited the wards weekly and patients and staff knew how to access this service.

Summary of findings

Are services responsive to people's needs?

We found the following areas of good practice:

- The service received four complaints across the last 12 months.
- Staff understood the complaint process and how to assist patients should they wish to complain.
- Most patients told us that they knew how to complain.

Are services well-led?

We found the following issues that the trust needs to improve:

- We identified lapses in management on Larkwood and Longview wards. We were concerned at the lack of management oversight on these wards.
- Managers did not ensure that all staff received mandatory training; compliance with mandatory training was below 75% on Larkwood and Longview ward.
- Managers did not ensure that staff received supervision in line with their policy. Compliance with supervision averaged 41% on Larkwood ward and 48% on Longview ward. Bank staff told us that they did not receive supervision.
- Managers did not ensure that all staff received appraisals. Overall, 65% of staff on Larkwood ward and 74% of staff on Longview ward received an appraisal in the last 12 months.
- Staff did not have access to regular team meetings on Larkwood and Longview wards. Not all staff felt supported in their roles.
- Managers did not ensure that wards were adequately staffed. Larkwood and Longview wards frequently worked with insufficient staffing numbers to meet the needs of the patients and to ensure the ward was safe.
- Seclusion documentation was not robust and there were gaps in paperwork.
- There were blanket restrictions across the service. Interventions were not individually risk assessed or care planned. Staff did not consistently change practice following lessons learnt.

However, we found the following areas of good practice:

- Staff participated in a variety of clinical audits around medication and care plans.
- Staff told us that they received feedback following investigation in handovers and team meetings if they attended.
- Compliance with mandatory training was 94% on Poplar ward.
- Compliance with appraisal was 93% on Poplar ward.
- Compliance with supervision was 92% on Poplar ward.

Summary of findings

Information about the service

The St Aubyn Centre is a children and adolescent mental health in-patient service managed by Essex Partnership University NHS Foundation Trust. It provides acute, intensive and secure care and treatment to young people between the ages of 13 and 18, who are experiencing acute, complex and/or severe mental health problems who cannot be safely or effectively treated in a community setting and where the treatment must be provided in a hospital.

The service has two mixed sex wards. Larkwood ward is a ten bedded psychiatric intensive care unit and Longview ward is a 15 bedded admission and treatment ward. There was an education facility on site providing education and vocational opportunities in line with the National Curriculum.

The CQC last inspected the St Aubyn Centre in August 2015. It was rated 'good' for safe, effective, responsive and well-led and 'outstanding' for caring.

Following the last inspection, we told the trust that it should take the following action:

- The trust should review the food provided to young people to ensure that it is enjoyed by patients and provides choice to young people.

Poplar child and adolescent ward is located at Rochford Hospital. This is a 15 bedded, mixed sex, inpatient assessment ward for young people aged 11 to 18 years old. Although this ward is described as open; we noted that there were three locked doors between the ward and the main entrance. There was an education facility on site providing education and vocational opportunities in line with the National Curriculum.

The CQC last inspected Poplar ward in June 2015. It was rated as good overall with safe rated as requires improvements.

Following the last inspection, we told the trust that it must take the following action:

- The trust must ensure that each episode of seclusion or segregation is recognised, recorded and reviewed in accordance with the Mental Health Act code of practice.

We also told the trust that it should take the following actions:

- The trust should ensure that consent is regularly reviewed and documented on the consent form
- The trust should ensure that local resolved complaints are recorded and monitored with outcomes

Regulated activities:

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

Since the last inspection, North Essex Partnership University NHS Foundation Trust had merged with South Essex Partnership University NHS Foundation Trust, forming Essex Partnership University NHS Foundation Trust on 1 April 2017.

Our inspection team

Our inspection team was led by:

Team Leader: Julie Meikle, head of hospital inspection (mental health) CQC.

Lead inspector: Victoria Green, inspection manager mental health hospitals, CQC.

The team that inspected the child and adolescent mental health wards consisted of three inspectors, two Mental Health Act reviewers and one nurse specialist professional advisor.

Summary of findings

Why we carried out this inspection

This was an unannounced inspection to this location. Our monitoring highlighted concerns and we decided to carry out a focused inspection to examine these. These included concerns about the maintenance of the ward environment and staff's management of patients.

How we carried out this inspection

We have reported in each of the five domains safe, effective, caring, responsive and well led. As this was a focused inspection we focused on specific key lines of enquiry in line with concerns raised with us. Therefore our report does not include all the headings and information usually found in a comprehensive inspection report. We have not given ratings for this core service, as this trust has not yet had a comprehensive inspection.

During the inspection visit, the inspection team:

- visited three wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- spoke with three carers
- spoke with 30 staff members; including doctors, nurses, teachers and managers
- attended and observed one hand-over meeting and one multi-disciplinary meeting
- looked at 19 treatment records of patients
- carried out a specific check of the medication management on the wards
- 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 19 patients currently receiving care within the service. Patients on Poplar ward told us that staff were available to them and that they were generally involved in their care plans.

Two patients told us that they did not always feel safe on the wards due to the behaviour of other patients. Some patients told us that staff spent time with then following incidents of restraint. Five informal patients told us they could not leave when they wished.

Three patients told us that they were not aware of their rights as an informal patient and were not aware of specific care plans in relation to their legal status. One informal patient told us that staff had indicated they would be detained under the Mental Health Act if they tried to leave the hospital. Two patients told that they did not feel that staff listened to their complaints. Patients told us that staff did not always communicate updates with family and external professionals in a timely manner.

Three patients reported they had been secluded during their admission, one in their bedroom and two in the de-escalation room. Patients confirmed that the door to the room was open but; two patients reported that staff told them they were not allowed to leave the room. Patients told us that they would like more access to their phones so they could keep in contact with their friends and family. Patients were aware of the advocacy service and how to complain.

Patients on Longview ward told us that there was not enough staff on the ward particularly if there were incidents. One patient did not always feel safe due to the opportunities on the ward to self-harm. One patient was not aware of who their named nurse was and told us that they were not aware of their rights and did not feel supported on admission. Patients knew how to complain.

One patient told us that they had been secluded overnight and staff did not provide bedding.

Summary of findings

One patient on Larkwood ward told us that there were frequent staff shortages and leave was often cancelled. One patient did not have rights explained to them upon admission and another did not feel supported upon admission. One patient did not feel involved in their care and treatment and another did not know who their named nursed was.

One patient told us that they did not feel safe on the ward, and did not feel that staff had time to listen to them. Patients reported that staff focused on the more challenging patients and the quieter patients had little attention. One patient told us that staff did not provide bedding when secluded and that they felt abandoned by staff, as they were not visible from the seclusion room. Patients told us that community meetings did not take place regularly. Not all patients knew how to complain.

Across the service, patients told us they could only access the gardens under supervision and that there were few activities over the weekend.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the seclusion facility is fit for purpose and in line with the Mental Health Act Code of Practice.
- The trust must ensure that their wards are safe and that all ligature risks are mitigated and managed.
- The trust must ensure that incidents of seclusion and long term segregation are documented in line with the Mental Health Act Code of Practice and their policies.
- The trust must ensure that there is adequate and appropriate staffing to meet the patients' needs safely.
- The trust must ensure that patients are involved in their care plans and that care plans are recovery-focused and holistic.
- The trust must ensure that staff are regularly supervised in line with their supervision policy.
- The trust must ensure that any restrictions placed on patients are individual, care planned and risk assessed.
- The trust must ensure that consent to treatment is documented in accordance to their policy and procedures.
- The trust must ensure that informal patients are aware of their rights.
- The trust must ensure that all staff receive mandatory training.

Action the provider SHOULD take to improve

- The trust should ensure that informal patients have clear care plans in place regarding their admission and treatment including legal status and leave arrangements.

Essex Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Poplar Ward	Rochford Hospital
Longview Ward	The St Aubyn Centre
Larkwood Ward	The St Aubyn Centre

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 allowed staff to observe some but not all areas of the wards. Managers told us they mitigated this risk with nursing observations. Bedroom corridors were locked on all wards to assist with observations. Patients had to ask staff to go to their bed space. Two carers told us that there was restricted access to bedrooms across the day. The wards had no mirrors or closed circuit television installed to assist with observation. There were numerous blinds spots. Staff at the St Aubyn Centre told us they were frequently short staffed; patients and review of rotas confirmed this. We were not reassured that there was sufficient staff to ensure all areas of the ward were observed at all times. Wards at St Aubyn Centre had large desks in the day area that were not in use and created further obstruction of sight.
- All wards had up to date ligature risk assessments showing managers had identified ligature points. A ligature is a place to which patients intent on self-harm could tie something to harm themselves. The ligature assessments for St Aubyn Centre had identified staff observation in areas of poor line of sight to mitigate risk. Risk assessments for these areas did not have time frames or action plans to make improvements. Poplar ward ligature audit was more detailed; showed clear mitigation, how to reduce risk for every area and actions were being monitored. We found numerous gaps in the observations records of four patients on Longview ward and six on Larkwood ward. We were not reassured that staff maintained patients' safety at all times via observation.
- The wards complied with the Department of Health's mixed sex accommodation guidance. There were segregated male and female areas.
- The clinic rooms were visibly clean, tidy and had enough space to prepare medications and undertake physical health observations. It was well equipped with weighing scales and blood pressure monitors. Equipment had been calibrated in the last 12 months and staff checked other equipment weekly to ensure it was in good working order. Emergency resuscitation equipment was in the clinic rooms and staff checked this regularly.
- The service had one seclusion room that was located on Larkwood ward at the St Aubyn Centre. This did not meet the Mental Health Act Code of Practice. There was no two-way communication and staff had to shout through a closed door to communicate with young people. This was checked on inspection and confirmed by staff and patients. There was no safe bedding and staff did not routinely provide bedding. Staff told us that when it was not safe to open the door patients had urinated on the floor. The ward did not have urinal bottles or bed pans. There was no access to a clock
- If a patient on Longview ward required seclusion staff would transfer them to Larkwood ward. We noted that there were a number of doors on this route. The gate to access Larkwood ward was locked and staff told us only Larkwood staff could open the gate which could cause a delay.
- Wards were generally maintained and the corridors were clear and clutter free. Cleaning records were up to date. On Larkwood ward, the patient phone was broken and part of the flooring had no covering. Staff told us they had been waiting several months for repairs.
- Staff adhered to infection control principles including hand washing.
- Staff carried personal alarms, which they could use to summon help, these were tested regularly. We observed staff respond to alarms at both St Aubyn Centre and Poplar ward.
- Staff had reviewed Longview ward environmental risk assessment and logged issues with the estates department however there were no timeframes for work and no specific action plans. St Aubyn Centre's fire risk assessment was comprehensive.

Safe staffing

- The wards had set staffing levels. Poplar ward had two qualified nurses and three support workers during the day. This reduced to one qualified nurse and three

support workers during the night. Longview and Larkwood wards each had two qualified nurse and three support workers during the day and reduced to one qualified nurse and three support workers at night. The manager and members of the multi-disciplinary team supported this establishment. Teaching staff were located in the school next to the wards.

- Longview and Larkwood wards were frequently working short staffed. We reviewed staffing rotas from Longview ward from August 2017 to October 2017. Overall, 718 shifts were filled by bank staff. In the same period there were 412 shifts unfilled. Following inspection the trust provided data showing 2218 shifts filled by bank and 248 shifts by agency staff between November 2016 and November 2017.
- We reviewed staffing rotas from Larkwood ward from August 2017 to October 2017. Overall, bank staff filled 1,059 shifts. In the same period there was 793 shifts unfilled.Following inspection the trust provided data showing 3336 shifts filled by bank and 489 shifts by agency staff between November 2016 and November 2017.
- During the day qualified staff shifts were not always covered. The trust provided data that showed between April and August 2017 78% of shifts were filled on Longview ward and 83% on Larkwood ward. The wards used additional support work to support this establishment.
- Poplar ward was able to fill their staffing needs. The trust provided data for Poplar ward. Between November 2016 and November 2017, there were 2,343 shifts filled by bank and 22 shifts by agency.
- Staff sickness rate for Poplar ward averaged at 10% between November 2016 and November 2017. This was significantly higher than the trust target of 4.5%. Sickness rate for Longview ward averaged 5% and Larkwood ward averaged 3%.
- At the time of inspection there were no vacancies on Poplar ward. Longview ward had two vacancies and Larkwood ward had five vacancies.
- Staff turnover for the last 12 months was 4% on Larkwood and 5% on Longview ward which equated to one member of staff each. On Poplar ward it was significantly higher at 18 %.
- The managers were able to adjust staffing levels daily to take account of patient mix. Extra staff were requested when patients were nursed on enhanced observations. Staff told us that there was difficulty requesting additional staff over the weekends as the bank staff office was closed.Managers told us that regular staff were offered additional hours as bank shifts in the first instance, and then shifts were offered to bank staff and then to agency. Staff told us that on Longview and Larkwood ward that bank and agency staff were not always familiar with the ward.
- Staff on Longview ward consistently told us that there were frequent staffing issues on the ward. Staff felt that this impacted on the level of care that they could provide. Some staff on Larkwood ward told us that at times the ward ran short staffed. This impacted on the patient leave and their ability to spend time with patients.
- On Larkwood and Longview wards qualified staff were not visible during inspection. Staff told us that they frequently worked with only one qualified nurse which made it difficult to spend time on direct patient activities. This was confirmed in the rotas that we reviewed.On Poplar ward staff told us that they had enough time to carry out their duties and support patients.We saw evidence of 1:1 sessions taking place.
- Leave and 1:1 sessions with staff were not routinely taking place on Larkwood and Longview wards. Staff told us that it was difficult to ensure that patients had regular 1:1 time with their named nurse due to staffing, and that leave was cancelled on occasion. Some patients on Poplar ward told us that they were not accessing leave as often as they would like.
- Routine physical health interventions were taking place. We saw evidence of this in care records.
- There was a consultant psychiatrist and staff grade doctor that provided medical cover during the day. There was a rota for medical cover across the nights.
- Compliance with mandatory training between November 2016 and October 2017 was 70% on Longview ward, 73% on Larkwood ward and 81% on Poplar ward; this was below the Trust target of 95%.

Assessing and managing risk to patients and staff

Are services safe?

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

- We asked the trust for data in relation to the number of seclusion that had taken place across Longview and Larkwood ward over the last 12 months.This information was not provided. Managers were unable to locate all of the seclusion paperwork on inspection and we noted gaps in most paperwork that was available.Between April and October 2017 there were seven episodes of seclusion on Poplar ward.
- There were 56 episodes of restraint on Longview ward between April 2017 and October 2017. Nine of these were in prone (face down) positions. There were 125 of episodes of restraint on Larkwood ward between April 2017 and October 2017. Twenty two of these were in prone (face down) positions. There were 67 of episodes of restraint on Poplar ward between April and October 2017. Fifteen of these were in prone (face down) positions.
- We reviewed 19 care records across the service. Staff undertook a risk assessment of most patients on admission and usually updated these after every incident. Two patients had no risk assessment in place after three days.
- Staff used the trust risk assessment tool to assess patient risk. This was detailed and updated regularly.
- On Longview ward staff removed all potential items from bedrooms for all patients who had a history of ligature risks regardless of current risk.Bedroom corridors were locked across the service and patients had to ask staff if they wished to access their bedrooms. Carers confirmed this. One patient that we spoke with had a card to access her bedroom without staff but this was not common practice. Patients were not permitted access to their own mobile phones, this was not risk assessed. Patients were able to have access to a mobile phone provided to the ward at certain times in the day; this was not risk assessed or individually care planned. Staff searched all patients following leave; this was not care planned or risk assessed.
- Informal patients told us that they could not leave at will. Some staff told us that they did not understand why informal patients were not permitted to leave the service upon request. Managers told us that if informal patients were presenting as high risk then staff would not automatically let them off the ward. Four informal patients on Poplar ward and one patient on Longview ward told us that they had not been allowed to leave the ward and were not aware of their rights.
- There was a trust policy and procedure in place for use of observation and searching patients. Some staff told us that the observation structure was complicated as there were many different levels and individuals observation changed across the day dependent upon whether a patient was awake or asleep. Bank staff told us that they did not always know what observations patients were on and why. We reviewed observation documentation; six patients records on Larkwood ward and four records on Longview ward had multiple gaps in their records; therefore we could not be reassured that patients were kept safe via nursing observations. On Larkwood ward we observed staff search two patients in the day area in front of staff and other patients. We could not be reassured that patients' privacy and dignity was always maintained.
- Staff were trained in restrictive interventions; staff used de-escalation and distraction techniques wherever possible.Staff told us that restraint was only used when de-escalation had failed.
- The use of rapid tranquilisation was in line with the National Institute for Health and Care Excellence guidelines. However, two patients on Larkwood ward did not have the appropriate authorities in place to allow the administration of medicines for rapid tranquilisation by the intra muscular route.
- We reviewed 21 seclusion records on Larkwood ward from August to October 2017. Paperwork was not always completed and eight records had gaps. There was no record of the doctor being informed in six records, one did not have a date, one record did not indicate the section status and another two did not have clear times recorded. Therefore it was not possible to determine the length of seclusion. We reviewed three seclusion records on Poplar ward; seclusion paperwork was generally complete however did not document if patients were prevented from leaving the room. Therefore it was difficult to establish by the records if these were incidents of segregation or seclusion. The manager and staff on Poplar ward told us that they did not seclude patients.

Are services safe?

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

- We reviewed all prescription charts and saw good management of medication. Medication was prescribed within recommended guidance and all documentation was present and in date. We saw appropriate authorised consent forms completed and attached to the drug charts for detained patients.
- There was good medicine management including transporting, storage, dispensing and reconciliation. Staff stored medicine in accordance to the manufacturers' guidelines. Staff recorded medicines on prescription charts. Prescriptions were in line with British National Formulary guidance and there were alerts in place for allergies.Staff recorded the temperature of the clinic room and refrigerator daily, to ensure that the temperature did not affect the efficacy of the medication.
- Staff planned and supported family's when they wanted to visit patients. There were family rooms where visits could take place.Staff supported patients to go home for visits following risk assessment.

Track record on safety

- There were seven serious incidents that required reporting over the last 12 months. Six related to Larkwood and one to Longview. Two of these were in relation to injury following restraint, four in relation to self-harming behaviour, and one in relation to staff behaviour.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents using the electronic reporting system. They could describe incidents that should be reported and understood the process.
- Staff reported most incidents. Staff managed and reported long-term segregations as seclusions on Poplar ward. We found one incident of restraint that had not been reported or documented in the patients' notes on Larkwood ward.
- Some but not all staff told us that they received feedback from investigation of incidents internal to the service. Feedback was provided in team meetings and shift to shift handovers on Poplar ward. Staff could describe incidents from across the service and changes to practice as a result of incidents.Staff did not consistently follow changes to practice required after an incident in the clinic and as further incidents of the same type had continued to occur on Longview ward. Some staff told us that they received feedback on the outcome of investigation of complaints and acted on the findings.
- Some staff told us they received de-brief and support following incidents although this was not always immediately. Other staff had not felt supported.

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

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

- Staff did not consistently record patients consent to treatment at the point of admission. Staff told us that if patients' signed their care plans this considered this as the patient consenting to treatment.
- We reviewed 10 patients consent to treatment paperwork on Longview ward. One patient's paperwork was missing and could not be located by staff. Five records did not indicate if the patients had capacity or not.
- We reviewed four patients consent to treatment paperwork on Larkwood ward. One patient lacked capacity to consent to treatment but there was no record of an assessment taking place.
- We reviewed nine patients consent to treatment on Poplar ward. One record indicated that the patient lacked capacity to consent but there was no record of assessment. One patient's consent paperwork was missing and could not be located by staff. One patients consent to treatment was dated two weeks after admission however; we saw that a detailed entry was made in all patients ward round which reviewed and updated consent.
- Managers told us that when informal patients signed their care plans they were consenting to treatment, the ward rules and expectations; including leave arrangements. If an informal patient wished to have leave and it was not indicated on their leave plan, staff did not view this as preventing leave. We reviewed 19 care records across the service only one patient had a leave care plan and this did not specifically indicate their rights as an informal patient.
- Informal patients told us that they could not leave at will. Two carers confirmed this.
- The understanding of capacity and consent issues for adolescents varied across the service. Three staff told us that they had not received training in this area. There was confusion over how staff were managing informal patients leave arrangements.
- Consent to treatment forms and current medication forms were kept together so staff could check patients' consent for medicines.
- Two patients on Larkwood ward did not have the appropriate authorities in place to allow the administration of medicines for rapid tranquilisation by the intra muscular route.

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 observed staff interactions with patients across the service. Staff were able to communicate with patients and we saw that some staff had a good rapport with some patients. On Longview ward we observed limited interactions between staff and patients on two occasions; staff were talking to one another rather than engaging with patients.
- The patients we met were generally positive about the quality of care provided by staff on Poplar ward. They described staff as mostly respectful, kind and available to them. Patients on Larkwood and Longview told us that staff were not always available to them. Three patients did not know who their named nurse was and told us that they did not have regular 1:1 sessions with staff.
- Permanent staff demonstrated an understanding of individual needs of patients. Some bank staff did not understand patients' observations or specific risk issues. Some staff told us that they did not understand why informal patients were not permitted to leave at will.

The involvement of people in the care that they receive

- We spoke with 19 patients. Most patients told us that they felt oriented and supported upon admission.
- We reviewed 19 care records across the service. We reviewed four care plans on Larkwood; care plans were in place but were not personalised and did not contain patients' views and there was little evidence of patient involvement. Patients confirmed this.
- We reviewed five care plans on Longview ward. Two patients had no care plans in place after more than three days on the ward; one of these patients was assessed as high risk of self-harm. Staff told us that they had not had time to make detailed entries or update care plans due to staffing issues. Two care plans were not personalised, recovery focused or contained patients' views.
- We reviewed nine care plans on Poplar ward. All patients had care plans that had been updated and reviewed regularly. Staff did not routinely document if patients were given a copy of their care plans however most were signed.
- Patients on Longview and Larkwood were not invited into ward rounds to discuss their care and treatment. Staff confirmed this.
- Across the service there was little evidence of care plans for specific issues such as leave for informal patients.
- There was access to advocacy. The advocate visited the ward weekly. There were posters displayed across the ward.
- Weekly community meetings took place on Poplar ward; we saw evidence of this and patients confirmed this. Regular community meetings were not taking place on Larkwood and Longview ward. Staff confirmed this.
- We saw evidence of appropriate involvement of families and carers in care records. Some patients told us that staff was slow to communicate incidents to family.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Listening to and learning from concerns and complaints

- There were four complaints across the service in the last 12 months, three were ongoing and still being investigated, one had been closed. Two were in relation to medication, one in relation to staff not meeting spiritual needs and one in relation to staff attitude.
- Poplar ward shared evidence of 10 compliments that the ward had directly received from patients and carers. Compliments were in relation to the care and treatment and the support provided by staff.
- Most patients told us that they knew how to complain. They told us that they would talk to staff or raise concerns with advocacy or family. Some patients did not feel staff would listen to them or record complaints formally.
- Staff that we spoke with knew how to handle complaints appropriately.

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

Good governance

- Compliance with mandatory training between November 2016 and October 2017 was 70% on Longview ward and 73% on Larkwood ward and 94% on Poplar ward.
- The trusts supervision target was set at 90%. Compliance for supervision was 93% on Poplar ward. Staff told us that they received supervision and felt supported by their manager. Between November 2016 and October 2017 compliance with supervision on Larkwood ward was 41% and Longview ward 48%. Staff told us that they did not receive regular supervision and did not always feel supported by managers. We reviewed 13 supervision files on Larkwood ward; overall compliance for the last 12 months was at 24%. We reviewed 19 supervision files on Longwood ward, overall compliance was at 26% for the last 12 months. Bank staff told us that they did not receive supervision.
- Compliance with appraisal for the last 12 months was 65% on Larkwood ward, 74% on Longview ward and 93% on Poplar ward.
- Not all wards had sufficient staff to keep the wards safe at all times. Between August and October 2017. Additional staffing needs were not consistently filled on Larkwood ward and Longview ward. Staff and patients confirmed this. The service relied on bank and agency staff to fill staffing needs. Over the last 12 months the service filled 5554 shifts with bank staff and 737 with agency staff. Staff told us that it was difficult to obtain additional staffing over the weekend as the office was closed.
- Larkwood and Longview wards frequently worked with one qualified nurse instead of two. Qualified staff were not visible on the wards and were not always able to take breaks or prioritise direct care activities. One restraint was not been recorded on the incident form or in the patient's records on Larkview ward. Staff told us that they did not always have time to update care plans and make detailed daily entries in care records.
- Staff participated in a variety of clinical audits around medication and care plans.
- Managers told us that they shared information on lesson learnt, complaints and feedback at team meetings, supervision and handovers.Staff confirmed information was shared at team meetings and handovers. Changes to practice in Longview clinic had not been adhered to which had resulted in further incidents of a similar nature.
- We found that documentation for seclusion was not robust. Poplar ward was routinely completing seclusion paperwork for segregation incidents. Overall, 38% of seclusion paperwork we reviewed on Larkwood ward had gaps in the documentation.
- There were numerous blanket restrictions across the services, which were not individually care planned or risk assessed.
- Concerns regarding staffing and seclusion were raised with executive staff during the course of the inspection. Members of the board were aware of issues relating to Larkwood and Longview wards. They described plans in place to address the issues and improve the quality of the service.

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 • Care plans were not recovery focused, individualised or holistic. • Two patients did not have care plans in placed following admission. • There was no care plans in place to assist patients to understand their legal status or leave arrangements. • There were restrictions in place across all wards that were not individual care planned. **This was a breach of regulation 9.**

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 layout of the building meant there were blind spots on the wards. There were no mirror or CCTV fitted to assist with observation. • The seclusion room on Larkwood ward did not meet the Mental Health Act Code of Practice: there was no clock, two way communication system. Staff had to enter seclusion to open the toilet door. Patients were not routinely provided bedding. There was no safe bedding within the service. Staff observed seclusion via CCTV from an office external to the seclusion room; this was due to blind spots. • Seclusion paperwork was not routinely completed and there were gaps in paperwork. **This was a breach of regulation 12.**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The provider was not routinely documenting consent for all patients. • Informal patients could not always leave at will. • There was no documentation to support capacity assessments. **This was a breach of regulation 11.**

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 trust did not always have sufficient staff to ensure that patient's needs were met. • Not all staff had received supervision on a regular basis. • Not all staff had undertaken required mandatory training. **This was a breach of regulation 18.**