Berkshire Healthcare NHS Foundation Trust

Quality Report

Berkshire Adolescent Unit, Wokingham Hospital,
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Core services inspected	CQC registered location	CQC location ID
Child and adolescent mental health wards	Berkshire Adolescent Unit	RWX70

This report describes our judgement of the quality of care at this provider. It 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.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

Contents

Summary of findings

Overall summary

We rated child and adolescent mental health wards as good overall because:

- Staff had carried out a detailed and thorough ligature risk assessment. All risks identified had been mitigated and the risks reduced effectively. Staff spoke confidently about managing ligature risks and they reviewed the risks at every shift handover. Staff carried out thorough and relevant risk assessments for patients and staff. Staff updated risk assessments regularly and ensured risk management followed through into care plans. Staff kept the ward clean and they maintained comprehensive cleaning schedules and audits to ensure the staff cleaned to the required standard.
- The trust ensured sufficient staff were available to deliver care to a proficient standard. Where agency and temporary staff were used, they received a thorough induction and in most cases these staff were familiar with the service and patients. Over 93% of staff were up to date with their mandatory training. Staff were confident in reporting incidents and were familiar with the trust's procedure for doing so.
- Patients had access to advocacy services. Patients met with the advocate as a group every two weeks. Managers told us that areas of concern and themes were fed back to them. There was information about the advocacy service and leaflets about the independent mental health advocacy service.
- Staff on the ward understood the vision and direction of the service and wider organisation. Staff at every level felt very much a part of the service and were able to discuss the philosophy of the unit confidently. Staff told us that staff morale was good and that they were being supported in their professional development.
- The service manager and ward manager maintained a series of clinical audits, data about staff and data on incidents and complaints. The information was summarised and presented clearly. The ward was organised and well-led. There was evidence of clear leadership at a local level.

However:

- Patients had raised safeguarding issues at a meeting. Although staff had seen the minutes of the meeting, they had not raised these issues formally as safeguarding concerns. When we raised our concerns, trust managers spoke to the meeting facilitator to ensure that any safeguarding issues would be raised in future. In addition, the senior managers formally raised the safeguarding concerns for investigation.
- Staff understood the concept of parental responsibility as set out in the Mental Health Act Code of Practice. However, we were unable to locate evidence that patients had given consent to share information with their parents in all six of the care records we reviewed. This was despite the trust reporting in January 2017 that a consent form for sharing information should be completed for all patients on admission to the unit.
- The quality of documentation in the care records in regards to capacity to consent to treatment was of a variable standard.
- Staff did not always record capacity or competence to consent appropriately. For example, there was no reference to Gillick competency in the care records and no record of the nature of the assessment against Gillick principles. This was despite the trust reporting in January 2017 that a Gillick competency template would be developed in April 2017. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive to people's needs?	**Good** 
Are services well-led?	**Good** 

Summary of findings

Our inspection team

The team that inspected this core service consisted of a Care Quality Commission inspection manager and two inspectors. The lead inspector was Jackie Drury.

Why we carried out this inspection

We undertook this inspection in response to a series of concerns raised with the Care Quality Commission and an alleged serious incident, which occurred on the Berkshire Adolescent Unit in the three months prior to this inspection.

When we last inspected the trust in December 2016, we rated child and adolescent mental health wards as good overall.

We rated the core service as good for safe, effective, caring, responsive and well-led.

There were no outstanding requirement notices for this service at the time of our inspection.

When the Care Quality Commission issue a requirement notice in one set of key questions, that domain is limited, at best, to a rating of requires improvement.

How we carried out this inspection

This inspection was a focused inspection concentrating on the safe and well-led key questions. Please refer to the report published 30 March 2016 for detailed findings of the caring, effective and responsive key questions.

Before the inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information and sought feedback from patients and carers using the service.

During the inspection visit, the inspection team:

- visited Berkshire Adolescent Unit (one of the visits was in the early hours of the morning) and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service, as a group
- spoke with the service manager and the ward manager for the unit
- spoke with seven other staff members including consultant psychiatrists, nurses, healthcare assistants and students
- reviewed six care records
- reviewed five medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service

Information about the provider

Berkshire Adolescent Unit is a nine-bed inpatient mental health unit for children and young people. It is the only inpatient mental health child and adolescent unit within Berkshire Healthcare NHS Foundation Trust and takes referrals from Berkshire as well as out of county referrals. The unit is mixed sex and admits children and young people aged 12 to 18. The service provides intensive interventions to facilitate the prevention, diagnosis, management and treatment of severe and enduring mental illness in young people who require hospital admission. There were nine patients in the unit at the time of our inspection.

When the Care Quality Commission inspected the trust in December 2015, we found that the trust had breached regulations under the Health and Social Care Act

Summary of findings

(Regulated Activities) Regulations 2014. We issued the trust with two requirement notices for child and adolescent mental health wards. These related to the following regulations:

- Regulation 9 HSCA (RA) Regulations 2014 Person centred care
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

When the Care Quality Commission carried out a follow up inspection of the Berkshire Adolescent Unit in December 2016, we found that the service had addressed the issues that had caused us to rate the safe domain as requires improvement following the December 2015 inspection. At that time, the service was now meeting regulations 9 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

What people who use the provider's services say

We received mixed feedback from the six patients we spoke with as a group. Some patients said staff were kind and had their welfare as a priority. Others said the quality of agency staff varied and they had no confidence that some agency staff had the skills to assist their recovery.

Areas for improvement

Action the provider MUST take to improve

- The trust must establish systems and processes to ensure that all safeguarding concerns are reported as safeguarding concerns and acted upon.

Action the provider SHOULD take to improve

- The trust should ensure staff document consent to share information with parents.
- The trust should ensure all documentation in the care records in regards to capacity to consent to treatment is to the required standard.
- The trust should ensure staff always record capacity to consent appropriately. The trust should ensure Gillick principles are documented appropriately.

Berkshire Healthcare NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

- Staff checked Mental Health Act paperwork regularly. Detention papers were in good order. However, one patient had been unlawfully detained for a period of five days, due to an incomplete form. The Mental Health Act administrator had detected the error and the patient and their parents had been informed. A staff member took the lead in ensuring compliance with the Mental Health Act Code of Practice. Tasks included undertaking a weekly audit of Mental Health Act documentation. Ninety one per cent of staff had received updated training on the Mental Health Act. Staff explained section 132 rights to patients at appropriate times and made a note of anyone refusing the discussion. Staff continued to try to hold this conversation with these patients. The system for recording patient leave was thorough. Staff undertook a risk assessment for each patient prior to going on leave and made a note of what they were wearing in case they failed to return to the ward.
- Staff understood the concept of parental responsibility as set out in the Mental Health Act Code of Practice. However, we were unable to locate evidence that patients had given consent to share information with their parents in all six of the care records we reviewed. The trust had reported in January 2017 that a consent form for sharing information should be completed for all patients on admission to the unit.
- Patients had access to advocacy services. Patients met with the advocate as a group every two weeks. Managers told us that issues and themes were fed back to them. There was information about the advocacy service and leaflets about the Independent mental health advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The quality of documentation in the care records in regards to capacity to consent to treatment was of a variable standard. There was no detailed account recorded in the documentation of the discussions which we were told had taken place about capacity and consent. There were examples of inconsistencies applying the principles of how staff assessed capacity and consent.
- Staff did not always record capacity to consent appropriately. For example, in one file we reviewed for an informal patient, the patient was under 16 years old. The referral documentation for the patient recorded that the patient had capacity to consent to admission, rather than referring to Gillick competency. The admitting doctor also recorded that the patient had capacity to consent to admission and treatment. There was no reference to Gillick competency and we saw no

record of the nature of the assessment against Gillick principles. Gillick competence is used to decide whether a child under 16 years of age is able to consent to his or her own treatment, without the need for parental consent or knowledge. The trust had reported in January 2017 that a Gillick competency template should be developed in April 2017.

Requires improvement

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

Summary of findings

We rated safe as requires improvement because:

- Patients had raised safeguarding issues at a meeting. Although staff had seen the minutes of the meeting, they had not raised these issues formally as safeguarding concerns. When we raised our concerns, trust managers spoke to the meeting facilitator to ensure that any safeguarding issues would be raised in future. In addition, the senior managers formally raised the safeguarding concerns for investigation.

However:

- Staff had carried out a detailed and thorough ligature risk assessment and risks were mitigated and reduced effectively. Staff spoke confidently about managing ligature risks and they reviewed the risks at every shift handover.
- Staff kept the ward clean and they maintained comprehensive cleaning schedules and audits to ensure the staff cleaned to the required standard.
- The trust ensured sufficient that staff were available to deliver care to a proficient standard. Where agency and temporary staff were used, they received a thorough induction and in most cases these staff were familiar with the service and patients.
- Over 93% of staff were up to date with their mandatory training.
- Staff carried out thorough and relevant risk assessments for patients and staff updated these regularly and fed the risks through into care plans.
- Staff were confident in reporting incidents and were familiar with the trust's procedure for doing so.

Our findings

Safe and clean environment

- The Berkshire Adolescent Unit had many areas not clearly visible to staff and this presented some challenges for clear observation of the patients. Staff managed these challenges through individual risk assessments and regular checks of patients. These checks were still made by staff, even if patients were known to be in the presence of other staff. There were sufficient staff available to increase the observation of patients should they be assessed as being at a high risk of self-harming.
- Staff had received training on managing ligature risks and staff were able to confidently tell us where the high-risk ligature anchor points and ligatures were and how these risks were mitigated and managed. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff implemented daily checks of the unit at each shift change and reported new ligature risks to the manager and took immediate action to mitigate and reduce the risk. The unit ligature check was present on the daily handover sheets. Staff had identified high-risk areas such as the games room, lounge and dining room and ensured they regularly monitored these areas. Bedrooms, bathrooms and toilets had been fitted with anti-ligature fixtures and fittings. Patients only used the kitchen and garden area with staff supervision. Floor plans of the unit identified high-risk areas and these were available on the office walls to guide staff. Staff observed all patients four times each hour, as a minimum, to mitigate risk of ligatures. Any new risks staff identified were reported through the trust's incident reporting system and if deemed appropriate escalated onto the unit risk register. For example, staff had recently reported that the curtain drawstrings were a ligature risk and the drawstrings were removed.
- The unit complied with the guidance on same-sex accommodation. The guidance states that all sleeping and bathroom areas should be segregated and patients should not have to walk through an area occupied by another gender to reach toilets or bathrooms. The ward was a mixed sex ward, the single bedrooms were along

one corridor with bathroom facilities close by. Staff ensured the same sex guidance was followed by designating one part of the corridor for male patients and the other for females. Toilet and bathroom facilities were designated male and female with clear signage and situated at either end of the corridor. There was a disabled toilet and shower room that could be designated for either gender. Managers ensured a staff member was always present in the bedroom corridor whenever a patient was in the area and continuously overnight from when the first young person went to bed until 8.30am the following morning. The ward had no female lounge. However, the family room could be used for this purpose if requested and young people had been informed about this arrangement

- The unit had a clinic room which was in good order and clean. Staff kept appropriate records which showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the ward in the clinic room. An automated external defibrillator and anaphylaxis pack were in place. The unit had recently acquired an electrocardiogram (ECG) machine. An ECG is a test which measures the electrical activity of the heart to show whether it is working normally. The equipment was regularly checked to ensure it was in order. Staff told us that equipment such as weighing scales and the blood pressure machines were regularly calibrated and that the equipment was checked on a regular basis. The clinic room was fully equipped and had an examination couch. Ligature cutters were easily accessible and were available in the clinic room and in the nursing office.
- Staff adhered to infection control principles and all staff had received up to date training in this area.
- There was no seclusion room on the unit. There was a quiet room which was used for de-escalation when patients became distressed. Staff remained with the patient and the door was not locked.
- Staff carried out regular environmental risk assessments and these formed part of the wider unit risk register. They were up to date and reviewed regularly. We reviewed both and found them to be thorough and comprehensive with the level of risk, action and timescales clearly identified. Bedroom doors had observation windows and two-way mirrors were present in assessment rooms on the main ward.
- All areas of the unit were clean. A cleaning schedule to guide staff was available for every room in the unit. Staff made regular checks to ensure cleaning was carried out to the required standard.
- Staff ensured that fixtures and fittings were well maintained. Patients had chosen furniture in the lounge area which was comfortable and colourful. The unit was bright and in good decorative order.
- Alarms were available throughout the ward, in all bedrooms and bathrooms and all staff carried alarms. Staff and patients said that alarms were responded to quickly.

Safe staffing

- There were 3.7 band six posts and three staff were in post. There are 8.2 band five posts and four staff were in post. There were 11.7 band three posts and six staff were in post. Additional multidisciplinary staff worked at the unit including medical staff, a family therapist and psychologist. The service manager and ward manager posts were supernumerary and there were also additional ancillary staff. The trust had recognised the high vacancy rate was an issue and the manager and service manager had an action plan to attempt to bring the vacancy rate down. Three staff nurses had been recruited recently and were due to start working at the unit within weeks. On average 161 shifts each month were filled by either agency or temporary bank staff. There were no occasions in the preceding three months when a shift had not been filled. All temporary staff were bank or agency staff who in the main were familiar with the service. The provider's own staff covered a large number of the available shifts. The sickness rate was 4% which is the trust target. Staff turnover rate was 3% which is very low and shows that staff were remaining in their posts for longer.
- All staff told us there were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were sufficient staff on duty. During each day shift, the unit had at least two nurses and a minimum of four health care assistants at work. However, the rota

showed that there were generally more staff on shift. The unit manager, service manager and the multidisciplinary team members were working in addition to the staff on each shift.

- There was effective administrative support available which included reception staff during the day. This meant clinical staff could spend more time in direct contact with patients.
- Staff were available to offer regular and frequent one-to-one support to their patients. There were enough staff on each shift to facilitate patients leave and for activities to be delivered. Staff and patients told us that activities were rarely cancelled due to staffing issues. Patients told us they were offered and received a one-to-one session with a member of staff most days. Information from the patients' daily records showed that this was the case.
- The unit had adequate medical cover over a 24 hour period, seven days a week. Out of office hours and at weekends, on-call doctors were available to respond and attend the unit in an emergency. Medical cover from the locality child and adolescent mental health team was available in an emergency. Consultant psychiatrists were identified to provide cover during the regular consultant's leave or absence.
- Staff told us that the senior managers were flexible and responded well if the needs of the patients increased and additional staff were required. We saw a number of examples during our visit of extra staffing being made available. For example, to provide one-to-one observations.
- Ninety three percent of all staff had completed mandatory training throughout the year. The lowest uptake of training was for the prevention and management of violence and aggression (PMVA) course at 71%. Two new staff members had been booked onto the next available PMVA training course due to take place shortly after the date of our inspection.

Assessing and managing risk to patients and staff

- Berkshire Adolescent Unit did not have a seclusion room and had never used long-term segregation. The unit operational policy stated there was no provision for seclusion or high dependency care and therefore they would not accept admissions for patients with a high risk of violence, aggression or challenging behaviours. Staff reported this was the case.
- Staff recorded all restraints as incidents. We reviewed the data on the preceding five restraints and found that in all cases staff documented the use of restraint appropriately. However, we had received information that one restraint allegedly had not been carried out appropriately and the trust were carrying out an investigation into the incident.
- We reviewed the trust policy on prevention and management of violence and aggression (PMVA). Staff practiced relational security to a high standard and staff actively promoted de-escalation techniques to avoid restraints where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict. All staff were trained in promoting safer and therapeutic services. All new staff had attended training in de-escalation techniques. Staff also attended breakaway techniques as part of their induction and 71% of staff on the unit attended a five-day PMVA teamwork course. Staff reviewed the number of substantive staff who were PMVA trained when booking agency and bank staff to ensure there were sufficient numbers of trained staff on each shift.
- Comprehensive and thorough risk assessments were in place for all patients on admission. Risk assessments were updated after 72 hours and then reviewed at least once a week or following any incidents. All patients received the short-term assessment of risk and treatability, a nationally recognised good practice tool for assessing risk. Reviews of risk were part of the multidisciplinary care review process and risks were reviewed daily and noted on the shift handover checklist. Risk management plans fed into the care plans. Staff were confident in discussing patients' risk assessments and 90% of staff had received clinical risk training.
- Staff had developed a chaperone policy and procedure to offer patients further assurances about their safety. The policy was widely advertised throughout the unit. Staff encouraged patients to request a chaperone, should they wish to, at any point while being interviewed by other staff.

Requires improvement

Are services safe?

- Physical health monitoring was undertaken for all patients using the national early warning score (NEWS). Staff informed us that the frequency of this was determined on an individual needs basis.
- Staff followed the trust policy on patient observations. Staff placed all new patients on level two observations, which is within eyesight at all times, for a minimum of 24 hours. Following review, all patients were on level three observations at all times. This meant staff checked on patients four times each hour. This was partly due to the layout of the building and the management of poor lines of sight and static ligature risks. Staff increased or decreased observation levels based on individual patient risk as needed. Staff made checks on all patients despite them being in the company of other staff.
- Any blanket restrictions on the unit, such as contraband items and locked doors to access and exit the ward doors were justified and clear notices were in place for patients explaining why these restrictions were being used. Contraband is an item which is banned from the ward such as weapons, drugs or alcohol. Informal patients were advised through signage that they were free to leave at will and this information was also detailed in the unit information leaflets. Staff fully reviewed all blanket restrictions every six months to ensure that they were still relevant and appropriate.
- We checked the management of medicines on the unit and looked at five medication administration records. There were no errors. The medicines were stored securely in the clinic room. Staff made daily checks of refrigerator temperatures to ensure that the medicines remained suitable for use. All medicines needed were available. We looked at the ordering process and saw the process for giving patients their regular medicines. Patients told us about the information they were given about their medications. A pharmacist visited the unit every week to audit the medication systems.
- The trust reported 13 safeguarding referrals made to the relevant local authorities in the last six months. We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. All staff had received training in safeguarding, however two staff were awaiting training to level three. Staff were aware of the provider's safeguarding policy. The trust employed a safeguarding lead who held monthly safeguarding supervision sessions for staff. We reviewed the content of safeguarding training and found it to be thorough.
- We reviewed six care records and found safeguarding risks, where they had been identified, were clearly recorded in the notes.
- We had concerns that safeguarding issues were raised by patients in a meeting and although the minutes of the meeting had been seen by staff, the issues had not been raised as safeguarding concerns. When we raised our concerns, trust managers spoke to the meeting facilitator to ensure that any safeguarding issues would be raised in future. In addition, the senior managers formally raised the safeguarding concerns for investigation.

Track record on safety

- The trust reported two serious incidents at the Berkshire Adolescent Unit in the last three months. The trust defined a serious incident as any event or occurrence that has led to moderate or severe harm or death, or harm for an extended period. Such incidents require investigation by the trust. The trust had developed an action plan to address issues relating to both incidents.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the trust's electronic recording system. The ward manager and service manager reviewed all incidents on a daily basis. All incidents were electronically forwarded to the patient safety team (governance). The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and respond to these. Lessons learnt from incidents were shared at the unit's weekly de-brief meeting. The trust published a monthly bulletin with details of incidents and learning identified with associated action plans. The manager reported that the process of reporting and learning from incidents was embedded in the unit procedures. All staff we spoke to, including agency staff, confirmed this and knew what and how to report. Examples of incidents reported included self-harm, assault, verbal abuse, inappropriate behaviour and restraint.

Requires improvement

Are services safe?

- The unit implemented a debriefing policy following incidents. This document outlined the support delivered to staff following incidents and stated debriefing sessions should take place within 24 hours of the incident. All staff we spoke to reported that debriefing took place. The trust provided independent, specialist support in addition if needed.
- Staff also debriefed patients following incidents. The advocacy group held on the ward had raised this issue and the managers implemented a process so that patients were supported following any incident. Staff and patients confirmed this took place.
- Staff learnt from incidents in order to prevent a re-occurrence. For example, the chaperone policy was developed and instigated to enable patients to feel safe within the ward environment.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person.
- The Berkshire Adolescent Unit debriefing policy included guidance on the Duty of Candour and set out the procedures staff should follow if this were required.

Good

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.

Summary of findings

At the last inspection in December 2015 we rated effective as good. Since that inspection, we have received no information that would cause us to re-inspect this key question or change the rating. However, we did inspect how well the staff understood the principles of the Mental Health Act and Mental Capacity Act.

We found the following good practice:

- Patients had access to advocacy services. Patients met with the advocate as a group every two weeks. Managers told us that issues and themes were fed back to them. There was information about the advocacy service and leaflets about the Independent mental health advocacy service.

However:

- Staff understood the concept of parental responsibility as set out in the Mental Health Act Code of Practice. However, we were unable to locate evidence that patients had given consent to share information with their parents in all six of the care records we reviewed. This was despite the trust reporting in January 2017 that a consent form for sharing information should be completed for all patients on admission to the unit.
- The quality of documentation in the care records in regards to capacity to consent to treatment was of a variable standard.
- Staff did not always record capacity to consent appropriately. For example, there was no reference to Gillick competency in the care records and no record of the nature of the assessment against Gillick principles. This was despite the trust reporting in January 2017 that a Gillick competency template would be developed in April 2017.

Our findings

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- Four patients were detained under the Mental Health Act when we inspected. Ninety-one per cent of staff had received updated training on the Mental Health Act.
- Staff checked Mental Health Act paperwork regularly. Detention papers were available for review and were in good order. However, one patient had been unlawfully detained for a preceding period of five days, due to an incomplete form. The Mental Health Act administrator had detected the error and the patient and their parents had been informed.
- A staff member had been trained and acted in a Mental Health Act lead role to facilitate compliance with the Code of Practice and maintain the expertise. Tasks included undertaking a weekly audit of Mental Health Act documentation.
- The Approved Mental Health Professional reports were available in the files.
- Staff explained section132 rights to patients at appropriate times and made a note of anyone refusing the discussion. Staff continued to try to hold this conversation with these patients.
- The system for recording patient leave was thorough. Staff undertook a risk assessment for each patient prior to going on leave and made a note of what they were wearing in case they failed to return to the ward.
- Staff understood the concept of parental responsibility as set out in the Mental Health Act Code of Practice. However, we were unable to locate evidence that patients had given consent to share information with their parents in all six of the care records we reviewed. The trust had reported in January 2017 that a consent form for sharing information would be completed for all patients on admission to the unit.

Good

Are services effective?

- Patients had access to advocacy services. Patients met with the advocate as a group every two weeks. Managers told us that issues and themes were fed back to them. There was information about the advocacy service and leaflets about the Independent mental health advocacy service.

Good practice in applying the Mental Capacity Act

- The quality of documentation in the care records in regards to capacity to consent to treatment was of a variable standard. There was no detailed account in the care records of the discussions which we were told had taken place about capacity and consent. There were examples of inconsistencies applying the principles of how staff assessed capacity and consent.
- Staff did not always record capacity to consent appropriately. For example, in one file we reviewed for an informal patient, the patient was under 16 years old. The referral documentation for the patient recorded that the patient had capacity to consent to admission, rather than referring to Gillick competency. The admitting doctor also recorded that the patient had capacity to consent to admission and treatment. There was no reference to Gillick competency and we saw no record of the nature of the assessment against Gillick principles. Gillick competence is used in medical law to decide whether a child under 16 years of age is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The trust had reported in January 2017 that a Gillick competency template would be developed in April 2017.

Good

Are services caring?

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

Summary of findings

At the last inspection in December 2015 we rated caring as good. Since that inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Our findings

At the last inspection in December 2016 we were satisfied that the child and adolescent mental health ward at this location was caring**.** Since that inspection, we have received no information that would cause us to re-inspect this key question.

Good

Are services responsive to people's needs?

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

Summary of findings

At the last inspection in December 2015 we rated responsive as good. Since that inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Our findings

At the last inspection in December 2016 we were satisfied that the child and adolescent mental health ward at this location was responsive**.** Since that inspection, we have received no information that would cause us to re-inspect this key question.

Good

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.

Summary of findings

We rated well-led as good because:

- Staff on the ward understood the vision and direction of the service and wider organisation. Staff at every level felt very much a part of the service and were able to discuss the philosophy of the unit confidently.
- The service manager and ward manager maintained a series of clinical audits, human resource management data and data on incidents and complaints. The information was summarised and presented clearly.
- The ward was organised and well-led. There was evidence of clear leadership at a local level.
- Staff felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers.
- Staff told us that staff morale was good and that they were being supported in their professional development.

Our findings

Vision and values

- The trust's vision, values and strategies for the service were evident and on display throughout the ward. Staff had developed their own core values based on the trust's vision. Staff on the ward understood the vision and direction of the service and wider organisation. Staff at every level felt very much a part of the service and were able to discuss the philosophy of the unit confidently. Staff told us that the purpose of the unit was to offer patients a safe environment, a thorough assessment, education and a structured therapy programme to enable them to recover as quickly as possible.
- The ward manager had daily contact with the service manager and the senior clinical team. The senior management and clinical team were highly visible and staff said that they regularly visited the ward.
- Staff commented on the high quality support they received from ancillary services such as housekeeping, reception staff and general administration.

Good governance

- The service manager and ward manager showed us a series of clinical audits, human resource management data and data on incidents and complaints. The information was summarised and presented clearly. This meant that the management team were able to apply clear controls to ensure the effective running of the service. Examples of ward audits carried out included, environmental and health and safety, adherence to good medication management, ensuring physical healthcare occurred and monitoring the standard of risk assessment and care plan documentation.
- The ward manager told us they felt they had the autonomy and authority to make decisions about changes to the service. The manager commented that they felt very well supported.
- The service manager showed us the ward and wider organisation risk register. Staff told us that they were able to submit items of risk for inclusion on the risk register.

Leadership, morale and staff engagement

- The ward was organised and well-led. There was evidence of clear leadership at a local level. The ward manager and service manager were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the ward was open and encouraged staff to bring forward ideas for improving care.
- All of the ward staff we spoke with, without exception, were enthusiastic and engaged with developments on

the ward. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of patients and said this had been received positively as a constructive challenge to ward practice.

- Staff told us that staff morale was good.They also told us how they were being supported in their professional development. The team had recently won the, 'trust team of the year' award, due to the work they carried out to move from a day service to a 24-hour inpatient service.
- Sickness and absence rates were at the trust target of 4%.
- At the time of our inspection there were no grievance procedures being pursued within the ward, and there were no allegations of bullying or harassment.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- The unit carried out peer reviews as part of the Quality Network for Inpatient CAMHS (QNIC). However, the unit was not fully accredited. QNIC was developed from the National Inpatient Child and Adolescent Study (NICAPS) in 2001. The network aims to demonstrate and improve the quality of inpatient care through a system of review against the QNIC service standards. This process follows a clinical audit cycle with self and peer reviews.
- Managers prepared a monthly quality report for commissioners.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Safeguarding issues were raised by patients in a meeting and although the minutes of the meeting had been seen by staff, the issues had not been raised as safeguarding concerns.