Requires improvement

Greater Manchester West Mental Health NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Trust Headquarters
Prestwich Hospital
Bury New Road
Manchester
M25 3BL
Tel: 0161 773 9121
Website: https://www.gmw.nhs.uk

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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)
RXV00	Greater Manchester West NHS Foundation Trust - HQ	Junction 17	M25 3BL
RXV00	Greater Manchester West NHS Foundation Trust - HQ	Gardener Unit	M25 3BL

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

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 the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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 rated child and adolescent mental health wards as requires improvement because:

- the wards did not always provide a safe environment, there were often insufficient numbers of staff to provide the care required. These staff had not always been trained in the specific needs of children and young people. When individuals had been assessed as requiring increased levels of support the documentation for the monitoring of this support was not always being completed. This included after patients had been administered additional medication following a period of disturbed behaviour
- staff were not trained in the Mental Health Act (MHA) and Mental Capacity Act (MCA). This meant that recent changes to the MHA code of practice were not understood or brought into practice and staff were not able to demonstrate how they considered the MCA when planning and delivering care
- on Junction 17, two patients told us that staff did not provide emotional support when needed. Three patients said that sometimes certain staff told them to 'grow up' and rolled their eyes at them
- staff did not keep a record of complaints resolved locally at ward level. There was limited accessible information available to patients
- monitoring systems in place did not identify when care was not being delivered safely nor did they identify when there was not enough staff and a lack of suitably qualified staff.

However:

- the wards were clean and tidy. Where there were risks of ligature points, action had been taken to reduce the risk. Regular risk assessments were carried out and staff knew when and how to report incidents. Staff had received training in safeguarding, but not at level 3, and knew how to protect patients from abuse
- patients could access psychological therapies. Staff received managerial and clinical supervision and were regularly appraised. Staff regularly communicated with local services and external agencies when planning and delivering care
- staff planned for discharge when patients were first admitted and communicated these plans with other services to ensure adequate support was available for patients. There was a range of food choices to meet patients' dietary requirements and a range of activities available including at weekends
- most staff were respectful and engaged positively with patients. We observed staff being encouraging and supportive and meaningfully engaging with patients. Patients were involved in the planning of their care and staff held regular meetings to encourage patient feedback
- staff knew who the senior management team were by name and told us that they visited the wards. On Junction 17 staff had implemented the 'safe wards' initiative and had participated in the Royal College of Psychiatrists accreditation for in-patient child and adolescent services.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- there were not always enough staff to safely support the patients with the care they needed. Staff members were not appropriately trained to carry out their roles as they had not received training specifically relating to CAMHS and had not received level three safeguarding training
- patient observations were not being recorded at the time of observation, which meant it was unclear as to whether observations had been carried out
- there were blanket restrictions on access to mobile phones and routine searches
- patients were being nursed in intensive nursing suite, and were prevented from entering the main ward area but this was not being treated as seclusion
- records showed that staff did not carry out physical observations following administration of rapid tranquilisation medication on three separate occasions. This meant patients were at risk of physical health complications not being recognised
- staff did not record fridge temperature checks in line with trust policy.

However:

- the wards were clean and tidy
- where there were risks of ligature points, action had been taken to reduce the risk
- regular risk assessments were carried out and staff knew when and how to report incidents
- staff knew how to protect patients from abuse.

Are services effective?

Good

We rated effective as good because:

- all patients received a comprehensive assessment during the admission process
- all care plans were up to date, person centred, holistic and included patients' views
- patients could access psychological therapies
- we found good prescribing practices on both wards
- staff participated in audits and learning from audits was shared
- staff received managerial and clinical supervision and were regularly appraised

Summary of findings

- staff regularly communicated with local services and external agencies when planning and delivering care.

However:

- staff were not trained in the Mental Health Act including the changes to the Code of Practice as MHA training was not mandatory
- staff were not trained in the Mental Capacity Act, therefore staff were unable to consider capacity issues in planning and delivering care to patients over the age of 16.

Are services caring?

Good

We rated caring as good because:

- most staff were respectful and engaged positively with patients
- on Junction 17, we observed staff being encouraging and supportive towards patients in multidisciplinary team meetings
- on Gardener unit, staff were meaningfully engaging with patients
- patients' views were included in care plans
- regular community meetings took place where patients were encouraged to give feedback
- patients accessed independent advocacy services.

However:

- on Junction 17, two patients told us that staff did not provide emotional support when needed
- on Junction 17, three patients said that sometimes certain staff told them to 'grow up' and rolled their eyes at them.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- there was a range of food choices to meet patients' dietary requirements
- staff started to plan for patients' discharge when patients were first admitted
- staff communicated with other services when planning patients' discharge
- a range of activities were available for patients including at weekends
- staff managed formal complaints made by patients appropriately.

However:

Summary of findings

- staff did not keep a record of complaints resolved locally at ward level
- there was limited accessible information available to patients.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- monitoring systems in place did not identify when care was not being delivered safely
- monitoring systems in place did not identify when there were not enough staff and a lack of suitably qualified staff
- governance systems in place were not operating effectively to ensure safe care was being delivered
- managers of the service could not assure themselves that staff members had the relevant knowledge and skills to provide safe care to young people as relevant up to date training had not been delivered to staff.

However:

- on Junction 17 staff had implemented the 'safe wards' initiative and had participated in the Royal College of Psychiatrists accreditation for in-patient child and adolescent services, demonstrating a commitment to quality and improvement
- staff knew who the senior management team were by name and reported that they visited the wards.

Summary of findings

Information about the service

Junction 17 is a specialist child and adolescent mental health service (CAMHS) for young people aged 13 to 17 who require assessment and treatment for a range of complex mental health difficulties. Junction 17 comprised the following:

- Pegasus a five bed ward currently for males aged 13 to 17 years
- Phoenix a 15 bed ward currently for females aged 13 to 17 years.

The Gardener Unit is a medium secure adolescent forensic unit providing highly specialised care in a secure environment. The unit was a ten bed ward for male aged 11 to 18 years.

The child and adolescent mental health wards at Greater Manchester West NHS Foundation Trust were last inspected in July 2013 in response to concerns that they were not meeting one or more of the essential standards. The inspection team found that the CAMHS service met all of the standards at that inspection.

Our inspection team

The team was led by:

Chair Dr Peter Jarrett (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team leader: Sarah Dunnett, Inspection Manager (mental health), Care Quality Commission

The team that inspected this core service comprised: two CQC inspectors, a Mental Health Act reviewer, two specialist advisors; a mental health nurse and a consultant psychiatrist who both specialised in child and adolescent mental health.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

We carried out announced inspection of the CAMHS wards on 9 and 10 February 2016. We carried out an unannounced inspection of the CAMHS ward on 23 February 2016. During the inspection visit, the inspection team:

- visited two wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service and one relative
- spoke with the manager for both wards

Summary of findings

- spoke with 28 other staff members; including doctors, nurses, the chaplain and teachers
- observed two multi-disciplinary meeting and one care programme approach meeting
- carried out a Mental Health Act review on Gardener unit
- collected feedback from one patient using a comment card
- looked at nine treatment records of patients
- carried out a specific check of the medication management on both 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 to 11 patients during our visit. Patients told us they had been given information about their care and treatment and knew how to complain. Patients told us they felt safe on the wards and their possessions were stored safely. They told us that some staff were respectful, supportive and caring.

On Junction 17, two patients told us that some staff did not offer support when they needed it.

Three patients said that sometimes certain staff told them to 'grow up' and rolled their eyes at them. Two informal patients also informed us that they had not received information on their rights as informal patients.

We spoke to one relative during our visit. They told us that staff were approachable and friendly. The relative told us that staff communicated with them regularly about the care and treatment of their child. They told us that the ward was clean and safe and had a relaxed atmosphere.

On our unannounced inspection, we completed a short observational framework for inspection (SOFI) on both wards, which is a tool used to gather evidence about the experience of patients especially where patients may not be able to fully describe this themselves. On Junction 17, we observed staff interacting positively with patients, asking about their well-being and inviting patients to attend meetings. On Gardener unit, we observed staff interacting with patients in a polite and friendly manner. Staff were meaningfully engaging with patients and there was evidence of good rapport and a friendly tone.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure there are sufficient number of staff who are adequately trained to provide safe care.
- The trust must ensure that mandatory training is completed by all staff to achieve the trust standard of 85%.
- The trust must ensure there is a plan in place to evaluate and minimise the use of blanket restrictions.
- The trust must ensure care and treatment is planned and delivered in line with the MHA code of practice.
- The trust must ensure that there are effective governance structures in place that address concerns in a timely manner to improve care standards.
- The trust must ensure that staff maintain accurate, complete and contemporaneous records.

Action the provider SHOULD take to improve

- The trust should ensure that staff record all complaints appropriately
- The trust should ensure that staff consider patients' competency and capacity when planning and delivering care through appropriate assessments

Summary of findings

- The trust should ensure that staff are trained in the Mental Health Act, including the changes to the Code of Practice and the Mental Capacity Act
- The trust should ensure that there is appropriate accessible information available for patients.
- The trust should ensure that all staff can access information on patients in a timely manner to deliver appropriate care.

Greater Manchester West Mental Health NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Junction 17	Greater Manchester West NHS Foundation Trust - HQ
Gardener Unit	Greater Manchester West NHS Foundation Trust - HQ

Mental Health Act responsibilities

As part of our inspection we carried out a full Mental Health Act (MHA) monitoring visit of Gardener unit. We examined the detention documentation for four detained patients and found it to be in order. The procedures for renewal of detention where applicable had been followed and the criteria for renewal had been met. We could not find any evidence in care records that a patient who had been on the ward for two weeks had been informed of their rights under section 132 of the MHA. In the MHA monitoring visit that took place in March 2015 on Junction 17 we had also found that records did not show that patients were being informed of their rights.

One patient should have been referred for their annual mental health tribunal in November 2015 by the hospital staff. This referral had not been made. We spoke to the mental health act administrator who confirmed this oversight and agreed to make the referral that day. This meant that a patient had not been afforded the safeguards provided in law to be referred for an annual review of the detention.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If patients under the age of 18 need to be deprived of their liberty, this can only be done by the courts unless the Children's Act or the Mental Health Act can be used.

The Mental Capacity Act (MCA) applies to young people aged 16 and 17. For children under the age of 16, decision-making ability is assessed through Gillick Competency. This allows staff to recognise that some children may have a sufficient level of maturity to make some decisions themselves.

At the time of our inspection 2% of staff had received training in the Mental Capacity Act (MCA or Gillick Competency assessment). Staff had limited understanding of the Act and were unable to describe how they considered patients' capacity to make decisions in planning and delivering care. Staff had some awareness of Gillick Competency/Fraser guidelines, however they told us they were not aware of this being applied.

We found evidence in care records of capacity assessments being completed. However, staff were unable to locate this information on the electronic records system when asked.

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

Our findings

Safe and clean environment

At Junction 17, the wards were clean and tidy and the furniture was in good repair.

Staff assessed ligature points (places to which patients intent on self-harm might tie something to strangle themselves). There was one identified ligature point on patient bathroom doors. It was recorded on the environmental risk assessment and was due to be changed. Staff knew how to manage the risk.

The curved layout of Pegasus ward made it difficult to observe all areas. The staff members were aware of this and reduced this risk through observing patients away from the main day area; we saw this while visiting the ward. Television and console wires were also removed when not in use to prevent risk of harm to young people. All patients were on a minimum of 15 minute observation checks to ensure their safety.

All bedrooms at Junction 17 were single rooms and had en suite facilities. The wards at Junction 17 complied with same-sex accommodation guidelines by having separate wards for male and female. When male patients wanted to use the activity room to play pool in the female area, this had to be planned and patients were supervised. We observed this during the inspection. This ensured single sex guidelines were adhered to.

The Gardener unit had a large communal living space, with a pool table, a seating area and a television behind a protective case. From the central communal area, patients could access the large therapeutic side room, internal courtyard, kitchen and the bedroom corridor. There was also access to a private booth with a payphone. This allowed patients to make phone calls in private.

Viewing along the bedroom corridor was restricted so the unit ensured that two members of staff were in the corridor at all times. We saw this during the inspection.

There was no perimeter fence behind one side of the bedrooms on the medium secure Gardener Unit. The windows met the standards for medium secure accommodation. Furniture in the Gardener unit had not been assessed as suitable for a medium secure environment. A table was used to break a window during the inspection period. Following this, staff had completed an assessment on the furniture to ensure that it was safe to use in the environment.

Some area of decoration on the Gardener unit, particularly patients' bedrooms, was very tired and worn. Refurbishment of the bedrooms started the week following our announced inspection.

All the blinds and shower curtains were on collapsible rails protecting against the risk of ligature use. Bedrooms were not fitted with anti-ligature doors but the risk was managed by staff observing in the corridor.

Four of the 10 bedrooms on Gardener unit had en suite facilities; the other six rooms shared two bathrooms and two shower rooms. This ensured that there were adequate washing facilities for the service users.

Each unit had their own clinic rooms. Both were clean and tidy. Fridge temperatures on Pegasus ward had not been checked daily. There were 19 omissions over the past month. This meant there was a risk medication that required refrigeration may not have been stored safely because appropriate checks were not made.

We found two different brands of intramuscular lorazepam (medication given as an injection to calm patients quickly) on the ward. These required to be administered differently. Staff did not know which lorazepam required mixing with water before being administered to patients and which did not. This meant in an emergency situation staff would not be able to prepare the medication safely and efficiently. Staff assured us this would be addressed with the pharmacy immediately to establish the correct process.

Hand washing signs showed staff how to wash their hands to prevent the spread of infection. We saw staff washing their hands during our inspection. The modern matron was the infection control lead for the wards. Staff completed an infection control audit annually, hand washing audit every six months and mattress management audit monthly. Records showed actions from quality checks of the environment that required completing. These included fridge temperature checks, recording a date on the sharps container, cleaning of furniture and dusting the corridor.

Requires improvement

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During our inspection we found that staff were not completing fridge temperature checks in line with trust policy. Staff completed a hand washing audit every six months. Records showed staff had completed a hand washing audit on the 4 January 2016 and all staff had achieved 100%. Records showed that the mattress management audit was completed monthly, the last one was completed in January 2016. Staff inspected each mattress and there was evidence that mattresses had been replaced when in poor condition.

All staff had access to emergency equipment. Records showed that the equipment was checked every day, with no omissions in the previous month. However, the oxygen mask at Junction 17 was not covered and was on the floor, which meant that it was not clean and ready to use in an emergency. This was reported to the ward manager who assured us this would be replaced. On returning to the ward during our unannounced visit, the mask remained uncovered. We reported this again to the ward manager.

Seclusion rooms were large and clean, with access to natural light, a clock and bathroom facilities. The seclusion suite on the female ward did not allow observation to be carried out in the shower room, so if a patient was thought to be at risk of self-harm the seclusion room on the male ward was used instead.

On Junction 17, patients told us that it was difficult to get away from disruption on the wards because access to bedrooms was restricted during school hours. This was a blanket restriction. On Gardener unit, staff told us that patients had access to their bedrooms outside of school hours. The information pack for patients admitted to Gardener unit stated 'Young people will have their rooms locked during the day to ensure the safety and security of the unit and to encourage you to spend time with the staff and other young people.' On returning to Junction 17 during an unannounced visit, patients had free access to their bedrooms during the day.

Staff carried emergency alarms. A member of staff on each shift was allocated to respond when the alarm was called. The system linked in with the wards based at the Prestwich site and staff would respond to alarms raised. On Junction 17, one member of staff told us that when the alarm was raised they would call the ward to ask whether assistance was required prior to responding when the ward was short staffed. On Gardener unit, a review of a recent serious incident highlighted a delay in staff responding from other wards due to the location of the wards across the Prestwich site. There were no actions identified within the review that related to the use of the emergency alarm and response. However, staff had increased the level of senior nurses on duty to support the team.

Safe staffing

The units had an agreed staffing level and skill mix determined at trust level. The nursing establishment across both units was 26 registered nurses and 36 support workers. Sixteen nurses and 20 support workers were permanently employed at the hospital. This meant 38% of nursing posts and 44% of support worker posts were vacant. The hospital had recently tried to recruit more staff, and the service manager reported the successful recruitment of four additional staff due to commence in the next month.

There were not always enough staff to safely support the patients. In a six month period to the end of December 2015, 193 shifts had been filled by bank and agency staff. There had been 94 shifts where the ward had not been able to get bank or agency staff to fill the shortages. Patients and staff both said staffing numbers were too low. It was reported on Phoenix ward that service users could not get out on leave when planned or have regular one to one therapeutic engagement with staff. The ward did not have a system to record when leave had been cancelled.

On Junction 17, on our unannounced inspection, there were four patients on one to one observations and seven staff on duty. We reviewed the allocation of duties rota for that day and found for six hours between 7am and 7pm all staff were allocated to duties. These duties included one to one observations, five and 15 minute observations, meal and snack times, reception duties, patient meal support, medication, handover and multidisciplinary review. This meant that there were no staff available to respond to patient requests, urgent or emergency situations and other general day to day tasks of managing the ward for the six hour period on that day.

On Gardener unit we found four staff were on shift over the weekend preceding our unannounced inspection, when there should have been six staff as one patient required two to one enhanced observations, this meant there was not enough staff on duty to maintain relational security. The lack of staff was identified as a contributing factor to a serious incident. We spoke to the deputy network director about staffing on both wards, they told us that they were

Requires improvement

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not aware that there had been difficulties filling shifts. However, as a result of the incidents on Gardener unit, they had scheduled regular meetings with staff to ensure adequate staffing levels. We also spoke to the chief executive of the trust during our unannounced inspection, they told us that staff could request agency staff to cover shifts when needed.

We saw on Junction 17 that essential observations on patients were not always recorded. There were 15 missing entries on observation records for seven patients during a period of eight days from the beginning of February 2016. There were eight missing entries between 6pm and 9pm, three missing entries between 10am and 3pm and four missing entries between 1am and 6am. The missing entries included five minute and 15 minute observations. There was one missing entry for a patient requiring one to one observations. One member of staff reported this 'happened quite a lot' that staff were not always recording observations completed. Staff were unsure whether the observations had been carried out for the missing entries. During our inspection, we observed staff completing observations of patients. The ward manager told us that any missing entries would be discussed with staff individually and during supervision. Staff told us and records showed that staff did not complete incident forms for missing observation records.

Less than 60% of staff on Junction 17 were up to date with training in the prevention and management of violence and aggression (PMVA) and less than 55% for Gardener unit. As not all staff were up to date with this training there was a risk of staff and patients being injured when they were being restrained.

Staff members were not appropriately trained to carry out their roles. Staff members explained that the PMVA training was standardised throughout the trust and there were no adaptation to ensure that it was specifically tailored to manage violence in children and young people. This was corroborated by the PMVA lesson plan. Staff members were unable to report any guidance or legislation around the use of restraint on children and young people such as the need to adjust holds so that they were proportionate to young person's height and weight, or de-escalation methods for these patients. The deputy network director reported that a bespoke package would be provided and this was on track to be delivered by the end of March 2016.

Managers on the Gardener unit did not have access to local training data, including details of which staff had attended and were up-to-date with PMVA and basic life support training. The ward manager reported that they were unable therefore to check that appropriately skilled staff were deployed when managing the staffing rota. This meant that patients were potentially put at risk because staff with the necessary skills required may not be on duty when needed.

The trust policy on PMVA had not been updated since 2014. Therefore it did not provide staff with the most recent guidance published including - Department of Heath Positive and Proactive Care Guidance (April 2015), the amended Mental Health Act Code of Practice (April 2015) or the National Institute for Health and Care Excellence guidance NG10 Violence and aggression guidance (May 2015). Language reflected in the policy was also inconsistent with latest guidance including the repeated use of the term 'control and restraint'.

Staff members were not adequately trained to provide skilled and effective care to young people Mandatory training rates was below 70% in areas including basic life support, immediate life support, PMVA, and fire safety. Mental Health Act, Mental Capacity Act and service specific training did not form part of the trust mandatory training system.

All three wards used regular bank staff where possible. This was confirmed by staff. Bank staff had a key and fire induction before starting work on the wards. Bank staff completed trust induction training.

All staff completed a corporate trust induction during their first week and a local induction during their first month. The corporate trust induction included an overview of the trust's values and ensured all immediate health and safety needs were met. The local induction was completed by the ward managers and ensured the minimum requirements to ensure patient safety were completed before staff started in their new role. We saw evidence of completed staff induction programmes during our inspection.

Newly qualified nurses completed a workbook as part of their preceptorship. The workbook provided information on the induction process and necessary skills required to fulfil the role. Staff completed medication management competency as part of this process. Band five nurses were also allocated a senior nurse mentor to help support them in their role.

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Patients were protected from abuse because staff understood what might constitute abuse and how to deal with it. Safeguarding adults and children training was completed on both units, and both units had over 85% completion rates. However, level three training was not provided. All staff members could explain the safeguarding procedure and knew how to raise an alert.

Assessing and managing risk to patients and staff

Risk assessment tools were used across both services (risk assessment tools allow staff to assess, record and manage risks to patients). Of the 11 care records examined risk assessments were completed on admission and updated regularly, and following incidents. On Gardener unit, two care records were looked at following seclusion reviews and demonstrated comprehensive risk assessments were completed on admission and updated following episodes of seclusion. Five incident records were examined on the trust's incident recording system across both services and cross referenced with risk assessments that further demonstrated risk assessments were updated following incidents. This meant that individual patient's risks were effectively managed.

Over a six month period to December 2015 there were 74 episodes of restraint at Junction 17, which were attributed to 23 different service users. This is below the national average for child and adolescent mental health services (CAMHS) concluded by the NHS benchmarking network. On Gardener unit, 50 episodes of restraint occurred; this was attributed to eight different service users. Again this is below the national average for forensic CAMHS service. There were two incidents of the use of prone restraint (face down restraint on the floor), on Gardener unit meaning prone restraint occurred in only 4% of all restraints which again is lower than the national average. This is line with trust policy and the Code of Practice which states prone restraint should only be used as a last resort. There were no incidents of rapid tranquilisation.

At Junction 17, there were 16 episodes of recorded seclusion over a six month period until December 2015 (seclusion is the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of the immediate necessity for the purpose of the containment of severe behaviour disturbance which is likely to cause harm to others). On Gardener unit there were 27 episodes of recorded seclusion over a six month period ending December 2015.

Incident forms showed that the intensive nursing suites (INS) located off the ward in both units were used to de-escalate patients following incidents of violence and aggression. Staff informed us that they would escort patients to the INS and that two staff would remain, preventing them from returning to the ward. This was also corroborated on the incident forms. Both the staff members and the ward manager confirmed that patients could remain in the INS suite for one hour before it would be considered seclusion. This was against both the trust policy and the Mental Health Act (MHA) code of practice which states where the de-escalation process has the features of seclusion, it should be treated as such, and comply with the safeguard checks as required by the MHA Code.

There were a number of blanket restrictions in place including:

- patients on Junction 17 were only allowed access to mobile phones when they were off the ward
- all patients on Junction 17were searched following leave
- patients were not allowed access to their bedroom during the day.

Patients told us that a lack of mobile phone limited contact with friends and family members, especially as access to the payphone was not available during meal and snack times as it was in the dining area. This meant young people could not be supported by family and friends during their stay in hospital. On Gardener unit there was a phone booth with a payphone that patients could access without restrictions.

On our unannounced visit, we discussed blanket restrictions with the advanced practitioner who informed us work had commenced to review the restrictions in place. This included talking to patients about what they felt, checking staff understanding of blanket restrictions and audits. Focus groups had been held with patients and staff and a new framework was being developed to promote least restrictive practice.

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Medication reconciliation (the process of creating the most accurate list possible of all medications a patient is taking including drug name, dosage, frequency, and route . This is then compared against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications) was being carried out on admission by the consultant, and this was also observed during clinical review meetings. On examination of the clinic room area, all medication was locked away. This meant that the medication was stored securely.

On occasions people may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence. This is known as rapid tranquillisation (RT). Following rapid tranquilisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate as identified in the trust's policy and in line with code of practice. We found that on Gardener unit, three episodes of RT were recorded on the medication charts. Physical observations were not carried out following RT on any of these episodes and there were no RT monitoring charts. This meant that patients were at risk of physical health complications because staff had not carried out the required observations.

The trust had a named child protection lead and staff told us they knew who this was and how to contact them for advice. We found evidence in care records of staff complying with local safeguarding children board procedures, including informing the local authority by letter if a patient was likely to remain on the unit for a consecutive period of three months.

Track record on safety

There were four serious incidents over the past 12 months ending January 2016, this included one patient taking a serious overdose, one allegation of assault by a staff member on a patient and two patients escaping from the Gardener unit.

The escapes from Gardener unit were investigated and outcomes around relational security were highlighted. The action plan from the investigation included changes to how bedrooms were allocated and accessed, specific risk items were removed and relational security had been identified as a training need. During our inspection we found that staff were following the changes to how bedrooms were allocated and the risk items had been removed. Staff told us that training in relational security was planned.

During the inspection period, there was a further escape by two patients. One patient was found quickly in the hospital grounds, and the second patient was returned shortly after. A three day review was undertaken and identified a number of contributing factors and actions needed to be taken which included a risk assessment of the environment, removal of furniture that does not meet medium secure standards and strengthening the secure perimeter.

There were six allegations of abuse over a 12 month period ending January 2016. These were all reported to the children safeguarding board, and the trust took comprehensive actions to investigate all allegations including independent reviews and joint working with outside agencies. The trust learnt from the investigations and planned to roll out the updated training in relational security as detailed in the national guidance on security issues in mental health called 'See, Think, Act'.

Reporting incidents and learning from when things go wrong

Staff members knew what incidents needed reporting and how to report on the electronic incident recording system. Over a period of 12 months to December 2015 the trust reported 1,172 incidents for the service. Of the 1,172 incidents reported, 326 were for 'Self-Harm'; 321 were for 'violence and aggression/abuse/harassment to Staff'. Phoenix ward recorded the highest number of incidents across the trust with 488 incidents over this period, with 151 reported as violence and aggression/abuse/harassment to patients from patients. Security incidents accounted for 139 of the reported incidents.

Learning took place following incidents, and this was discussed during staff meetings. It was also reported that lessons from incidents were discussed during supervision. Staff members explained actions taken following serious incidents, and explained changes to practice. All staff members reported that they felt supported by their line manager following serious incidents and that debriefing occurred routinely.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed four care records at Gardener unit and seven care records at Junction 17 on the inspection. On Junction 17, all patients had received a comprehensive assessment during the admission process. On Gardener unit, the consultant psychiatrist and the advanced nurse practitioner carried out separate assessments as part of the referral process. Staff then carried out a pre-admission review to ensure they gathered all necessary information before a decision was made by specialist secure commissioners to admit the to the Gardener Unit.

We examined 11 care records across both units. One care record on Gardener unit had abnormal blood results, and there was no record of further investigations. This was reported to staff who assured us this would be looked into. On Junction 17 one care record did not include physical health examination on admission, but had further subsequent health checks. All other records demonstrated ongoing physical health monitoring.

All care plans we saw were up to date, person centred, holistic, recovery orientated and included patients' views. There was evidence of patients' involvement in care plans. On Gardener unit, all patients had been given a copy of their care plan. On Junction 17, out of the seven care records looked at, all but one patient had a record of being given a copy of their care plan. Staff reviewed and updated care plans weekly as part of the multidisciplinary team. Patients told us that staff sat with them to develop their care plans.

Care records were stored in an electronic format. Staff inputted information directly onto the system when entering daily records. Staff told us that the trust had recently introduced the new electronic system and they were having difficulties inputting and accessing information. Staff told us that blank care plan templates were not available on the system and this cause them difficulties when updating care plans. Staff told us they kept a copy of the care plan on their computer, updated the copy after review and then re-uploaded the information to the electronic system. During our inspection, we observed some staff having difficulties accessing and navigating care records. This meant that information relating to patient care was not readily available to staff when needed. The trust had provided extra training and support to staff to address these problems.

Best practice in treatment and care

We reviewed 25 medication cards during our visit. We found good prescribing practices on both wards. All prescriptions were signed and dated and all antipsychotic medications prescribed were within the children's and young people's British National Formulary limits.

Staff told us that they followed National Institute for Health and Care Excellence (NICE) guidance when providing treatment to patients. These included Depression in Children and Young People: identification and management CG28, Eating Disorders in Over 8s: management CG9 and Self-harm in Over 8's: short term management and prevention of reoccurrence. We found evidence that staff followed NICE guidance in care records.

Psychological therapies were available as part of the treatment provided. Staff told us that all patients were assessed on admission and if psychological therapy was recommended a referral would be made for treatment. Therapies offered included family therapy, art therapy, music therapy, occupational therapy, dialectical behaviour therapy, cognitive behavioural therapy and self-harm group therapy. We found evidence in care records of patients being referred to and accessing therapy.

Care records showed that physical healthcare was assessed and monitored throughout admission. There was access to specialist input when needed. We found evidence of specialist input from podiatry and endocrinology.

Staff used the Health of the Nation Outcome Scale for children and adolescents and the Children's Global Assessment Scale to assess and record symptom severity and monitor patient outcomes. On Gardener unit, staff also used the Health of the Nation Outcome Scale - Secure for use in a forensic setting.

Staff participated in a number of audits on the wards. These included audits on medication cards, care plans and infection prevention and control measures. Records showed that staff had completed a medication audit on Gardener unit in January 2016. The audit included legibility of prescriptions, stock availability, patient photograph, patient weight and allergies. Findings from the audit indicated that on six occasions staff had not recorded the

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administration of medication. Staff identified actions to be taken which included a discussion with individual staff in supervision and monthly audits to monitor improvements. On Junction 17, staff had completed a risk assessment audit of care records in January 2016. The audit showed that from a sample of 15 care records, 88% of patients had a current, finalised risk assessment within the last week. Actions from the audit included communication with nursing staff to ensure risk assessments were updated weekly and for the consultant psychiatrist and advanced practitioner to meet weekly to review the risk assessments. On both wards, we found evidence that staff had completed the actions recommended from the audits completed. Staff told us that learning from audits were shared with staff through emails and team meetings.

Prior to our inspection the trust provided information on an audit carried out on both wards relating to the availability of physical examinations, venepuncture and cannulation equipment (used for obtaining blood samples from patients). The audit identified that various items of equipment were missing on the wards and there was no system in place for checking stock levels and replenishing missing items. There were a number of recommendations included in the action plan from the audit. These included developing an equipment checklist, identifying a designated member of staff to check stock levels, identifying one room to store all equipment and providing clear labelling of storage in the treatment room. The audit was dated February 2015 and all actions had been completed, and we found this to be the case on inspection.

Skilled staff to deliver care

There was a sufficient range of skilled staff delivering care to patients on the ward. This included nurses, doctors, advanced nurse practitioners, activity workers, occupational therapists, social workers, psychologists, psychotherapists and dieticians. Staff were experienced and appropriately qualified to carry out their roles. Some nurses had achieved qualifications in psychosocial interventions. Children Act training was provided as part of the trust safeguarding training. However, Mental Health Act, Mental Capacity Act and service specific training did not form part of the trust mandatory training.

Initial data provided prior to our inspection showed that 87% of CAMHS inpatient staff had received an appraisal in the last 12 months. Records showed that staff had regular appraisals. The appraisal records were complete and comprehensive. The appraisal document included preparation for the member of staff, objectives, appraisee comments, appraiser comments and a rating of performance.

Staff received managerial supervision every six to eight weeks. Staff told us that individuals were responsible for arranging and attending clinical supervision sessions and attendance dates were provided to ward managers. If staff had not attended clinical supervision, joint managerial and clinical supervision would take place. Records showed that staff received regular managerial and clinical supervision. The clinical supervision target for both wards was six times per year. The average percentage rate for clinical supervision was 79%. On Gardener unit, staff also attended reflective practice sessions with the clinical psychologist.

Staff told us they had access to monthly team meetings. We reviewed minutes of team meetings during our inspection. We found good communication of updates to policies and procedures, lessons learned and the implementation of 'safe wards' initiative. Staff discussed actions completed from previous meetings and were involved in decision making about the service.

Staff received in-house training delivered by a clinical psychologist. The training included information on attachment theory, relationships, challenging behaviour and positive working with children and young people.

We found evidence of poor staff performance being addressed promptly and effectively. At the time of our inspection appropriate action had been taken following a small number of recent incidents and disciplinary investigations were ongoing.

Multi-disciplinary and inter-agency team work

Staff held multidisciplinary team meetings (MDT) weekly. There was a range of staff that attended the MDT which included the consultant psychiatrist, junior doctor, advanced nurse practitioner, social worker and deputy headmaster from the school attached to the wards. We observed two MDT meetings during our inspection. At Junction 17 we observed patients attending their MDT apart from one patient who had chosen not to. Relatives' views were discussed during the meeting. On Gardener unit, patients did not routinely attend MDT meetings, patients were involved by completing a form with their views detailed for discussion during the meeting.

Are services effective?

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Handovers took place three times during each 24 hours at each change of shift with the nurse in charge and available staff on shift. We observed a handover on Junction 17 during our inspection. Staff used a handover sheet to discuss each patient on the ward. Staff discussed risks, the level of observation, medication, patient presentation, education, leave, personal hygiene, diet, discharge planning and communication with relatives. Staff spoke positively about patients' progress during handover.

Staff had regular contact with community child and adolescent teams, social services and the local authority. We found evidence of communication relating to admission, treatment and discharge.

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

A Mental Health Act (MHA) monitoring review was carried out on Gardener unit during the comprehensive inspection. The review found one patient had not been read their rights since admission, there was no information displayed on how to contact the Care Quality Commission or how to make a complaint and one patient should have been referred for his annual mental health tribunal in November 2015. This referral had not been made. We spoke to the mental health act administrator who confirmed this oversight and agreed to make the referral that day.

We found not all staff had been trained in the MHA. At the time of our inspection 9% of staff had received formal training in the MHA. Staff told us they had not received training in the MHA regarding the changes to the MHA Code of Practice. Some staff had limited understanding of the MHA and their role in relation to the Act. On Gardener unit, staff told us that they discussed forensic sections during supervision and the ward manager had communicated the changes to the Code of Practice.

At the time of our inspection there were seven patients detained under the MHA. We reviewed all patient records during our visit. We found consent to treatment and capacity requirements were adhered to. Copies of forms showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts. However, one of the T3 forms did not include a medication that was prescribed to the patient, but was not being administered. We informed the nursing staff about this who gave assurances this would be rectified.

Staff told us that patients' rights under the MHA were read on admission, every three months and when there were changes to detention status and medication changes. On Junction 17, staff were unable to identify when patients' rights were due to be read. On Gardener unit, dates for staff reading patients their rights were documented in the care plan. Patients told us staff read them their rights.

There was a central MHA office where staff received support on the implementation of the MHA. Staff were aware of the support and told us they contacted the MHA office when needed.

Original detention paperwork was filed and stored appropriately. Copies of detention paperwork were scanned onto electronic patient records.

As part of our inspection we requested the latest audit completed to ensure the MHA was applied correctly. There had been no audits completed on specific to the wards we visited.

Independent Mental Health Advocacy services were provided by a local organisation, with information on how to access displayed on the noticeboard.

Good practice in applying the Mental Capacity Act

The deprivation of liberty safeguards (DoLS) does not apply to people under the age of 18 years. The Mental Capacity Act (MCA) applies to young people aged 16 and 17. For children under the age of 16, decision-making ability is assessed through Gillick competency. This allows staff to recognise that some children may have a sufficient level of maturity to make some decisions themselves.

At the time of our inspection 2% of staff had received training in the MCA. Some staff had limited understanding of the Act and were unable to describe how they considered patients' capacity to make decisions in planning and delivering care. Staff had some awareness of Gillick Competency; however they told us they were not aware of this being applied.

Staff told us that capacity to consent to treatment was assessed by the consultant psychiatrist on admission and within multidisciplinary team meetings weekly. We found evidence in care records of capacity assessments being completed. However, staff were unable to locate this information on the electronic care records system when asked.

Are services effective?

Good

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Staff were aware that there was a policy on MCA located on the intranet. Staff told us they would seek advice from the multidisciplinary team and the MCA lead for the trust.

As part of our inspection, we requested information on how adherence to MCA was monitored for the wards. There had been no audits completed specific to the wards we visited.

Good

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

On Junction 17, patients told us that some staff were respectful, supportive and caring. They said staff would knock on bedroom doors before entering and that staff were happy to talk to patients.

Staff told us that they had a good understanding of the needs of patients. Staff were able to discuss individual care plans and the rationale for the care plans in place.

On our unannounced inspection, we completed a short observational framework for inspection on both wards, which is a tool used to gather evidence about the experience of patients especially where patients may not be able to fully describe this themselves. On Junction 17, we observed a twenty minute period where there were no staff present in a communal area where patients were present. During this period patients were entering other patient's bedrooms and there were no staff to supervise whether this was appropriate. When we did observe staff they were interacting positively with patients, asking about their well-being and inviting patients to attend meetings. During our visit, we observed staff being encouraging and supportive towards patients in multidisciplinary team meetings. On Gardener unit, we observed staff interacting with patients in a polite and friendly manner. Staff were meaningfully engaging with patients and there was evidence of good rapport and a friendly tone.

On Junction 17, three patients told us that some staff would 'roll their eyes' when patients asked questions and asked for support. Patients told us that some staff would also tell them to 'grow up'. Two patients told us that some staff did not offer emotional support when they were visibly upset. Two different patients told us that as part of their care plan they required support at mealtimes, however some staff did not provide them with the support they needed. Patients told us that some staff did not give support unless patients asked for it. Records showed that staff were allocated to provide meal support to patients who needed it.

On the day of the inspection a patient was placed in seclusion and placed in tear proof clothing. We looked at the care records and found that a multi-disciplinary team discussion had not taken place to decide if the person should be deprived of their daytime clothing in line with the requirements of the Mental Health Act Code of Practice. This meant that the patient's dignity had not been maintained in line with guidance. On our unannounced inspection, we found that this practice had changed. Tear proof clothing was stored with the advanced practitioner and staff members had to contact the responsible clinician and manager to discuss this option before making the decision to remove any individual from their own clothing in seclusion.

The involvement of people in the care that they receive

Staff gave patients an information pack on admission. The information pack for the Gardener unit included information about the location, team, admission, first day, treatment, mealtimes, activities, school, visitors and complaints. The information pack for Junction 17 included information about the service and was not specifically aimed at patients. Staff told us that on admission staff gave patients verbal information about the ward and treatment. Patients told us that they received information relating to their stay on admission.

We saw evidence of patients' views included in care plans. Patients told us that they understood their care plans and staff offered them a copy. On Junction 17, patients had asked staff if they could be involved in multidisciplinary team meetings (MDT) as they previously did not attend these meetings. On Gardener unit, patients did not attend MDT as it was considered a risk. We observed MDT meetings on both wards as part of our inspection. Patients had contributed to discussions before the meetings took place and patients' wishes were clearly identified and these were discussed in the meetings we observed.

All patients had access to independent advocacy. Staff told us that advocacy visited the wards once a week. Patients told us they saw the advocate regularly and were able to request support from advocacy when needed. We found posters displayed around both wards detailing information about advocacy services.

Staff involved relatives in patient care. We found evidence in care records of regular communication with patients' relatives. Staff told us that they contacted relatives after MDT reviews to provide information and ask for their views. Relatives' views were discussed in the MDT meetings that we observed. Staff asked patients for consent to contact

Good

Are services caring?

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

relatives and this was documented in their care records. Staff told us that some patients' relatives had attended training sessions provided by the wards on attachment and safety planning.

Wards held community meetings once a week to gain feedback from patients. On Gardener unit, patients provided feedback about food choices and changes to care plans. There was a standard agenda item about mutual expectations, where issues around boundaries and respect were discussed. On Junction 17, patients provided feedback about food choices and staff being loud when waking patients in the morning. On both wards we saw evidence of changes being made as a result of patient feedback. There was a suggestions box for patients to give feedback if they did not wish to attend the weekly meetings.

Patients told us that they had not been involved in helping to recruit staff. Staff told us that patients would be involved in decisions about décor. Staff told us paint and fabric swatches were made available to patients when these decisions were made. We found evidence in community meeting minutes of patients being involved in decisions about décor on Gardener unit.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy in the six months prior to our inspection was 102%. The bed occupancy on Gardener unit was 78% and 126% on Junction 17. Staff had submitted low bed occupancy as an item on the risk register for Junction 17 dated 16 October 2015. Staff informed us that five beds were commissioned on a nightly basis. This meant that when these beds were being used and despite beds being available on the ward, the ward figures appeared above 100% occupancy.

On Junction 17, the majority of referrals were received from Bolton, Manchester, Salford and Trafford. Staff told us that the service did accept referrals from outside the local area. Gardener unit accepted referrals from a wider area, including referrals from Her Majesty's Prison Young Offender Institutions.

There was a procedure in place for admitting and discharging patients to the wards. On Junction 17 the multidisciplinary team assessed referrals to the ward. There were exclusion criteria in place which allowed staff to assess if they were able to meet a patient's needs. On Gardener unit, the consultant psychiatrist and senior nurse conducted independent assessments of new referrals and both assessments had to concur for the patient to be admitted to the ward. A pre-admission review would then be held to ensure staff had all relevant information relating to the patient. The final decision to admit to the Gardener unit was made by specialist secure commissioners within NHS England in consultation with Gardener unit staff.

In the six months prior to our inspection all of the young people who required to be admitted were cared for in the unit. No young people were treated out of the area. On Junction 17, there was a system in place to admit patients into 'safe leave beds'. These beds were only available for new admissions if there was a plan in place for discharge for the current patient and the patient was taking leave leading up to discharge. On Gardener unit, beds were not used when a patient went on leave.

Patients remained on the ward for the duration of their stay, unless there was a clinical need to move patients elsewhere. Staff told us a psychiatric intensive care (PICU) bed would be sought when patients required more intensive care. On Gardener unit, when there was a clinical need to transfer patients elsewhere this was planned in advance and staff made a referral to another unit. The consultant psychiatrist and the operational manager held discussions when there was a clinical need to transfer a patient in an emergency.

Staff planned for discharge in advance and patients were involved in this process. During our inspection we saw evidence in care records of discharge planning. On Junction 17, staff gave patients a provisional discharge date and community child and adolescent teams were involved in the discharge planning process.

The average length of stay for patients discharged in the last 12 months was 80 days. On Junction 17, the average length of stay for current patients was 44 days. On Gardener unit, the average length of stay for current patients was 237 days, which was within the target length of stay of 12 months. This was because patients on Gardener unit were subject to conditions of medium secure care and tended to have longer stays.

The facilities promote recovery, comfort, dignity and confidentiality

The wards offered a range of rooms to support patient treatment and care. For Junction 17, these included male and female lounges, dining rooms, kitchens, clinic rooms, male and female bathrooms, utility room, therapy room, multifaith room, art therapy room, activities of daily living kitchen and a recreation room. On Gardener Unit the rooms included a communal lounge, dining room, kitchen, music therapy room, activities room and laundry room. Both wards had separate education areas that included classrooms and sports halls.

There was access to secure outdoor space on both wards; however patients told us that they had to ask staff to escort them outside. One patient on Junction 17 told us that they enjoyed being outside and used this as a coping mechanism, however staff were not always available to spend time outside. There were quiet areas on both wards and rooms available where patients could meet visitors.

Food was delivered to the wards from the hospital kitchen and served to patients in the dining rooms. Patients told us that the food was good; however the choices were not to everyone's taste. One patient told us that they had requested pasta but staff had not added this to the menu.

Are services responsive to people's needs?

Good

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

Staff told us that the hospital kitchen had recently provided sealed food for a patient that would not eat as they thought their food had been tampered with. This enabled staff to ensure the patient was eating regularly.

There was access to hot drinks and snacks but staff had to provide these when patients requested them.

Patients were able to personalise their bedrooms with their own belongings. On Junction 17, we found evidence in minutes of community meetings of patients requesting to use their own bedsheets. Staff refused this request on the grounds of fire risks.

There was an activity worker on both wards providing activities throughout the week and at weekends. Activities included baking, gym, pool, table tennis, movie night, community trips, bowling, current affairs discussions and pet therapy.

Services at Prestwich Hospital, including Child and Adolescent Mental Health services scored 96% for privacy, dignity and wellbeing and 100% for condition, appearance and maintenance in the 2014 Patient Led Assessment of the Care Environment (PLACE). PLACE self-assessments are undertaken by teams of NHS providers and patient assessors with members of the public making up at least 50% of the team. This meant members of the public and patients felt the environment was of high standard in 2014.

Meeting the needs of all people who use the service

On Junction 17, there was wheelchair access around the ward and one bedroom had been adjusted to support patients with mobility difficulties. On Gardener unit, there was wheelchair access into the building. Staff told us they would consider the environment when assessing patients' with mobility difficulties due to the layout of the ward and the number of steps on the ward.

There was limited provision of information available on the wards. Information displayed on Junction 17 included advocacy, spiritual support contact numbers, how to make a complaint and carers information. On Gardener unit there was no information available on how to complain or how to contact the Care Quality Commission.

Staff told us that they would book an interpreter when needed. Interpreting services were available by telephone and face to face visits. Staff could access information leaflets in different languages on the trust's intranet, however staff told us they would arrange for an interpreter to visit in the first instance.

Staff told us there were a variety of food choices to meet patients' dietary requirements. These included vegetarian, vegan, Halal and gluten free. We found evidence of staff providing one patient with a Caribbean diet at the patient's request.

There was access to chaplaincy on both wards. There was a range of spiritual support available, which included Christianity, Catholicism, Judaism and Islam. Staff told us that the hospital chaplaincy team could request support for other religions on request. We spoke to the Imam during our inspection. They told us that they provide weekly support to Muslim patients and delivered religious education sessions on the wards.

Patients attended education on site on both units. Staff told us that 25 hours of education were provided each week, and patients could continue with GCSEs and a range of post 16 vocational based courses. We spoke with four teachers during our visit. They told us that communication with ward staff was good and information about patient progress was discussed daily. Patients were supported on the wards by teachers and ward staff if they could not attend education. Healthcare staff provided training to teachers monthly, which included attachment, eating disorders, risk, self-harm, mindfulness and relational security. The deputy headmaster attended weekly multidisciplinary team meetings. The education facilities onsite had been inspected by the Office for Standards in Education, Children's services and Skills in June 2014 and were rated as good.

Listening to and learning from concerns and complaints

Initial data provided by the trust showed two complaints on Gardener unit in the 12 months prior to our inspection. One of the complaints was partially upheld. On Junction 17, there were eight complaints, one of which was upheld and one partially upheld. Gardener unit had received one compliment in the past twelve months and Junction 17 had received 19 compliments.

Patients told us that they knew how to complain and had raised complaints with staff. On Junction 17, one patient told us they would speak with the advocate for support

Are services responsive to people's needs?

Good

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

with a complaint. Three patients reported making five complaints without receiving feedback. On Gardener unit, staff told us that a patient had recently complained about an item of clothing that went missing and the trust had replaced the missing item. Staff told us feedback from complaints was shared in community meetings and staff team meetings.

Staff told us that they would make attempts to resolve complaints on the wards. There was a customer care team within the trust that managed complaints when these could not be resolved at ward level. During our visit we found that staff managed formal complaints appropriately, however staff did not record complaints made on and resolved by the wards. Both wards had a complaints file which included forms for informal complaints to be recorded. We found evidence of completed complaints forms for February 2014 and April 2012. On Gardener unit, there were completed complaints forms for April 2015. We did not find completed forms for complaints that patients had told us about during our inspection which we raised with staff. Therefore staff were not recording complaints that were resolved at ward level. This meant there was no way of identifying any themes or trends occurring as a result of complaints that should influence a change in practice

On Junction 17, there was a complaints policy on the wards that detailed the procedure for staff to follow when dealing with a complaint. The policy was dated April 2009 and had a review date of April 2012.

Are services well-led?

Requires improvement

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

Vision and values

Staff had knowledge around the organisation visions and values, and these were displayed on posters and leaflets around the wards. The trust values were 'we are caring and kind, we go the extra mile, we value and respect, we are welcoming and friendly and we work together'. The objectives of the wards all met the organisations values. An example of this was the implementation of 'safe wards' (ideas aimed at making the ward safer) at Junction 17. This was in line with the organisation's drive to innovate and improve in line with national guidance. Staff appraisals included the trust's values and staff identified objectives that were based on the values.

Staff knew who the senior management team were by name and reported that they visited the wards.

Good governance

Governance structures were in place but had failed to identify that there were insufficient staff on the wards to care for patients safely due to high levels of enhanced observation, and that the staff did not have the necessary skills or knowledge to provide safe care including knowledge around the Children Act and approaches to take to manage aggression in young people. Mental Health Act, Mental Capacity Act and service specific training did not form part of the trust mandatory training system. This meant that managers of the service could not assure themselves that staff members had the relevant knowledge and skills to provide safe care to young people.

The trust used key performance indicators to measure performance. Ward managers reported that they received feedback of where performance needed to be improved. An example given was when not meeting mandatory training targets. Improvements in mandatory training had not occurred and this was attributed to being either unable to release staff from the wards or from training being cancelled.

Ward managers reported having enough autonomy to manage the wards and felt supported by the service leads. Shortages in staffing were acknowledged and recruitment was ongoing to resolve the shortfall. The service manager reported the recent recruitment of four additional staff due to commence in the March 2016, however interim measures were not adequate to ensure the service could deliver safe and effective care. Managers acknowledged that shortage in staffing had contributed to the recent incident on Gardener unit.

Incidents were being reported and learning from incidents at organisational and ward level was taking place.

Safeguarding procedures were followed consistently, and all staff were knowledgeable around when and how to report abuse. However, staff had not been trained in level three safeguarding.

Leadership, morale and staff engagement

The staff sickness rate across the service was Gardener unit at 11%, Pegasus ward at 4% and Phoenix ward at 6 %. It was acknowledged that sickness levels on Gardener were significantly impacting on the wards ability to deliver safe care.

Staff members were aware of the whistle blowing policy and how to use it. Staff members we spoke with all felt that they were able to raise concerns without fear of victimisation.

The service lead provided an example of when staff performance issues were managed promptly and effectively, and with support.

Positive comments about the ward managers and services managers were received from staff. Staff reported that they felt fully supported.

Staff members were encouraged to develop. Two staff stated that they had worked in the trust for many years and had progressed through personal development and training, with one reaching the position of advanced practitioner as a result of investment in personal development.

The trust had a policy on duty of candour. Duty of Candour regulations state that providers should be open and transparent with patients. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The service manager was able to provide an explanation of the duty of candour process but not an example of this being required.

Are services well-led?

Requires improvement

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.

Commitment to quality improvement and innovation

The service at junction 17 had implemented 'safe wards' and reported this had helped in reducing incidents of violence and aggression. However staff had not had chance to undertake further study of overall incident numbers before and after starting the safe wards initiative.

Junction 17 has participated in the Royal College of Psychiatrists' accreditation for in-patient child and adolescent services (QNIC) and had received accreditation, demonstrating a commitment to quality and improvement. This was due to undergo its peer review in March 2016.

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 10 HSCA (RA) Regulations 2014 Dignity and respect On Junction 17, there were a number of blanket restrictions in place including restricted access to mobile phones and routine searches following periods of leave. This was a breach of regulation 10(1) and 10(2)(b)

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 Patients were being nursed in the intensive nursing suite and were prevented from entering the main ward area. Records showed that staff did not carry out physical observations following administration of rapid tranquilisation medication on three separate occasions. This meant patients were at risk of physical health complications not being recognised. This was a breach of regulation 12(1) and 12(2)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Monitoring systems in place had failed to identify that care was not being delivered safely or effectively due to insufficient staffing numbers and lack of suitably trained staff. On Junction 17, we saw 15 missing entries on patient observation records. On Junction 17, we saw 19 missing entries on fridge temperature monitoring records.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17 (2)(b)(c) and 17 (2)(d)(ii)

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 There were not always enough staff on duty to deliver safe care. We found insufficient staffing on duty to cover enhanced observations and to manage incidents effectively. Staff had not received service specific training, including the need to alter the approach when manging violence and aggression with children and adolescents. This was a breach of regulation 18(1)(2)(a)