Good

South West London and St George's Mental Health NHS Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQY01	Springfield University Hospital	Aquarius Ward	SW17 7DJ

This report describes our judgement of the quality of care provided within this core service by South West London and St. George's Mental Health NHS 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 South West London and St. George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St. George's Mental Health NHS 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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated child and adolescent inpatient mental health services as **good** because:

Staff were kind and treated children and young people with dignity and respect. Young people were able to participate actively in decisions about their care and in decisions about the running of the ward. Staff undertook a comprehensive assessment of the physical and mental health of each young person on admission and these were monitored throughout their stay.

The ward provided a comprehensive range of treatments using medication and therapies in accordance with best practice from bodies such as the national institute for health and care excellence. Care and treatment was provided by a team of qualified doctors, nurses, social workers and therapists, all of whom showed a good knowledge and understanding of the young people. Staff received specialist training for their role, including a psycho-social interventions course, dialectical behavioural therapy training and training on the Children's Act 1989.

Young people had access to quiet areas of the ward. Outside there was a courtyard where young people could play games. The trust had adapted a bedroom and bathroom for young people with disabilities. Young people could continue with their education at an on-site school.

The manager supported staff to raise concerns. The views of young people and their families were collected and reviewed to measure the quality of the service.

However, staff were not recognising that when young people were using the low stimulus room that this was seclusion and so the correct safeguards including medical and nursing reviews were not in place. . Staff supervision records were not being stored appropriately.

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**:**

- A low stimulus room was used for seclusion. The policy needed to be clearer, to state that the use of this room did amount to seclusion and the safeguards within the Code of Practice must be applied.

However:

- Risk assessments were comprehensive and regularly updated.
- Staffing levels had recently been increased and most staff working on the ward knew the service.
- There was clear segregation between the male and female sleeping areas.
- All the patients we spoke to said they felt safe.

Are services effective?

Good

We rated effective as **good** because:

- Young people received a comprehensive assessment of their physical and mental health on admission. These assessments were monitored and updated throughout their stay.
- The ward provided a comprehensive range of treatments using medication and therapies in accordance with best practice from appropriate bodies such as the national institute for health and care excellence.
- Care and treatment was provided by a team of qualified doctors, nurses, social workers and therapies, all of whom showed a good knowledge and understanding of the young people.
- Staff received specialist training for their role, including a psycho-social interventions course, dialectical behavioural therapy (DBT) training and training on the Children's Act 1989.

However:

- A new template for care planning had been introduced but was not yet fully embedded.
- Records of supervision sessions were not kept securely or consistently.

Are services caring?

Good

We rated caring as **good** because**:**

Summary of findings

- Staff were kind and treated children and young people with dignity and respect.
- Young people were able to actively participate in decisions about their care and decisions about the running of the ward.
- An advocacy service regularly attended the ward to provide independent support and information.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Staff responded to the individual needs of young people, providing care and treatment that was appropriate to the age and understanding of each patient.
- Young people had access to quiet areas of the ward.
- Outside there was a courtyard where young people could play games.
- The ward had a bedroom and bathroom that had been adapted for people with disabilities.
- Young people could continue with their education at an on-site school.

However:

- There were difficulties in accessing psychiatric intensive care units. Young people often had to wait a number of days for these facilities to become available and they were likely to be placed in another part of the country. This was a national commissioning issue.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff were aware of the vision and values of the trust and sought to implement these in their work.
- Staff were able to raise concerns, for example about the workload on the ward.
- There was a positive team culture on the ward.
- There were governance processes in place to monitor the progress of the ward.
- The views of young people and their families were collected and reviewed to measure the quality of the service.

Summary of findings

Information about the service

South West London and St George's Mental Health NHS Trust provides a specialist tier four child and adolescent mental health service on Aquarius ward at Springfield University Hospital. This is a nationally commissioned service. The ward has twelve beds, one-third of which were usually allocated to young people from the London boroughs of Wandsworth, Richmond, Kingston, Sutton and Merton.

The ward provides mental health care for young people aged between 12 and 18 with serious mental illness who require hospital admission. Diagnosis and treatment is provided for psychosis, bipolar affective disorder, severe anxiety disorders, obsessive compulsive disorders and emerging personality disorder. The service offers both planned and emergency admissions. Admissions are accepted 24 hours a day, 365 days a year. The service accepts admissions under the Mental Health Act 1983.

Following an inspection in March 2014, Springfield University Hospital was non-compliant for regulation 9 care and welfare of people who use services, for lack of comprehensive risk assessments and lack of single sex care on Aquarius ward. Since that inspection a full refurbishment of the ward has been carried out. These areas of non-compliance had been addressed.

Our inspection team

The team that inspected child and adolescent mental health wards consisted of an inspector, a Mental Health Act reviewer, a pharmacist, a social worker, a nurse and an expert by experience.

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 and sought feedback from patients at nine focus groups.

During the inspection visit, the inspection team:

- visited Aquarius ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the ward manager
- spoke with five other staff members; including doctors and nurses
- attended and observed a hand-over meeting and a multi-disciplinary team meeting.
- reviewed eight prescription charts
- looked at four treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of findings

What people who use the provider's services say

The young people we interviewed were positive about the ward and about staff. They said that staff were friendly, supportive and helpful. They also said that staff listened to them. One young person described the staff as amazing.

Most of the young people said that they found the ward to be restrictive and some said that the locked doors and restrictions on going out made them feel claustrophobic. Some young people were unhappy about specific restrictions such as having shoe laces, socks and bandages removed and not being allowed to go outside.

Young people spoke positively about friendships they had developed on the ward.

Some of the people we spoke to were anxious about getting behind with their school work and missing their friends at home.

Everyone said they felt safe on the ward. One young person said that there had been improvements since last time he was there.

Young people told us that they would like more access to the gym and to be able to use the computer more often.

Good practice

We found the following areas of good practice:

- There were facilities for parents to stay on site and young people could be given leave to stay with them at this accommodation.
- Specialist training was being provided to all staff in dialectical behavioural therapy.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the use of seclusion is correctly recognised and the necessary safeguards put into place.

Action the provider SHOULD take to improve

- The trust should ensure that staff training is correctly recorded so training can be arranged as needed.
- The trust should ensure that the use of the new care planning format is embedded.

The trust should ensure that that staff supervision records and any other records about people employed to carry out regulated activity are stored appropriately.

South West London and St George's Mental Health NHS Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Aquarius Ward	Springfield University Hospital

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 Mental Health Act was covered in the induction training and in the mandatory training on consent.

At the time of the inspection, four patients on Aquarius ward were detained under the Mental Health Act 1983 (MHA).

Leave under section 17 was promoted as part of the treatment plan. In the records we reviewed, all leave was authorised through a standardised system, was appropriately recorded and included specified conditions. Young people were given copies of their leave forms.

Holding powers under section 5(2) had been used incorrectly on the day before the inspection. The assessment of a young person for admission for treatment had been delayed because of a potential objection by the nearest relative. Eventually the young person was made subject to section 3 but the use of section 5(2) was very poor practice and the case showed poor anticipation in terms of the Mental Health Act. The mistakes were fully explained to the young person and to the nearest relative but there was scope for improvement in planning.

One record had no Approved Mental Health Professional report available for scrutiny for either section 2 or section 3 applications

There was a sign on the ward door informing informal young people of their right to leave but it was on the outside of the door and could not be read from the inside.

The young people we interviewed were aware of their rights and said they had had them explained. This was also evidenced on the records scrutinised. There was an active independent mental health advocate service available to young people. The advocate visited the ward each week and as requested by young people.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act was covered in the induction and in the mandatory training on consent which 57% of staff had completed.
- For young people over the age of 16 they were presumed to have capacity to consent or refuse treatment in their own right.
- For young people under the age of 16 an assessment had taken place to show they had Gillick competency to consent to their treatment. The children and their parents (where appropriate) were given information about the reason and nature of the treatment. The record of this assessment was very brief and only noted in ward rounds.

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

- Staff were able to observe the young people throughout the communal areas of the ward. A convex mirror was used to improve visibility of a small corridor leading from the main ward area to a single bedroom. Bedrooms were situated on corridors away from the main part of the ward. This could have led to patients in their bedrooms being out-of-sight and a long way from the nurses' station. This risk was managed by limiting patient's access to their bedrooms during the day.
- There were ligature points throughout the ward. A ligature point risk assessment had been completed. This rated all patient bedrooms and bathrooms as presenting an 'amber' level of risk. The ligature anchors identified in the assessment were door hinges, air fresheners, soap dispensers and curtains. Individual risk assessments were carried out for all patients and the frequency of observations were increased for patients considered to be at risk. All the risk assessments we read stated that patients had a risk of self-harm or suicidal ideation. There was a schedule for ligature point reduction work to take place on the ward.
- The clinic room was clean and tidy. At the time of the inspection the refrigerator in the clinic room was not working. All refrigerated medicines were being stored on Wisteria ward (downstairs). This meant that the staff on this ward did not have immediate access to intramuscular lorazepam injections if they needed to use this in an emergency. To get to Wisteria ward, staff had to go through a series of locked doors. We were told that the fridge had been broken for several weeks but the ward team had not arranged with the pharmacy for another fridge to be provided while this one was being repaired. We were told the broken fridge was replaced immediately after the inspection.
- There was resuscitation equipment in the clinic room. Staff checked this on a daily basis. Other equipment appeared clean and well maintained.
- At the end of the ward, there was a low stimulus room. The area comprised of a room with a window and mattress, a hallway with a soft couch, a shower and a toilet. Young people were taken to this area for de-escalation, using restraint if necessary. The room was used to administer rapid tranquilisation. The use of this facility was governed by a specific policy, written in March 2016. The policy stated that a young person should not be locked in and must be supervised on one-to-one observations at all times. However, the policy would benefit from clearly stating that any use of room involves the supervised confinement and isolation of the young person and therefore amounts to seclusion, as defined in the Mental Health Act 1983 Code of Practice. The policy sets out the requirements for the frequency of nursing reviews, medical reviews and multidisciplinary reviews that are consistent with the Code of Practice. Whilst the room did not meet the Code of Practice requirements for external controls for lighting, temperature and sound, these were mitigated by ensuring that patients were not locked in the room and were accompanied by a nurse at all times.
- Ward areas were mostly clean and well-maintained. There was a broken lamp and a broken projector in the sensory room and some of the decoration was falling off the walls and ceiling. The staff room was poorly maintained with furniture covers that were torn and a broken fridge was being used as a table.
- Nurses and health care assistants were designated as 'champions' for specific aspects of running the ward. We spoke to the infection control champion who led initiatives such as a hand washing audit, placing infection control notices across the ward and checking that sharps bins had been changed. Handwashing instructions were printed on soap dispensers. One patient bedroom had been designated as an isolation room, if required.
- There was an alarm system operating on the ward. This could be activated by staff using personal alarms or by pressing alarm buttons in bedrooms and other areas of the ward.

Safe staffing

- The established level of staffing was three qualified nurses and two healthcare assistants (HCAs) during the

Requires improvement

Are services safe?

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day and two nurses and two HCAs at night. This level had been set following a review of staffing on the ward. Often the actual staffing levels were higher based on the individual needs of the young people.

- The ward manager told us that it was rare for the established staffing levels not to be achieved. Safe staffing figures showed that in the three months prior to the inspection, the full quota of staff was not achieved on 22 shifts.
- Agency and bank staff were used when additional staff were needed to provide additional observation of young people. In addition, one permanent nurse was on maternity leave and two nurses were on a period of phased return to work following an episode of sick leave. There were no staff vacancies. Whenever possible, bank staff who were familiar to with the ward were used to cover shortfalls, rather than agency staff. During the three months prior to the inspection (December 2015-February 2016), 534 shifts were filled by bank staff and 103 shifts were filled by agency staff.
- Agency staff received an induction to the ward covering the layout of the ward, emergency procedures, managing levels of risk, care planning and plans of care that needed to be provided on the specific shift. On completing this induction, agency staff were required to fill in and sign a checklist.
- A conference call was held each day for all ward managers. This call gave managers the opportunity to request additional staff. Additional staff were allocated if there was more than one patient on enhanced observations, if a patient was being admitted to the ward or if there was a heightened level of risk. The ward manager said that extra staff could always be allocated very quickly.
- A qualified nurse was on duty at all times. Nursing offices had been situated to ensure that nurses could continuously monitor the communal areas of the ward.
- All patients had a named nurse and regularly met with this nurse on a one-to-one basis. We saw that nurses were able to respond quickly to the needs of patients and provide one-to-one support to help patients who were upset or distressed.
- Medical cover was provided by a ward doctor. The ward was based on a large hospital site with medical cover available at all times. Thorough physical health assessments took place upon admission and at regular intervals.
- The ward manager was unable to provide accurate figures on the number of staff who had completed their mandatory training as some training for staff who had recently joined was not entered onto the electronic monitoring system.

Assessing and managing risk to patients and staff

- The seclusion room had been used on 31 occasions in the first three months of 2016. Each of these occasions was a response to an incident of either violence and aggression or self-harm. There were 56 incidents involving restraint in the six months from 1 May to 30 November 2015. Of these restraints, four were in the prone position.
- When patients became distressed, agitated or aggressive the first response of staff was to verbally de-escalate the situation. Staff supported patients to use individual coping strategies that were developed in therapy sessions. Often this would involve the use of dialectical behavioural therapy. If these interventions did not work, staff would offer the young person oral medication. If the young person continued to be very distressed the patient was transferred to the 'low-stimulus' room, using restraint if necessary where they could if needed receive intra-muscular rapid tranquilisation. Following rapid tranquilisation, physical health checks would be carried out, including checks of their heart rate and blood pressure, and patients would be placed on constant observation.
- The ward manager said that all staff received training in managing violence and aggression that was specifically designed for staff working with children and young people. When needed the ward would ask the trust wide virtual risk team for support to manage the risks.
- Records showed that risk assessments were carried out and recorded within 24 hours of admission. These assessments were updated after incidents involving the young person and after multi-disciplinary reviews. Risk assessments included a comprehensive patient history

Requires improvement

Are services safe?

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and set out the risks the patient was presenting at the time, classified according the severity of risk a crisis and contingency plan was made with each young person and their parents.

- There were some 'blanket' rules on the ward. Mobile phones were not allowed on the ward but there was a phone available. Routine searches were carried out when young people were returning from leave. Patients were not permitted to smoke but nicotine replacement therapies were available. Patients were also required to go to bed by 10.30 during the week and to be up at 7.30 in the morning.
- At the time of the inspection the ward had locked the toilets and bathrooms due to the risks to the young people. They said that when possible the multi-disciplinary team reviewed this decision and left the doors unlocked.
- Informal patients were able to leave the ward subject to parental consent where appropriate. There was a notice on the door to the ward advising informal patients of their right to leave.
- Training on safeguarding children and young people (level 3) was part of the mandatory training for staff on the ward. Staff were required to attend this training during their induction and every three years thereafter. The completion rate for this was 90%.
- We reviewed the medication records for eight patients and found no missed doses. An audit of medication charts took place each month. Emergency equipment was checked every day. Drugs were stored securely. At the time of the visit there were no controlled drugs on the ward, but we were told that when controlled drugs were needed they were checked every day. The pharmacist provided support to the ward and regularly attended ward rounds.
- There was a room next to the entrance to the ward for visitors. This allowed children to visit young people without having to enter the main areas of the ward.

Track record on safety

- Three serious incidents were recorded for this service between October 2014 and October 2015. These incidents involved a patient absconding, a patient sustaining an injury during restraint and a patient becoming unresponsive after using a ligature. A root cause analysis investigation was carried out for each of these incidents covering the background and context, details of how practice compared to local and national standards. Each investigation found that staff had acted appropriately and that the incidents had been caused by the acuity and unpredictability of the patients involved. The report of the ligature incident noted that the level of staffing fell below practice standards, with two temporary staff on shift who were unfamiliar with the ward. Since this incident, a full quota of staff has been recruited. In all cases the patients' families were notified and staff met with families to discuss the incident if the family wanted to do so.

Reporting incidents and learning from when things go wrong

- Incidents were recorded on a form and reported using an electronic system. Incidents entered onto this record were reviewed by the serious incident governance group. This group included the trust's risk manager, safeguarding lead and the heads of nursing. A monthly report of incidents was collated and sent to the ward manager.
- A total of 43 incidents were reported in February 2016, indicating that there was a positive approach to incident reporting by all staff. These incidents were then classified according to impact. We found that the classification of incidents appeared to under-state the severity. For example, in one incident a patient known be at risk of self-harm had bought paracetamol tablets onto the ward concealed in their clothing. This was classified as a level two incident, which means there was no risk to the patient. The classification of the incident was then reviewed by the manager and then the trust wide quality governance department to ensure it was correct.
- Staff were open and transparent with patients. Staff used an approach known as 'behaviour chain analysis' following incidents. This involved speaking with the young person about how they were feeling and what they were thinking about prior to the incident, and consideration of what triggered the incident. During our inspection, an error was made in detaining a patient. Once staff had realised this, they explained what had happened and apologised to both the young person and their parents.

Requires improvement

Are services safe?

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- Staff received feedback from internal and external investigations. For example, during a trip to a seaside town the previous year and patient had absconded. Following the recommendations of an investigation into this incident a protocol was introduced ensuring that consent was given by parents, a risk assessment was carried out for each young person and used as the basis for ascertaining the number of staff needed, and an action plan was agreed on what to do if a patient did abscond.
- The team held debriefs and case discussions to learn from serious incidents. A report on incidents was discussed at each monthly business meeting. Nursing staff found it difficult to attend this meeting if the ward was busy or if there were patients requiring constant observation although minutes of the meeting were circulated. At the February 2016 business meeting, there had been a lengthy discussion about a serious incident involving an adverse reaction to medication.

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

- Comprehensive assessments of young people were completed on admission.
- Physical examinations took place on admission. Physical health observations of patients were recorded daily and patients' weight was checked each week.
- Care plans were written with the patient and updated each week. Thought had been given to how care plans should be written. The ward did not use the care planning template on the electronic patient record as staff felt these plans were difficult to understand. A template had been devised for a simpler and more relevant care plan which it was hoped would prove more meaningful to young people. This had recently been introduced and was not yet fully embedded so there was some confusion evident on the records with some practitioners still using the old care plan template.
- Information was stored securely on an electronic patient record system that could be accessed by all the multi-disciplinary team.

Best practice in treatment and care

- The ward manager told us that treatment is consistent with national institute for health and care excellence guidance on 'psychosis and schizophrenia in children and young people: recognition and management' and 'depression in children and young people: identification and management'. Antipsychotic medication was offered in conjunction with psychological interventions. We also saw that clinicians were skilled in explaining medication to young people in a way that was age appropriate and relevant to the person.
- The ward provided therapies including dialectical behavioural therapy, a coping skills group, a goal setting group, a mindfulness group and a self-reflection group. Family work included family therapy, parenting skills training and psycho-education with parents. A support group for parents and carers was facilitated by ward staff. A consultant psychiatrist was responsible for prescribing and reviewing medication. Patients were offered individual talking therapies. A school reintegration programme was also provided for young people who had disengaged with education.
- Young people had access to care and treatment for their physical health from doctors based on the ward. If a patient had a more serious condition they were transferred to the local hospital.
- A health of the nation outcome scales for children and young people was used to measure outcomes. During the last three month quarter of 2015/16, these assessments were carried out on 83% of patients when they were admitted. All patients were assessed when they were discharged and all patients showed evidence of improvement. The ward had short lengths of stay and low readmission rates which showed evidence of an effective care.
- Nursing staff told us that they had been involved in audits of care plans, medication, handwashing and health and safety. The specialist registrar said they had been involved in an audit of the treatment of emerging personality disorders and mental capacity assessments.

Skilled staff to deliver care

- The multidisciplinary team comprised of an occupational therapist (OT), an OT assistant, two psychologists, a social worker, family therapist and music therapist. This enabled the team to offer a full range of psychological and group interventions and to engage with the families of the young people admitted. Staff were qualified and experienced. The ward manager had worked on Aquarius ward for eleven years.
- All new staff were required to work through a comprehensive induction checklist, although this did not require any signatures or dates of tasks being completed. Seven newly qualified nurses had joined the ward in November 2015 and were in a period of post-qualifying employment known as preceptorship. The ward paid special attention to the preceptorship programme, ensuring that preceptorship nurses were rostered with an experienced member of staff.
- Staff received monthly supervision. However, notes of these sessions were not kept systematically. We were told that some employees notes were simply kept in their non-confidential pigeon hole. Staff also had access to group supervision including systemic psychology workshops and reflective group practice.
- Team meetings did take place each month, but nursing staff were unable to attend these meetings if young

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.

people required constant observations or if the ward was particularly busy for other reasons. Minutes of the team meetings were circulated throughout the staff team.

- On the 1 December 2015, the appraisal rate for non-medical staff was 79%.
- Staff received specialist training for their role, including a psycho-social interventions course, DBT training and training on the Children Act 1989.
- There were no examples of poor performance being addressed.

Multidisciplinary and inter-agency team work

- We observed a handover meeting and a multidisciplinary team meeting. During the meeting care plans were updated and new referrals were discussed. Handover meetings took place at the start and end of each shift. A co-ordination sheet was used to record updated information for each young person. These handover sheets were uploaded to the electronic patient record and available to all staff.
- The clinical and teaching staff worked together to support the continued education of the young people.

Adherence to the MHA and the MHA Code of Practice

- The Mental Health Act was covered in the induction training and in the mandatory training on consent.
- We carried out a Mental Health Act Review as part of this inspection. During the review we interviewed three detained patients and reviewed the care records of all four patients who were detained at the time of the visit. The young people we interviewed were aware of their rights and said they had had them explained. Discussions with patients about the MHA and their rights were recorded on the patients' records.
- One young person had been incorrectly held under section 5(2) of the MHA. Eventually the young person was made subject to section 3 but the use of section 5(2) was poor practice and the case showed poor anticipation in terms of the MHA. The mistakes were fully explained to the young person and to the nearest relative but there was scope for improvement in planning.
- Administrative support was available from the MHA office based on the Springfield site. Detention paperwork was in order. One record had no approved mental health professional (AMHP) reports available for scrutiny for either section 2 or section 3 applications.
- There was an active independent mental health advocacy service available to young people. The advocate visited the ward each week and as requested by young people.

Good practice in applying the MCA

- The Mental Capacity Act was covered in the induction and in the mandatory training on consent which 57% of staff had completed.
- For young people over the age of 16 they were presumed to have capacity to consent or refuse treatment in their own right.
- For young people under the age of 16 an assessment had taken place to show they had Gillick competency to consent to their treatment. The children and their parents (where appropriate) were given information about the reason and nature of the treatment. These assessments were reviewed in ward rounds.

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

- We saw staff speaking to patients in a kind a respectful manner. For example, when one patient was particularly upset a nurse took her to a quite area and offered comfort and reassurance. Staff we spoke to were very positive about the young people and were committed to their work. All the staff used language that was caring and respectful.
- We spoke to four patients. Whilst all these patients were keen to return home, there were many positive comments about the service. One patient said the staff were amazing. Another patient said that staff were always nice to them.
- During the team meeting, all the staff had a good understanding of the patients being discussed. They spoke about the progress the young person had made, the relationship they had with their families and other problems such difficulties at school.

The involvement of people in the care they receive

- On admission, young people were shown around the ward and introduced to the staff. Young people received a 'welcome pack' containing information about the ward.
- New care plans templates were being developed better to represent young people's views and to be more useful and informative for them.
- There was an active independent mental health advocacy service available to young people. The advocate visited the ward each week and as requested by young people.
- The ward consultant and ward manager offer each young person a weekly business meeting where they are encouraged to express any concerns about their care and treatment. The ward manager also holds a weekly drop-in clinic.
- Families and carers were very much involved in care and treatment. Up to half of the therapeutic work that took place with each young person involved their family through family therapy and developing strategies for problems to be resolved together. There was a weekly co-produced parent support group.
- Young people were actively involved in the running of the ward through community meetings three times a week and a business meeting once a week, all of which were recorded.
- Young people could provide real time feedback using a kiosk on the ward.
- There were plenty of informative signs relating to services and treatments and there was a 'tell us what you think' machine which patients could use to give feedback on the service.

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

- Bed occupancy between 1 June and 30 November 2015 was 93% (including leave).
- Aquarius was a national ward. The ward manager said that about one-third of patients were from the local area. Other patients were usually from elsewhere in London and the South-East of England.
- Patients were not admitted to the ward into beds allocated to patients on leave. Patients always had access to a bed when they returned from leave.
- Patients were not moved between wards during their admission unless it was justified on clinical grounds. Transfers would only occur if the patient needed to be moved to a psychiatric intensive care unit (PICU) or to a ward for the treatment of their physical healthcare.
- Admissions to the ward were usually emergency transfers from accident and emergency departments. The ward managers said that there were very few planned admissions. As a result, admissions could take place at any time. Discharge did tend to be planned and would take place at an appropriate time of the day.
- The ward manager said that it could be difficult to find a bed in a PICU because there were very few services available. One young person had recently been transferred to a PICU in Norwich as this was the only place available at the time. On the day of our visit, a female patient was being transferred to a PICU after waiting five days for the placement. During the times when patients are waiting for a transfer, their level of observation was increased. The trust had routinely escalated concerns to NHS England and also supported NHS England in offering solutions.
- Discharge could be delayed due to difficulties in arranging accommodation. Some young people required transfers to specialist placements, such as services for young people with learning disabilities and autism. One young person had waited four months to be transferred to a therapeutic community. The ward manager suggested that cuts in tier three community CAMH services and cuts to social care services for children had contributed to an increase in average lengths of stay for young people from around 25 days to the current level of 43 days. Between May and October 2015, no patients were formally recorded as having their discharge delayed.

The facilities promote recovery, comfort, dignity and confidentiality

- Aquarius was a large ward with a full range of rooms and equipment to support treatment and care. There were separate corridors with bedrooms for male and female patients. Bedrooms did not have en-suite facilities but there were sufficient toilets and bathrooms on these corridors. In the main communal area of the ward there were sofas and bean bags, along with books, board games and a television. The atmosphere on the ward felt welcoming and relaxed.
- There were plenty of quiet areas on the ward. There was a sensory room, sometimes described as a 'chill-out' room, with large cushions, a music system and a lava lamp. Some of the facilities in this room were broken. There was a family room where young people could meet with their families, including children under 18 who may not have been able to enter the main area of the ward. A house on the Springfield hospital site was available to enable families of young people who lived a long way away to visit and stay overnight. Young people could be granted leave to stay with their families at this accommodation.
- Young people had access to a telephone and could make calls in private.
- Young people had supervised access to an outdoor courtyard. There were facilities there to play basketball, badminton and ride bicycles. There was also a slide with a rope climber.
- Young people thought the food was reasonable. Young people had supervised access to a small kitchen where they were able to prepare hot drinks and snacks throughout the day.
- Young people were able to personalise their bedrooms. However, the young people on the ward at the time of our inspection had chosen not to add any personal touches to their rooms which meant the bedrooms looked quite bare and austere.
- Patients were able to store their belongings securely.
- Young people attended an on-site school during the week. Other recreational, physical and creative activities took place on the ward. There were also outings and

Are services responsive to people's needs?

Good

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

youth club meetings. However, the provision of an activities co-ordinator had been reduced from full-time to 15 hours per week. This has meant that activities including the daily planning group and mindfulness walking group had, at times, been cancelled, especially when nurses had to prioritise patient observations and manage a heightened risk level.

- In the 2015 patient-led assessment of the caring environment, the ward scored 99.5% for cleanliness, 95% for food, 94% for privacy, and 96% for condition, appearance and maintenance of the ward.

Meeting the needs of all people who use the service

- The ward was situated on the first floor and could be accessed by a lift. One bedroom was equipped for disability access. The adjacent bathroom had been adapted for people with disabilities.
- Information could be translated into community languages if required and interpreters were available to attend meetings on the ward.
- A dietician was assigned to the ward and specific meals could be prepared to meet with religious and dietary requirements of patients.

Listening to and learning from concerns and complaints

- There were seven complaints between October 2014 and September 2015. Two complaints were not upheld, three were partly upheld and two were upheld.
- All of these complaints were investigated. When complaints were made by young people about restrictions by ward staff, the reasons for these restrictions were fully explained to the young person. When young people complained about a shortage of permanent staff, the modern matron and clinical director met with them, listened to their concerns, gave assurances that additional staff were being recruited and apologised for the difficulties that shortage of staff had caused. Four complaints were by parents or carers concerning specific incidents. In response to each complaint the trust gave an apology for problems that could have been avoided.
- One complaint concerning a failure to respond to an incident off the ward was formally discussed with the staff team
- Information on how to complain was displayed and included in the welcome pack.

Are services well-led?

Good

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 told us about the importance of understanding the young person's perception of the problems they were experiencing and building relationships with young people based on trust, honesty and respect. This reflected the vision and values of the trust.
- Staff knew who the senior managers were. Staff told us that the head of nursing had been supportive to the ward in increasing the allocation of nurses.

Good governance

- There were systems for good governance in place. The ward contributed to a trust-wide system of rating performance in relation to leadership and teamwork, staffing and capacity, risk and harm, service user experience, and regulation and compliance. Most of the high risks on this performance report related to the high number of staff that left in October 2015 and there being a high number of new staff on the ward. Stress levels were shown as increasing in January 2016.
- The ward manager said that they had sufficient authority to make decisions on the ward. For example, nurses were concerned about inappropriate admissions of patients who presented a risk of violence and aggression. These patients needed a more secure environment. The ward manager had introduced a clear criteria for admission. The criteria stated that the ward could not accept young people with a forensic history or were on the sex offenders register. As a result the on-call team had a better understanding of the referrals that could be accepted and there were fewer inappropriate admissions.

Leadership, morale and staff engagement

- The level of staff sickness between 1 November 2014 and 31 October 2015 was 2.9%. The turnover for this period was relatively high at 42%.This was due to seven staff leaving at around the same time. Five of these staff were promoted.
- None of the staff we spoke to had concerns about bullying or harassment. Staff were able to raise concerns without fear of victimisation. A member of staff said that they had raised a concern recently about the level of their workload. They felt their concerns had been listened to a dealt with appropriately.
- All the staff we spoke to acknowledged that their work could be stressful, but they all spoke positively about the sense of team work and support amongst colleagues. A member of staff said that the there was a very strong, positive culture among the seven nurses in preceptorship. There was good staff morale and job satisfaction.
- There were opportunities for leadership development. Staff were able to take responsibility for specific aspects of running the ward.
- There was a good sense of team working and mutual support. A clinician said that it was one of the best teams they had worked for. Another member of staff said that the level of team working was excellent.
- Staff told us they had been specifically asked for feedback about the levels of workload. Staff felt that the monthly business meeting provided an opportunity for them to provide input into the development of the service.

Commitment to quality improvement and innovation

- The service was participating but not yet accredited with the Royal College of Psychiatrists, Quality Network for Improving CAMHS (QNIC).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The trust had not ensured that systems and processes were operated effectively to prevent the abuse of patients** **Service users were not protected from abuse and improper treatment because the provider operated practices, which had not been recognised as seclusion practices. Patients subject to these practices did not meet the safeguards set out in the MHA Code of Practice.** **This was a breach of regulation 13(2)**