Ellingham Hospital

Quality Report

Ellingham Road,
Attleborough, Norfolk, NR17 1AE
Tel:01953 459000
Website: www.partnershipsincare.co.uk

Date of inspection visit: 12 to 13 January 2016
Date of publication: 28/06/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Ellingham Hospital as requires improvement because:

- Doctors did not always attend seclusions within an hour to carry out the necessary patient checks as required under the Mental Health Act Code of practice. The doctors had not always completed the seclusion log correctly.
- The service had a 50% staff turnover in the past 12 months. This meant that they had to rely on agency staff to cover the shortfall.
- Staff did not receive regular supervision and appraisal to support them in their role, and to monitor their performance.
- The staff on the wards lacked knowledge of The Mental Capacity Act (MCA) and its use within a CAMHS setting; particularly in regards to Gillick competency, and how to assess. Staff training records showed a low rate of completion for mandatory training and no specialist training in working with patients with Autism and Learning Disabilities.
- We found a number of ligature points on both wards that maintenance staff had not rectified within the time specified in the maintenance plan.
- The décor of the ward needed improvement and maintenance staff did not always repair damage in a timely manner.
- Partnership in Care (PiC) continued to use the previous provider's policies to run the hospital and did not have a date for when they would start to use their own.

However:

- Staff completed comprehensive risk assessments and care plans. These covered a wide range of risk and needs. Patients were involved in the development of their care plans. Patients completed review forms, which gave them the opportunity to rate their week and say what they wanted to discuss in their care review. Staff gave families copies of care plans.
- The provider had robust safeguarding procedures in place, and good links with the local authority safeguarding team.
- The service introduced activities during the evenings and weekends. This was as a response to a high number of incidents during these times. The service provided a suggestion box for the patients to suggest activities and outings.
- The provider had arrangements with a local GP service and a GP attended weekly and monitored patients physical health needs.
- The provider offered education facilities at the on-site school. The provider also offered a variety of activities that promoted recovery. Patients were involved in developing the activities programme.
- The provider offered accommodation to parents. Many parents had to travel long distances to visit, and this allowed them to spend more time with their children.

The provider takes part in the Quality Network for Inpatient CAMHS (QNIC) peer review scheme. This monitors the quality of the service they provide.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires improvement 	

Summary of findings

Contents

Requires improvement

Ellingham Hospital

Services we looked at

Child and adolescent mental health wards;

Summary of this inspection

Background to Ellingham Hospital

Ellingham hospital is Tier 4 hospital provision with open and secure beds for patients aged 12-18 years, with behavioural and psychological difficulties. The service is regulated for assessment or medical treatment for persons detained under the Mental Health Act 1983 and Treatment of disease, disorder, or injury. Ellingham hospital provides two wards, one low secure, and an acute ward.

Cherry Oak ward is a low secure ward for patients with conditions such as complex neuro-developmental disorder, learning disability, attention deficit hyperactivity disorder (ADHD) and mental health problems. It is a mixed gender ward and has 10 beds.

Woodlands ward is a specialist ward that cares for patients with psychiatric, emotional, behavioural and social difficulties, including learning disabilities and autism spectrum disorder. It is a mixed gender ward and has 15 beds.

Our inspection team

Inspection manager: Peter Johnson. Team leader: Lee Sears

The team that inspected the service included four CQC inspectors and a Mental Health Act reviewer.

We also had an expert by experience that had previous experience of using CAMHS services.

Why we carried out this inspection

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

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 the location, asked a range of other organisations for information.

During the inspection visit, the inspection team:

• visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;

• spoke with nine patients who were using the service;

• spoke with the registered manager and managers or acting managers for each of the wards;

• spoke with 12 other staff members; including doctors, nurses, occupational therapists, psychologists, social workers, educational staff and kitchen staff

• spoke with an independent mental health advocate;

• attended and observed one multi-disciplinary meeting;

Summary of this inspection

- collected feedback from five patients using comment cards;
- Looked at 14 care and treatment records of patients:
- carried out a specific check of the medication management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We rated safe as requires improvement because:

Requires improvement

• Doctors were not attending the ward within an hour when patients were secluded. This is in breach of the Mental Health Code of Practice, chapter 26., which states 'If not authorized by a psychiatrist, there must be a medical review within one hour or without delay if the individual is not known, or there is a significant change from their usual presentation'.

• We found ligature points on the wards. The provider had a ligature audit and action plan but maintenance staff had not completed the work within the specified time-frame. The audit did not include the garden.

• The provider used high numbers of agency staff. This was due to a high turnover of staff and a high number of vacancies. They block booked agency staff to try to maintain consistency. However, they were not able to guarantee staff would be familiar with the ward.

• Staff were not up to date with mandatory training. The training matrix showed that some mandatory training compliance was as low as 26%. Staff had poor knowledge on The Mental Capacity Act and was unsure how to respond if someone lacked capacity.

• The décor of the wards needed improvement. The provider did not always repair damage to the environment in a timely manner.

However:

• Staff completed thorough and comprehensive risk assessments covering a range of risk issues.

• The provider had robust safeguarding procedures in place. Staff knew how to report concerns for a patient's welfare.

Are services effective?
We rated effective as requires improvement because:

Requires improvement

• The provider had mandatory training on the Mental Health Act. However, only 68% of staff had completed this.

• The provider had mandatory training on the Mental Capacity Act. Only 42% of staff had completed this. Staff knowledge of issues of capacity for children and adolescents was poor. They could not adequately assess and plan the appropriate support for patients lacking capacity.

Summary of this inspection

• Staff completed comprehensive care plans that covered a range of needs. Staff involved the patients in the development of their care plans. Staff gave these to patients in 'wonder files' which could be personalised.

• The provider had good physical health monitoring systems in place. A local G.P attended the unit on a weekly basis to monitor patients' physical health.

• Staff worked well as part of a multi-disciplinary team. Staff attended early morning review meetings where they discussed recent incidents, patient's risks, and changes to care plans. There was good collaboration between the school and hospital staff.

Are services caring?
We rated caring as good because:

Good

• Patients were involved in all aspects of their care. The use of wonder files and "My review" forms helped patients to be involved in decision making around their care.

• The provider held regular community meetings. This helped patients influence menu choices and activities. There was also a suggestion box for activities.

• Most patients and carers were very positive about the staff saying that 'if it wasn't for the staff it would be very boring here'. They felt that the staff were sensitive to their needs, encouraging and supportive.

However:

• Patients complained about the quality of care at night. Some patients described night staff as 'mean'. We raised this with the manager. There were also complaints of night staff sleeping on duty, which we found evidence of in the minutes of the charge nurse meeting.

Are services responsive?
We rated responsive as good because:

Good

• The provider had effective referral and assessment processes. Two members of the multi-disciplinary team assessed new referrals. Assessments were comprehensive and included both current and historical information.

• Staff provided activities that promoted recovery. Staff gave each young person an activity schedule tailored to their needs.

• The occupational therapist introduced activities during evenings and weekends. This was as a response to a high level of aggressive incidents at these times. Since staff introduced these activities, incidents had reduced.

Summary of this inspection

• The school provided education in line with the national curriculum. They also provided vocational training for patients as well as some higher education classes.

• The provider had facilities to accommodate parents if they have travelled a long way to visit. This could be pre-booked at any time and allowed parents to spend more time with their child.

• The provider had good complaints procedures in place. Staff investigated these in a timely manner and there was evidence of lessons learned. Staff shared outcomes with all involved.

Are services well-led?
We rated well led as requires improvement because:

Requires improvement

• Despite Partnerships in Care taking over the provider four months prior to the inspection, staff still worked under the old organisations policies. The provider did not have a date for when they would implement the new policies.

• Staff did not receive regular supervision and yearly appraisals. This meant there was not sufficient support in place and managers could not routinely monitor staff performance.

• Staff did not feel engaged with the process of the changing of organisation. They felt the senior management could have consulted with them more frequently.

• Senior management were not visible. Staff told us they have not seen the managers since Partnerships in Care took over. Some staff did not know who the senior executive team were.

However:

• The service was involved in national peer review schemes. They planned to start peer reviews with other Partnerships in Care services.

• The provider used staff and patients views to shape and improve the services. The provider had patient and carer forums in place and regular staff meetings to gather patient and staff views.

Detailed findings from this inspection

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.

• The provider had mandatory training on the Mental Health Act and Code of Practice. However, the training matrix showed that only 68% of staff had completed this. The providers target was 90%.

• The provider had easy read Mental Health Act information leaflets on display for patients. We saw in the care records that staff read patients their rights on a monthly basis.

• Staff completed The Mental Health Act Paper documentation correctly including Section 17 leave forms.

• Second opinion approved doctors (SOAD'S) had assessed where appropriate and the necessary documentation completed.

• There had not been an audit of the Mental Health Act documentation. The provider had recently appointed a Mental Health Act administrator and it was planned that they would do an audit as part or the next years audit schedule.

• The provider did not have photographs of the patients in the care records or on their medicine administration records as required by the Mental Health Act Code of Practice. We found some consent forms for photographs in the care records.

• Patients had access to independent mental health advocates. The provider had arrangements with a local organisation that provided the advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

• The staff were given training on the Mental Capacity Act. However, only 42% of staff had completed the training. The providers target was 90%.

• A multi-disciplinary approach was not taken in assessing patients' capacity. Doctors were responsible for completing capacity assessments, which were recorded in care notes. Whilst these were comprehensive decision specific assessments, they did not document additional information such as views of parents, or advocacy support. Nursing staff did not have very good knowledge of issues of capacity. They were unable to describe how they would assess capacity. Named nurses did not get involved in capacity assessments, in spite of having care planned for individual needs.

• We looked at the clinical records and found evidence of consent forms signed by patients.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Child and adolescent mental health wards

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

• Staff could not always see patients on the ward and 'blind spots' were identified for Woodlands ward in some corridors. The provider did not have mirrors appropriately placed to help staff observe patients. The provider increased staff to monitor these areas and used CCTV to monitor communal areas. A designated staff member monitored this. The provider also used CCTV when investigating incidents or accusations.

• There was damage to the wards and some peeling paint and plaster. One window had been broken for several weeks without repair. On Cherry Oak ward, some furniture needed replacing. The provider had an action plan for work to be completed. However, this did not have dates for expected completion. This meant that maintenance staff did not know what work to prioritise, and therefore they did not complete work in a timely manner.

• The provider had not identified all ligature risks on their ligature audit. This included playground equipment such as swings, doors, window handles, and taps. Staff mitigated the risk to patients in the garden by observing them at all times. If a patient was considered a risk of ligature, they would be placed on an increased observation level to mitigate the risk of harm. The provider had an action plan, which described the work they planned to do to reduce ligature risks on the wards. However, the provider had not completed this work within the identified timeframe of December 2015. There was no amended date for completion.

• Staff kept the clinic room clean and tidy and medication was stored securely. There were fridges for storage of medication. However, on Woodlands ward, the fridge was not working and they had to use the fridge on Cherry Oak ward. Consequently, the Fridge on Cherry Oak ward was overstocked. This meant that air could not circulate freely and could prevent the fridge from working efficiently, potentially causing damage to medication stored inside. Staff monitored the fridge temperature. We checked the log and found that the fridge had been kept at an appropriate temperature. The manager ordered a new fridge for woodlands on the 5th January. Staff checked the fridge temperature daily; however, they had not always recorded this for November and December.

• The provider had arrangements in place for medication reconciliation with a local pharmacy. The pharmacist visited the ward on a weekly basis to audit the medication stocks, make sure all medication was in date, and there were sufficient quantities.The provider had disposal of medication procedures in place. We checked the drug disposal records and staff completed these correctly for all medication.

• We checked the storage and management of controlled drugs. Both wards had separate locked cupboards for storing controlled drugs. Staff maintained records of controlled drugs kept on the premises and two nurses signed these as per the providers' policy. The nurse in charge held the keys. The hospital manager is the accountable officer for controlled drugs.

Requires improvement

Child and adolescent mental health wards

Safe staffing

• Woodlands ward had a staff patient ratio of one to three. Cherry Oak ward had a staff to patient ratio of two to three. The provider used the Quality Network for Inpatient CAMHS (QNIC) guidelines to determine staffing levels. There were 12 qualified nurses and 28 care assistants. The provider had seven vacancies for qualified nurses meaning they had 42% of their establishment of qualified staff. The provider also had six vacancies for care assistants. This equates to 42% of vacancies. During interview with the service manager, he told us that the provider had a recruitment action plan. We reviewed this and saw that the manager has ordered a banner advertising vacancies that he will display outside the hospital and they are attending jobs fairs at the local university. The manager was also in discussion with the local university about accreditation to become a placement site for student nurse.

• The service had 50% staff turnover rate in the past year and has used agency staff to manage this. QNIC guidelines state there should not be more than 15% of agency use in a week. The provider used an average 58% agency staff a week. However, agency staff were block booked to provide consistency for patients. staff at night was 78%. During interviews with patients, they reported issues with the quality of care at night saying staff were 'mean' and were not nice to them.

• Patients complained of staff sleeping on night shifts. Staff discussed this in the charge nurse meetings and recorded it in the minutes. The minutes also included actions taken to deal with those staff involved.

• Staff were 49% compliant with mandatory training. The provider set a target of be 90% compliance. None of the 20 mandatory training courses were compliant with the provider's target. Only safeguarding children, immediate life support, and management of aggressive behaviour training were above 75%. Some agency staff had received mandatory training however, we spoke to one agency staff who said they only had management of aggressive behaviour training.

Assessing and managing risk to patients and staff

• Staff completed a comprehensive risk assessment of patients prior to admission to the hospital. This included both historic and current risks. We reviewed 14 care records and found that staff regularly reviewed risk assessments. The staff and consultant psychiatrist discussed risk assessments during ward rounds. We attended the early morning review, where staff discussed recent incidents and changes to young peoples' risk management plans.

• The provider had good safeguarding protocols in place. Staff were aware of the safeguarding processes and how they should respond if they had concerns. Staff were able to tell us who they would report safeguarding concerns to. They knew the local safeguarding procedure and understood their responsibilities about reporting concerns. 78% of staff had completed safeguarding training. The providers target was 90%. We reviewed the providers safeguarding policy and looked at the safeguarding log. This showed that the provider was responding and reporting safeguarding concerns in line with their policy.

• Staff nursed two patients in a separate corridor from the main ward. For one patient this was due to privacy and dignity issues, and staff allowed them to come and go as they pleased. The other patient was in a corridor segregated from others. Whilst the provider had a long-term segregation policy in place, they had not recognised that they had segregated this patient. Consequently, staff had not completed a long-term segregation care plan that would address issues of isolation and gradual integration with other patients. Staff completed a care plan once we raised this issue, although they attempted to back date it, which we told them was not appropriate.

• The provider had recently refurbished the seclusion room to make it fit for purpose. However, you could see into the room from other areas of the hospital, which meant the privacy and dignity of those secluded had not been considered. We pointed this out to the manager who had already arranged for this to be rectified, and the maintenance staff completed this on the second day of inspection. Staff had good knowledge of the purpose of restrictive practices, such as physical restraint, rapid tranquilisation, and seclusion. We observed staff dealing with some challenging behaviour. This was managed in a calm manner which allowed the patient time and space to calm down.

• Doctors did not attend incidents of seclusion within an hour of seclusion starting. This is in breach of The Mental Health Act Code of Practice, which states that 'If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the individual is

Requires improvement

Child and adolescent mental health wards

not known or there is a significant change from their usual presentation'. When doctors attended, they did not always sign to say they had attended and what time they arrived. This meant we could not be sure that a doctor had reviewed patient seclusions or the length of time from seclusion starting and their arrival. We raised this with the provider and they told us they were aware of the issue. The Manager had spoken to the doctors and he had sent the policy via email. The seclusion audit showed this was an ongoing piece of work.

Track record on safety

• There were five incidents in the last six months. These related to accusations against staff. Senior managers investigated these in a timely manner. Investigations were thorough. Staff were aware of their responsibilities to raise and record concerns and near misses, and to report them internally and externally such as, to the local safeguarding authority, and the police. Staff logged this in an incident log. Debriefing sessions took place after serious incidents. The provider fed back lessons learned through multi-disciplinary team meetings and through staff supervision.

Reporting incidents and learning from when things go wrong

• The provider had good systems for reporting incidents. There was evidence of lessons learned. The provider fed back lessons learned through early morning review meetings, handovers and team meetings. We reviewed three staff meeting minutes, and six charge nurse meeting minutes. This showed staff discussed lessons learned.During interviews with staff, they were able to give examples of how this had happened recently. We attended the early morning review in which staff discussed an incident that happened the previous day and lessons learned. Staff would inform parents or carers when incidents happened.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

• We reviewed 14 care records across both wards.Two members of the multi-disciplinary team completed pre admission assessments that included a review of historical and current information. The wider multi-disciplinary team would continue this assessment process following admission. Staff completed care plans that addressed a range of needs and included specific interventions such as how to manage aggressive behaviour. Staff reviewed care plans regularly in the ward rounds every two weeks.

• Staff had access to a consultant and a junior doctor between Monday and Friday 9-5. The junior doctors were on call out of hours.The provider managed this on a rota system, including staff from other local services. If there were a medical emergency then the staff would access the ambulance services.

• Staff told us that they carried out comprehensive assessments of patients' needs when they admit them. This can take up to 12 weeks to complete due to the complex needs of the patients admitted. We looked at the care records and found assessments that were detailed and covered a variety of needs. Staff then used the information in the assessments to write care plans. Staff wrote care plans that addressed all needs identified during the assessment period, these were holistic, and recovery orientated.

• The provider used an electronic recording system. They also kept some basic information in paper records. Regular staff had access to the electronic records however, some agency staff we spoke to told us they did not have access to the electronic system and had to use other staffs log in to record information.

Best practice in treatment and care

• The provider was adopting the TEACCH (Treatment and Education of Autistic and Communication-Handicapped Children) approach within the school. The primary aim of the TEACCH programme is to help prepare people with autism to live or work more effectively at home, at school

and in the community. Special emphasis was placed on helping people with autism and their families live together more effectively by reducing or removing 'autistic behaviours'. We interviewed the head teacher who explained that she had started training staff to embed the culture in the hospital. However due to the high staff turnover she has had to start the training again.

• Psychology staff were using a variety of therapeutic interventions recommended by the national institute for clinical health excellence (NICE). These included cognitive behaviour therapy, cognitive analytical therapy, dialectic behaviour therapy, and eco-behavioural approaches.

• The staff used a variety of nationally recognised rating scales. Examples of these are the Children's Global Assessment Scale. This is a numeric scale used to assess a child's level of functioning. Staff also used Health of the Nation Outcome Scale for children and adolescents. This is an assessment and outcome measurement tool intended to be used routinely to score the behaviour, impairments, symptoms, and social functioning of children and young people with mental health problems.

• Clinical staff participated in clinical audits. We saw care plan audits completed by clinical staff with actions attached for follow up. Staff followed up on actions and this was evidenced in the following month's audits.

• The local GP attended the hospital on a weekly basis to monitor physical health concerns. The GP completed a full physical examination within one week of admission and reviewed any physical issues weekly. When staff admitted a patient to the ward, the GP gave the patient a full physical exam within a week. The GP follows this up during the routine weekly visits. We found staff regularly recorded physical health monitoring in the care records.

Skilled staff to deliver care

• The provider employed a range of disciplines. These included nursing staff, occupational therapists, a social worker, psychologists, and doctors. They did not have a speech and language therapist in post at present but were in the process of recruiting one.

• Staff were meant to attend a five day induction prior to starting work on the ward. The training matrix showed that two recent starters had not attended the induction. This meant that provider had not equipped new staff with the appropriate knowledge to care for people effectively. One staff member told us they were training to be a care certificate assessor. The care certificate covers a national set of standards that unqualified staff should achieve during a period of induction to care work. The provider did not have a date for when they would introduce it.

• The provider did not offer specific training for learning disabilities or autistic spectrum disorder despite the fact that part of their patient group suffer with these conditions. One member of staff said during interview that they need training in autism. Some staff had done some additional training including positive behaviour support and positive record keeping. However, the provider also has further training planned for the next financial year.

• We checked the supervision and appraisal records. These showed that staff were not receiving regular supervision or appraisals. Information given to us by the provider showed that staff appraisal rate was 33%. Management had not updated the supervision log since November. Staff we spoke too gave a mixed response regarding supervision. One staff said they had not received clinical supervision since August 2015, but had 'adhoc sessions'. Another staff told us they receive regular supervision with the clinical service manager but their appraisal was overdue. This meant that the provider was not supporting staff in line with the organisational supervision policy.

Multi-disciplinary and inter-agency team work

• Staff worked in a multi-disciplinary way. Each morning the senior management and members of the multidisciplinary team, including nurses, occupational therapists, psychologists, social workers, and teachers had a morning review meeting where staff discussed risk, referrals, and issues on the wards.

• The social worker and the safeguarding committee had a positive working relationship with the local area safeguarding boards. This included the hospital manager and the named safeguarding doctor.The provider also held a monthly safeguarding board meeting which the local area designated officer attended with the local area safeguarding children board.

Adherence to the MHA and the MHA Code of Practice

• Staff received Mental Health Act training as part of their mandatory training. Staff read patients' rights to them on a monthly basis. However, some staff, including registered nurses, had limited knowledge of the Mental Health Act Code of Practice, 1983, 2015. The provider had not

reviewed their policies and procedures related to the changes to the Mental Health Code of Practice in 2015. This meant some staff did not fully understand the rights and restrictions for people held under the act, and therefore could not competently ensure that people's rights were protected. For example, explaining to someone about their right to appeal or to receive support from advocacy services. They explained that the doctors managed Mental Health Act assessments and documentation. All Mental Health Act documentation was filled in correctly and we did not find any issues. The provider has recently appointed a Mental Health Act administrator who will manage and monitor the Mental Health Act documentation in future.

• An advocacy service was available for patients. Advocates attended the ward on a weekly basis. Some staff did not know how to access the advocacy service. Despite information being displayed on the ward.

• We found evidence of consent to treatment. Staff obtained consent to treatment and they put signed forms in the clinical records. Where necessary consent to treatment forms were attached to medication administration cards.

Good practice in applying the MCA

• Staff we spoke to had limited knowledge of the Mental Capacity Act. They were not able to explain how to use Gillick competency assessments. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. Staff did not take a multi-disciplinary approach in assessing patients' capacity. Doctors were responsible for completing capacity assessments and they recorded them in care notes. Whilst these were comprehensive decision specific assessments, they did not document additional information such as views of parents, or advocacy support. Name nurses did not get involved in capacity assessments, in spite of having care planned for individual needs.

• Records from care reviews showed that staff supported patients to make decisions where they lacked capacity. Families and carers were encouraged to attend care reviews and were involved in supporting patients to make decisions.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

• Patients had mixed views about staff. Mostly they were complimentary about staff saying, "If it weren't for the staff it would be very boring." They felt that the staff were sensitive to their needs and were encouraging and supportive. However, we received feedback that some of the staff were 'mean' and did not treat them with kindness and compassion. We fed this back to the manager. Some patients also stated that care at night was not as good as the day. Most patients we spoke to said they felt safe on the ward. Patients also stated they got regular time to speak with their nurse. They are able to request this when required and staff will make time available to talk.

• Staff involved parents in developing patients care plans. We spoke to parents and carers who said staff contacted them regarding care plans and that they were sent a copy with the patients' agreement. The occupational therapy team also offered one to one sessions with families. During these sessions, staff supported families to attend activities that may benefit the patients when they go home on leave.

• Carers and relatives felt that staff were kind and respectful and provided good quality care. Staff were available when they called to speak to someone. We observed interactions between staff and patients and on one occasion, a patient was behaving in a hostile manner. The staff remained calm and respectful at all times and treated the patient with dignity and respect.

• Staff felt that they were able to speak out should they witness poor care. We found evidence of this in the incident log when staff informed management after witnessing poor restraint techniques. Management dealt with this through the organisations disciplinary policy.

• There were various notice boards and leaflet racks around both wards containing information on care and treatment. The leaflets were available in languages spoken by patients. The nursing staff had also designed easy read

leaflets regarding various medications. This meant that information was meaningful and accessible to patients on the wards. There was also information on different treatment options available to the patients.

The involvement of people in the care they receive

• Staff gave patient's a 'wonder file', which was a personalised file containing a care plan, activity schedule and other important information relating to their care and treatment. Prior to attending ward review, staff gave patients a 'my ward review' sheet. This was a form for the patient to record how their week had been and to document what they would like to discuss during their review. Patients said that they were involved in their care plan. Staff gave patients copies and they signed to say they agreed with them. Patients could personalise their files.

• The provider held regular community meetings. We reviewed the minutes of these meetings and saw that staff followed up actions and gave patients updates at the following meeting. Staff gave patients the opportunity to discuss various topics such as activities they would like to do and what food they would like on the menu. The provider also had a suggestion box that patients could use to suggest activities. Patients accessed a variety of activities including trips out and sports.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

• Ellingham hospital has 25 beds; NHS England contracted 19 of these beds. The provider admits patients from across the country. Patient's average length of stay on Woodlands ward was three to six months, however patients on Cherry Oak ward stayed for an average of 6-18 months before being discharged. The consultant psychiatrist said they had longer than average length of stay for CAMHS as the patients have neuro development needs. The bed occupancy rates for the past three months showed there were between eighteen to twenty beds occupied. The occupancy rate was due to the refurbishment of the seclusion room. This meant that they could not admit anyone who would be very challenging, as they did not have the means to manage such challenging behaviour.

• Staff discussed new referrals during the early morning review meeting. The consultant psychiatrist and charge nurse went out to assess referrals for their suitability for admission. Assessors used an admission checklist to assess suitability. The doctor described difficulties in getting information from agencies prior to admission because they took referrals from across the country. There was a small waiting list for assessments. The service did not take emergency admissions but would if they have the capacity to do so. Staff plan admissions and consider the current mix of patients on the ward.

• Staff began to plan discharge at admission due to the complex presentation of some of their patients. There were two delayed discharges currently on the wards. This was due to delays in the local authorities finding appropriate placements for patients. They also have a patient turning 18 who was due to move to an appropriate placement. This placement was delayed, and the manager was liaising with the local agencies and professionals to resolve the situation.

The facilities promote recovery, comfort, dignity and confidentiality

• Patients had individual activity schedules as part of their care plan. This included therapeutic activities, educational needs as well as physical activity. The service had an OFSTED registered school on site offering up to 18 hours a week of education for patients. The school has not been inspected by OFSTED so does not have a rating. They link in with schools prior to admission and for discharge and provide individualised timetables to meet patients' educational needs. Patients receive weekly keyworker sessions to review their education. They also offer careers advice for patients prior to discharge. The school follows the National curriculum. One patient we spoke to told us that they were able to continue to work on their qualification in a Bachelor of Technology (BTEC vocational qualification). Teaching staff provide ward based sessions if patients are not able to leave the ward, and have dedicated rooms on the ward for this purpose.

• The provider has a building on site that they use for parent accommodation. The provider had patients admitted from across the country meaning parents have to

Requires improvement

Child and adolescent mental health wards

travel long distances to visit their children. This enables the patients to spend more time with family. We spoke to parents and carers who said how helpful it was that the provider offered this service. They felt that by being able to have that extra time with their family helped promote recovery.

Meeting the needs of all people who use the service

• The charge nurses gave us a tour of the wards. All bedrooms had ensuite facilities. The patients were able to personalise their bedrooms with artwork and items from home. The bedrooms were in separate male and female areas and there were male and female lounges. However, we did observe a male patient in a female area.

• The provider had an activities room with a pool table, table tennis, table football, age appropriate books and board games for the patients. The provider had a room with a play station for the patients to utilise. Staff kept this locked behind a Perspex screen for safety. The provider also had a garden area the patients could utilise. This contained playground equipment and trampolines. The trampolines had not been in use for some time due to safety reasons and not been repaired. The manager told us that he has been in contact with the company and is trying to resolve this.

• We spoke with the occupational therapist (OT) and activity coordinator. They told us they provide a variety of activities both on and off the ward. These include sporting activities and trips off the ward to various activities chosen by the patients. The OT told us that she recognised that there was a high incidence of aggressive behaviour in the evenings and weekends. She had arranged activities for these times and this had helped reduce incidences.

• The provider had a faith room for use by patients of various faiths. There was a bible and a copy of the Quran. However, there was nothing to indicate the direction of Mecca. This could make it difficult for Muslim patients to pray unless they had access to a compass.

• The environment met the needs of patients who had physical disabilities with good access to living space and outside areas.

Listening to and learning from concerns and complaints

• In the reception area, we observed a parent information book with information on making complaints. There was also a 'we hear you' suggestion box and posters with patients' comments on.

• The clinical service manager and mental health act administrator lead on managing complaints. When staff received a complaint, they wrote to the complainant to acknowledge receipt of the complaint and explain the process. Other staff we spoke to said that they knew how to support patients to make complaints. Partnerships in Care had produced a poster for patients about how to complain. However, the provider did not display information on how to make a complaint for patients held under the Mental Health Act, including how to appeal against their section.

• We reviewed the complaints log. There were two complaints that did not have an outcome documented. We raised this with the manager. He told us that these had been resolved and the families informed of the outcome. Staff received feedback from complaints via supervision and staff informed patients via patient forum meetings.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

• The service was in a period of transition to Partnerships in Care. The staff we spoke to were positive about the change. They received a Partnership in Care welcome pack, which exampled the organisations visions and values. There was also information regarding the organisation including quality governance and pictures of senior management.

• The senior management team visited the unit during the changeover period. However, staff said they had not seen them since and would not know who management were.

Good governance

• Since the change of organisation in September, the provider had continued to work with Danshell's policies. The manager told us that this was due to a delay in getting I.T connections installed. Senior management were aware of the I.T issues and agreed for the provider to continue with the old organisations policies. There were no plans

put in place to allow the provider to start working with the new organisations policies. This meant that the provider was not consistently using policies and procedures of the organisation. Staff we spoke to said that there was a lot of confusion about policies and procedures since the change of organisation. The manager informed us that the I.T connection was installed the week before inspection. The manager was working with the senior management team on a plan to implement the new organisations policies. There were no dates for completion of this plan.

• The manager produces a monthly governance report, which he feeds back during the senior management team meeting. This includes actions and lessons learned from incidences as well as complaints and family and friends surveys. The Psychologist told us she analyses incidents and reports her findings within this meeting.

Leadership, morale and staff engagement

• Staff we spoke to told us that they feel able to raise concerns and complaints and was aware of the whistle blowing process. Some staff told us that they had raised concerns and that the manager had responded appropriately. One staff member told us that they requested more resources. The manager responded to this and the provider purchased new equipment. Staff said they had no concerns of bullying or harassment. The Partnerships in Care welcome pack contained an independent advice and counselling service and concern line for staff to raise issues anonymously.

• The staff gave mixed views on the management of the change in organisation. Most staff felt the change was positive but felt the new organisation could have kept them more involved and informed about the change process.

• The provider offered patient and carer forums, which they attended regularly. Meeting minutes showed that the provider had put into place ideas for improvement. This included the suggestion box for activities as well as changes to the menu and activity plan.

Commitment to quality improvement and innovation

• The provider was using the Quality network for inpatient CAMHS (QNIC) standards as a benchmarking tool. The provider also participates in National Service accreditation and peer review schemes. The provider submitted reports from their last peer review in February 2015. These show that over the previous year there had been continued improvements in the quality of care. For example, the report highlighted that the provider needed to improve collaboration when writing care plans so that patients feel more involved. This was evident in the care plans we reviewed that staff had made improvements in this area.

• The manager planned to develop peer review audits now they are part of Partnerships in Care. Part of this plan is for staff from other units to come to the service and vice versa. This will give staff a fresh insight into the care they provide so they can continuously develop services.

• The manager is currently in discussion with the University Of East Anglia about becoming a placement area for student nurses.

Outstanding practice and areas for improvement

Outstanding practice

The family accommodation that the provider offered for use by parents was evidence of outstanding practice. The provider admits patients from across the country and many parents have to travel very long distances to visit their children. This allows patients to spend more quality time with their family and helps promote their recovery.

Areas for improvement

Action the provider MUST take to improve

• Doctors must attend seclusion incidents when necessary to ensure adherence to The Mental Health Act code of conduct chapter 26. Paragraph, 112.

• The provider must ensure that staff receives regular supervision and appraisal in line with organisational policy.

• The provider must ensure that mandatory training needs of staff meets the provider's target of 90%. This includes but is not limited to, the Mental Health Act and code of practice, the Mental Capacity Act and Safeguarding vulnerable adults, and children.

• The provider should implement an action plan to remove ligature points identified in the ligature audit.

• The provider must provide specialist training in learning disabilities and autism for staff working on the wards.

.

Action the provider SHOULD take to improve

• The provider should implement an action plan to transfer over to Partnerships in Care policies to enable a consistent approach across the organisation.

• The provider should implement a recruitment plan to make sure they have enough substantive staff and to reduce the rate of agency use. Where regular agency staff are used, the provider should ensure that staff are inducted appropriately in line with the expectations of the service.

• The provider should ensure that staff on both wards have a clear understanding of MCA and the implications for their practice.

• The provider should ensure all maintenance work is completed in a timely manner.

• The provider should ensure staff comply with the long-term segregation policy.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: Staff were not assessing capacity in a multi-disciplinary way. The provider had not trained all staff on The Mental Capacity Act. This was a breach of regulation 11(1)(2)

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 How the regulation was not being met: Staff were not up to date on their mandatory training, which included training on the Mental Health Act and safeguarding vulnerable adults and children. This was a breach of regulation 12 (2)(c)

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 How the regulation was not being met: Staff were not up to date on their mandatory training, which included training on the Mental Health Act and safeguarding vulnerable adults and children.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The provider had not updated their policies to include changes to the Mental Health Act code of practice. This was a breach of regulation 17 (2)(a)

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 How the regulation was not being met: Staff were not receiving regular supervision and appraisal. Some staff had not had supervision in 5 months. Staff appraisal rate was thirty-three percent. this was a breach of regulation 18 (2)(a)