Care Quality Commission

Good

Berkshire Healthcare NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWX70	Berkshire Adolescent Unit	Berkshire CAMHS	GR41 2RE

This report describes our judgement of the quality of care provided within this core service by Berkshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Berkshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Berkshire Healthcare NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	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 the child and adolescent wards as good because:

- We carried out an unannounced visit to the ward on 16 December 2015 following our scheduled inspection on 8 and 9 December 2015. Management took urgent steps to ensure that all staff were made aware of the ward's ligature risks and how to manage them. Staff had started to allocate patients to bedrooms that contained ligature risks only if the risk assessment indicated that they were at low risk of self harm. The ward had made immediate changes to meet the Department of Health's guidance on Eliminating Mixed Sex Accommodation. This was done by agreeing to cluster the male and female bedrooms at opposite ends of the corridor as new patients were admitted. Furthermore, male and female bathrooms were situated at opposite ends of the bedroom corridor. Patients were asked to wear appropriate clothing when walking from their bedrooms to their bathroom facilities. In addition, a member of staff was available to observe the corridor throughout each night.
- The ward was clean and well organised.
- Care plans, risk assessments and progress notes were up to date and present in the seven client files we read.
- Staff offered patients a wide range of therapies such as drama therapy, cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT).
- All staff received regular supervision.
- Staff demonstrated compassion and caring when they spoke to patients. Patients told us that staff were polite to them and respected their privacy.
- The ward had a wide range of rooms for activities and patients had access to a garden when accompanied by a member of staff.
- Patients had access to education. Ofsted assessed the education unit as outstanding in 2013.

However:

- Staff did not include risks they identified in two of the three inpatient care plans we read. This meant there was no evidence of a written plan describing how staff and patients would manage these risks on the ward or in the community.
- Staff completed Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA) and Children's Global Assessment Scale (CGAS) outcome measuring tools on only three out of seven files we scrutinised. Staff used these tools to measure patient improvement wellbeing while in a CAMHS unit.
- Two members of staff said they did not understand Gillick competence. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. 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.
- Patients did not have access to advocacy services on the ward. Advocates can help patients get the services they need and make sure their wishes are heard.
- There were unboxed fuse and other electrical boxes on the corridor walls which were not secured. They could be reached by patients to stop power supply to the ward. Fire extinguishers around the ward were not secured. This meant patients could use them to harm themselves or others. There was an unboxed metal pipe and tap on the ward which could be a danger to patients at risk of self harm.

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:

- Staff had not identified all potential ligature anchor points when they had undertaken a ward risk assessment. However, following our visit management took urgent steps to ensure that all staff were made aware of the ward's ligature risks and how to manage them.
- Staff did not include risks they identified in two out of three of the inpatient care plans we read. This meant we did not see evidence that patient risk was managed on the ward or in the community.
- The ward did not meet the Department of Health's guidance on Eliminating mixed Sex Accommodation. However, following our feedback management developed mixed sex accommodation guidelines and took immediate steps to ensure the ward followed them. This was done by clustering bedrooms and bathroom facilities at gender specific opposite ends of the corridor.
- Staff told us that management did not routinely de-brief them after incidents on the ward. We heard that staff wanted an official process to feedback and learn from events.

However:

- The ward was clean and well organised.
- The risk assessments were up to date and present in each of the seven client files we read.
- Despite staff shortages, the ward used agency staff known to the ward to support the daily running of the unit.
- There was always a registered nurse on duty.
- All staff received mandatory training during a SMART week. This meant that training was completed over six days to avoid staff missing single days at work for training and disrupting ward rotas.

Are services effective?

Good

We rated effective as **good** because:

- Staff offered patients a wide range of therapies such as drama therapy, CBT and DBT.
- All staff received regular supervision.

However:

- Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA) and Children's Global Assessment

Summary of findings

Scale (CGAS) outcome measuring tools had only been completed on only three out of seven files we scrutinised. Staff used these tools to measure patient improvement wellbeing while in a CAMHS unit.

- Some staff we spoke to did not understand Gillick competence. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. 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.
- Care plans we read were instructive rather than recovery oriented and were not written in the patients' voice. This meant that staff wrote what a patient needed to do and did not explain how this might improve their wellbeing.

Are services caring?

Good

We rated caring as **good** because:

- We observed compassion and care when staff spoke to patients. Patients told us that staff were polite to them and respected their privacy.
- The education lead spoke with care about the patients and attended ward meetings to ensure that they met patients' health and educational needs.
- Staff gave patients a tour of the ward, where possible, before admission. Staff involved parents and patients in regular meetings to review and plan patients' care.
- Patients chaired and minuted a weekly community meeting where they gave feedback to staff about the ward and suggested new activities.

However:

- Patients did not have access to advocacy services on the ward. Advocates can help patients get the services they need and make sure their wishes are heard.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The ward had a wide range of rooms for activities and patients had access to a garden when accompanied by a member of staff.
- There was an accessible bathroom for people who needed wheelchair access.

Summary of findings

- Patients had access to education. Ofsted assessed the education unit as outstanding in 2013.

However:

- Due to staff shortages the ward management agreed with NHS commissioners to accept a small number of patients onto the nine-bed unit until it is fully staffed.

Patients we spoke to said they did not know how to make a complaint.

Are services well-led?

Good

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

- Staff were aware of the trust's vision and values. Staff were supervised and trained.
- Staff understood the whistleblowing policy. This was demonstrated when staff alerted management to issues with some members of staff on the ward and management investigated and took appropriate action.
- We carried out an unannounced visit to the ward on 16 December 2015 following our scheduled inspection. We observed that staff had made improvements to ligature risk identification and management. Management did this by ensuring all staff were aware of the ligature risks and how to manage them. Staff agreed to allocate patients to bedrooms with ligature risks following risk assessments which indicated low self harm risk. We also saw that the ward made changes to meet the Department of Health's guidance on Eliminating Mixed Sex Accommodation. This was done by agreeing to cluster the male and female bedrooms at opposite ends of the corridor as new patients were admitted. Furthermore, male and female bathrooms were placed at opposite ends of the bedroom corridor. Patients were asked to wear appropriate clothing when walking from their bedrooms to their bathroom facilities. In addition, a member of staff was available to observe the corridor throughout each night.

Summary of findings

Information about the service

The Berkshire Adolescent Unit is a nine-bedded inpatient mental health ward for young people in Wokingham. The unit also has day patients. It is the only inpatient child and adolescent service within the trust. The unit is mixed sex and treats young people aged between 12 and 18. They provide 24 hour specialist psychiatric care and treatment for those with a variety of mental health difficulties, which can include anxiety, depression, stressful relationships at home or school, eating disorders and specific mental health problems. At the time of our visit there were three patients admitted to the ward.

The unit has an on-site school which is registered with the office for standards in education, children's services and skills (Ofsted).

In April 2015 the unit changed to a service supporting day patients and inpatients seven days per week. Before this, the service only was open from Monday to Friday.

Our inspection team

The team who inspected the child and adolescent mental health ward comprised of six people: two CQC inspectors, a Mental Health Act Reviewer, a pharmacist inspector, and two specialist advisors with experience in child and adolescent mental health services.

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 this service, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with three patients who were using the service.
- Spoke with the manager and interim service managers for the ward.
- Spoke with 10 other staff members; including a psychiatrist, the ward manager, nurses, health care assistants, and a family therapist.
- Looked at seven treatment records; four for day patients and three for inpatients.
- Looked at other relevant records such as checks of resuscitation equipment, medicine records, staff rotas and trust policies.
- Visited the on-site education unit.
- Carried out a Mental Health Act Review.

Summary of findings

What people who use the provider's services say

Patients told us that they liked the unit. We heard that the staff were nice, respected patients' privacy, knocked before entering their rooms and ensured there were enough activities during the long lunch breaks.

Patients told us that the food was nice and were happy it was cooked by staff on the premises. However sometimes they had the same evening meal two days in a row. Patients reported they were happy with the range of therapies available and felt they had some choice in which therapies they could choose.

Patients told us staff gave them a welcome pack and told them their rights, however we heard that some did not know how to make a complaint.

Patients we spoke to said that staff searched them when they returned to the ward and that they could use their mobile phones from 6pm to 8pm each evening. Patients also told us that they had access to drinks and snacks throughout the day if It was appropriate to their care plan. However, as the kitchen door was locked following a recent patient incident, patients had to rely on staff to open the door to get snacks drinks at the time of our visit.

We heard that patients were free to personalise their rooms and had a named worker who they saw for regular sessions. In between those sessions, patients spoke to staff who were on duty for support if their named worker was unavailable.

Good practice

The joint work with the on-site education unit was good. Teachers in the unit's school passed academic work to patients from their main schools to ensure the patients were learning the same material as other students in their year. Ofsted assessed the school as Outstanding in 2013. Education leads attended ward meetings to ensure that patients' health needs were taken into account when developing learning plans.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the ligature risk assessment is updated and includes details about how all risks are managed. All staff must know where the ligature risks are, understand how to manage those risks, and improve patient risk assessment when allocating bedrooms.

The provider must ensure that staff include all risks that they identify, when making a risk assessment of a patient, in the patient's care plan.

Action the provider SHOULD take to improve

- The provider should ensure that all staff understand Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents' consent
- The provider should ensure that patients have access to a mental health advocate to make sure they have a voice to ask for what they need.
- The provider should ensure staff complete 'health of the nation Scales for children and adolescents' and 'children's global assessment scale' outcome tools for all patients to monitor improvements in patients' wellbeing.
- The provider should ensure management develops and agrees a formal debriefing policy for staff following incidents on the ward.
- The provider should ensure that Gillick competence is assessed for each patient under 16 years of age and ensure that capacity is assessed for those over the age of 16. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is

Summary of findings

governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

- The provider should ensure that patients understand their rights. Staff told us that they told patients their rights. However, there were no signs stating whether patients had the right to leave the building. Also, three patients we spoke to told us they did not know how to make a complaint.
- The provider should ensure that fire extinguishers around the ward are secured to stop patients using them to harm themselves or others.
- The provider shold ensure that the unboxed fuse and other electrical point boxes on the corridor walls are secured to ensure they are tamper proof. They can be reached by patients to stop power supply to the ward.
- The provider should ensure that the unboxed metal pipe and tap on the ward is addressed so it is not a risk to patients.
- The provider should ensure all incidents of restraint are recorded.

Care Quality Commission

Berkshire Healthcare NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Berkshire CAMHS	Berkshire Adolescent Unit

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.

- No patients were detained under the Mental Health Act or the Mental Capacity Act at the time of our inspection. However, we did not see any evidence that staff sought confirmation that the admitting person had parental responsibility for the child or young person to consent to that admission.
- We did not see that staff recorded if children and young people on the ward had been assessed for Gillick competency. There was also no evidence that staff considered any other authority for admitting the children and young people.
- We could not find evidence in the casenotes that staff had assessed whether the children and young people had the capacity to consent to admission and treatment. This was important because none of the patients were detained under the Mental Health Act and some were of an age where they were likely to be able (or be competent) to agree to admission and treatment.
- Two staff said they were unaware of criteria for Gillick competence described in the Code of Practice. We were concerned that patients were being denied leave and access to parts of the ward despite possibly being able to make the decision for themselves.
- The service was not aware of any advocacy support for patients.
- The ward layout did not meet the mixed sex accommodation guidelines required under the code of practice. This meant that that male and female bathing facilities and bedrooms were not in gender specific areas of the ward. However, management took steps to improve this during the inspection.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- No patients were detained under the Mental Capacity Act or Deprivation of Liberty Safeguards on the ward at the time of the inspection.

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

- The unit was bright, in good decorative order, was cleaned daily and was well furnished. Staff had decorated the corridors with patients' art work. Photographs and names of all staff were on display. Lines of sight around the unit were not clear. However there were viewing windows into assessment rooms so that staff could observe patient and family meetings and there was closed circuit television throughout most of the ward. We observed some fire extinguishers in the corridors which were not boxed in. This meant patients could use them to harm themselves or others. There were unboxed fuse and other electrical boxes on the corridor walls which were not secured. They could be reached by patients to stop power supply to the ward. There was an unboxed metal pipe and tap on the ward which could be a danger to patients at risk of self harm. However all radiators on the ward were boxed in.
- The bedroom doors did not have window viewing panels, however staff told us these will be fitted. This meant that if a patient was under observation, staff watched them through an open door throughout the night which did not respect a patient's dignity. The doors were anti-barricade doors.
- The ward did not follow the Department of Health's guidance on Eliminating Mixed Sex Accommodation. We alerted the service manager to this. The senior manager wrote to tell us about changes they made in response to our concerns. The changes included: appropriate gender signage was displayed on toilet and bathroom doors, bathrooms were designated at opposite ends of the corridor for male and female patients, staff discussed with patients the importance of wearing appropriate clothing on the ward at all times, staff will carry out better risk assessments of patients to decide which bedrooms are given to which patients, a printed document about managing gender accommodation was given to all staff to read, staff asked patients in a community meeting about their experience of mixed sex accommodation, an extra member of staff will watch the bedroom area from when the first person goes to bed until 08.30am, the corridor will be split into male and female bedroom areas ongoing as new patients arrive, and the patient admission pack will contain information about appropriate nightwear. The service manager will speak with the trust to discuss possibilities of turning one bedroom into a male bathroom.
- The site had a ligature risk assessment and action plan. Bedrooms had anti ligature fittings. However, we observed ligature points in five out of nine bedrooms which staff had not noted on the assessment. This meant that young people had unsupervised access to rooms with ligature points. We made the ward manager aware of this. Some staff we spoke to were not aware of where the ligature risks were or how to manage the risks they knew of. However, following our visit, management immediately took steps to ensure all staff knew were the risks were and how to manage them. They had done this by the time we carried out an unannounced visit the following week.
- Staff wore personal alarms which they signed in and out daily at reception. There were security alarms in meeting rooms and all bedrooms. The ward's pinpoint alarm system allowed staff to carry alarms throughout the ward and call for assistance if needed. Other staff could find the location of the caller via a display in the main reception office. Staff had to attend the alert as soon as the location was identified.
- There was an assessment bedroom with en suite bathroom on the ward. The manager told us that this was used when a patient was admitted late at night and also as a de-escalation room where a patient could be calmed. The bedroom and shower had anti-ligature curtain rails. However we observed ligature points in the room around the window and panels in the bathroom. We advised the ward manager about this. The furniture layout prevented quick exit for staff in an emergency. The door to this room had a window viewing panel.
- The clinic room was clean and well organised and the medicine expiry dates we checked were all within date. Staff took fridge temperatures. However. this was only evident for two weeks prior to our inspection. Staff printed out a range of medical equipment checklists. However, two of them did not have dates when checks were done. Staff told us that agency staff had written

Requires improvement

Are services safe?

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

dates on one checklist. However, permanent staff were unsure whether checks took place weekly or daily. We observed that staff had used tippex on some forms. We advised the ward manager about this. Staff had checked only 12 pieces of equipment on a list of 37.

- All medical appliances in the clinical room had portable appliance tests in December 2015. The emergency equipment grab bag was fully stocked. We checked the medicines and they were in good supply. There was a defibrillator checklist, however it was blank. Staff took photographs of new patients for prescription cards. Staff completed medicine capacity forms for all new patients to record whether patients understood why they had to take medicine prescribed for them.
- The clinic had some emergency medicines for emergency resuscitation of patients. Staff told us they risk assessed each patient when they were admitted to the ward and ordered emergency medicines as required. The oxygen cylinder was full and the heartstart defibrillator was working. An emergency equipment bag was available.
- There were a range of unboxed fuse and other electrical point boxes on the corridor walls which could be reached by patients to stop power supply to the ward. There was an unboxed metal pipe with a metal tap which a patient could use to self harm. We pointed these issues out to the ward manager.

Safe staffing

- During the day there was a minimum of two registered nurses and three healthcare assistants on duty. Night cover depended on the number of patients, for example, one patient would require two staff and more than two patients required three staff as a minimum. These staffing levels were adequate to meet the needs of the three patients on the ward during our visit. The ward was unable to take more than three patients due to low staffing numbers.
- In April 2015, the unit changed to a service supporting day patients and inpatients seven days a week. Before this the service was only open from Monday to Friday.During this time some staff left and the ward manager told us it was difficult to recruit qualified staff for the new service. There were 2.45 qualified nursing staff vacancies when we visited the ward. The ward required 15 full time nursing staff to meet full staffing levels. NHS commissioners agreed that the ward could have a maximum of three inpatients until more staff were in post. Staffing levels were supported during the recruitment period by three agency staff with three month contracts.
- We heard that some staff found it difficult to carry out patient work while also helping new agency staff who were unfamiliar with the ward.
- Some staff told us that the ward needed a permanent service manager to lead the Tier 4 service. At the time of our inspection, the ward had two interim part time service managers while the trust recruited a full time lead.
- Patients had access to a psychiatrist and doctors as part of the staff team. Out of hours medical care was available from West Call. Out of hours psychiatric care was available via the Prospect Park switchboard which gave access to the junior doctor on call and the on call CAMHS consultant psychiatrist. The unit also had a band 6 or 7 nurse on call.
- Staff were up to date with mandatory training. All staff received mandatory training during a SMART week. This meant that training was completed during a six day period to avoid staff missing single days and disrupting ward rotas. The training included DBT, CBT and prevention and management of violence and aggression training.

Assessing and managing risk to patients and staff

- Staff completed risk assessments using the RIO electronic care records system. There was no record of discussions regarding safeguarding in relation to incidents involving risk and young people on the seven files we scrutinised. For example, one patient recently attempted an overdose and staff took them to A&E however there was no record of safeguarding discussions on their file. Risk assessments were in place and current. However, care plans did not show how risks identified in the risk assessment were managed.
- The three patients on the ward were on general observation except for one who was on 15 minute observations. These were carried out at night by a staff member sitting outside their bedroom with the door ajar which did not protect the patient's dignity.
- The ward had a policy of searching patients by staff who were trained to carry out searches. Staff searched

Requires improvement

Are services safe?

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

inpatients with a metal detector and asked day patients to empty their pockets. Staff took banned articles such as razors and tweezers from patients when they were admitted to the ward.

- Staff were trained in safeguarding and knew who to contact regarding any safeguarding concerns. However there was no evidence of safeguarding input following a number of serious incidents we read in seven client files. For example, a client escaped from the ward through a window and over a wall. Staff found the patient close to the train tracks and brought them back to the ward. There was no evidence on file that this incident was discussed with safeguarding.
- All staff were trained in prevention and management of violence and aggression. The manager reported that de-escalation was always used in the first instance. However a patient told us they had been restrained and a member of staff told us that they had restrained another patient in recent weeks. We concluded that the ward needed to improve how they record incidents of restraint.
- Patients were not allowed to smoke on the trust premises. Nicotine replacement therapy was available and patients were individually assessed by staff to discuss which treatment would suit them best.
- No notices were displayed explaining the rights of informal patients on the ward or close to the locked external and internal ward doors. However, informal patients told us they knew they were free to leave at will.

The kitchen area was locked after a patient incident and could only be accessed using a digital key entry system. This meant that patients relied on staff when they wanted to get drinks and snacks.

Track record on safety

- There had been three serious incidents in the previous six months relating to inpatients. These were where patients had attempted to take an overdose, taken a knife from the kitchen and absconded from the ward. However two members of staff said that the ward manager had not formally debriefed them.
- One incident involved a patient who escaped through a window and over a fence. In response, management increased the height of the fence and fitted window restrictors. Following a non fatal patient overdose on the ward, staff gave patients more water to swallow medicines and asked them to stick their tongues out to make sure they had swallowed the tablets.

Reporting incidents and learning from when things go wrong

- We observed that staff completed incident reporting on an electronic recording program called Datix.
- We heard that the team were waiting for a de-brief for the absconsion incident which took place 14 September 2015. The manager reported the team met with families to de-brief two to three days after incidents took place.
- Staff reported low levels of feedback and learning following recent incidents, including an absconsion and attempted overdose, and suggested that the ward needed a formal de-briefing process so that staff knew what to expect following an incident.

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

- There was a detailed and timely assessment and care plan in each of the seven client files we reviewed. Staff included patients' views in the care plans, however staff did not write them in the patients' voices. The care plans we scrutinised were not recovery focussed. This meant that plans stated what a patient would do but not why and how this task might improve their wellbeing. Physical health assessments were present on all inpatient records.
- Patients told us that they were included in the planning of their care.
- However, we were told by the ward manager that staff started discharge planning on admissionCare plans did not show any evidence of discharge planning. .
- All care plans were stored securely on the RIO electronic recording system.

Best practice in treatment and care

- Staff followed NICE guidance when delivering evidence based treatments, for example Cognitive Behavioural Therapy (CBT) for depression in young people. The ward also followed a multi disciplinary model to deliver patient care by involving a wide range of professionals. We observed that the ward followed NICE guidance by prescribing medicine in small doses together with therapies approved for CAMHS patients, for example CBT. Patients had access to a range of psychological therapies such as CBT, drama, art and eating disorder therapy, Dialectical Behavioural Therapy (DBT), one to one sessions and group work. Some patients told us that this work had helped decrease their anxiety. Patients also had access to a psychologist and family therapist.
- Staff told us that since September 2015 the ward completed Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA) and Children's Global Assessment Scale (CGAS) to record patient outcomes within two weeks of admission. These tools were used to measure any improvement in a patient's wellbeing while in a CAMHS unit. However we only saw these forms on three out of seven files we reviewed. This meant there was no evidence that staff routinely monitored all patients' progress.
- Staff told us they undertook a blank box audit on prescription charts. They had an external child protection audit and an external care plan and case notes audit.

Skilled staff to deliver care

- The multi disciplinary team on the ward included a psychiatrist, psychologist, nurses, health care assistants, family therapist, eating disorder nurse, art therapist, doctors, activity co-ordinator and an education team. A trust pharmacist visited monthly to audit medicine stock.
- All staff received training which included prevention and management of violence and aggression training. Some staff had access to mentorship and leadership programmes and could develop their careers by attending CBT and DBT training.
- Staff were appraised annually and supervised monthly and we observed these meeting dates in staff files. However we did not see supervision notes as one of the service managers told us that staff held their own notes. We heard that preceptorship meetings had not taken place due to staff sickness. These meetings supported learning for nursing staff.

Multi-disciplinary and inter-agency team work

- The unit held a weekly multi disciplinary meeting to review patients' progress and care. The local CAMHS team and social workers attended the weekly meetings and care planning meetings when required.
- We observed handover between shifts. A wide range of professionals were present and we observed good detailed discussion about patient care, risks and progress. Staff in the meeting demonstrated high levels of care for the patients discussed. This was shown through their behaviour and time they took to explore each case.
- Staff told us they involved patients' social workers in all care plan approach (CPA) meetings when staff, family members and the patient agree what should happen next for the patient.

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

- No patients were detained under the Mental Health Act or the Mental Capacity Act at the time of our inspection.

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.

However, we did not see any evidence that staff sought confirmation that the admitting person had parental responsibility for the child or young person to consent to that admission.

- We did not see that staff recorded if children and young people on the ward had been assessed for Gillick competency. There was also no evidence that staff considered any other authority for admitting the children and young people.
- We could not find evidence in the casenotes that staff had assessed whether the children and young people had the capacity to consent to admission and treatment. This was important because none of the patients were detained under the Mental Health Act and some were of an age where they were likely to be able (or be competent) to agree to admission and treatment.
- Two staff said they were unaware of criteria for Gillick competence described in the Code of Practice. We were concerned that patients were being denied leave and access to parts of the ward despite possibly being able to make the decision for themselves.
- The service was not aware of any advocacy support for patients.
- The ward layout did not meet the Eliminating Mixed Sex Accommodation guidelines required under the code of practice. This meant that that male and female bathing facilities and bedrooms were not in gender specific areas of the ward. However, management took steps to improve this during the inspection.

Good practice in applying the Mental Capacity Act

- No patients were detained under the Mental Capacity Act or Deprivation of Liberty safeguards on the ward at the time of the inspection.
- Some staff we asked did not have an understanding of Gillick competence. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. 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.

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 observed staff demonstrating compassion and genuine care towards patients on the ward during our visit. Patients we spoke to said staff were caring and respected them.
- Patients we spoke to said staff organised activities to keep the patients busy.
- Staff we spoke to in the education unit spoke with care about the patients, were proud of their progress and displayed their work on the walls.
- We observed staff gently asking patients if they wanted to speak to us and told them they could meet us as a group if that was easier than meeting us individually.

The involvement of people in the care that they receive

- Staff gave new patients a welcome pack when they arrived at the ward. New patients were invited to visit the ward for a day before being admitted, where possible, so staff could show them the environment and answer their questions.
- Information was given to patients about treatments in their individual sessions.
- Patients we spoke to said they were involved in developing and signing their care plans. However the care plans we scrutinised were not written in the patients' voices.
- The patients we spoke to said they had some choice in which treatments they received. For example, one patient told us they did not like a group session and was allowed to stop and was offered a different therapy instead.
- Patients we spoke to said they knew the names of the staff who looked after them.
- Staff we spoke to were not aware of any mental health advocacy support available for young people. Advocates can help patients get the services they need and make sure their wishes are heard.
- The family therapist ran regular group sessions for family members of patients with eating disorders. Parents were invited to fortnightly care review meetings with staff and patients. Staff we spoke to said families were involved to help reduce risk to patients.
- Staff told us there was an iPad at reception where patients gave feedback. Some patients we spoke to said they did not know how to give feedback or make a complaint. Some staff told us that patients could give feedback on the service they receive in review and family meetings. Some patients told us they did not speak in these meetings however the adults spoke to each other about the patient.
- We heard that a patient was recently took part in an interview panel to recruit new staff. The ward held a weekly community meeting where patients helped to make decisions about their ward. Patients took turns to take minutes and chair the meetings.

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

- Admissions to the ward were planned. Patients were referred to the unit from the community child and adolescent mental health team and their admissions were planned once agreed by the clinical team. Due to staffing levels the NHS England commissioners agreed that a maximum of three patients were admitted to ensure ward safety.
- Staff we spoke to told us that patients were able to return to their bedrooms after coming back to the ward after leave. This meant that the ward did not admit new patients to beds that belonged to patients who were on leave.
- We heard that NHS England arranged for patients to be placed out of area if a patient needed psychiatric intensive care which could not be offered by this ward due to bed availability.
- Patients were discharged during the week and not during the weekend. Care plan approach meetings were held to agree discharge dates with patients, family members and staff. There were zero delayed discharges in the six months prior to our inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to their bedrooms throughout the day.
- There was no lockable space in patient bedrooms or locks to the bedroom doors to keep property safe. Staff told us that patients could put small valuable items for safe keeping in the ward safe.
- Patients could use their mobile phones between 6pm and 8pm. There was no public phone on the ward but patients could use the office phone if they needed to make a phone call Patients carried the office phone to a private area when they made personal calls.
- The ward had a range of rooms including meeting rooms, an activity room, laundry room, dining room, kitchen, medical room, art room and a garden which was accessed by patients with staff. The education unit had two school rooms and a small library.
- There was a secure garden for patients to use when accompanied by a member of staff.
- Patients had access to education three days per week in the education unit located next to the ward. In 2013 Ofsted rated the education unit as outstanding. The education lead attended weekly ward meetings, review and planning meetings to ensure education was developed to meet the needs of each patient. The education unit had computers and internet access and patients signed an internet usage policy to make sure they used the internet safely. Teachers at the unit arranged for patients' schools to send through academic work to ensure that patients' education was developed in line with other students in their classes.
- Patients told us they were happy with the range of activities available however there were fewer activities available at weekends. Staff told us they were arranging more activities for the weekend as part of the transition from a five day service to a seven day service.
- Patients were allowed to personalise their own rooms and we observed this during a tour of the bedroom area. Patients did this by putting posters, photographs and soft toys in their rooms.
- The ward was on the ground floor with wheelchair access, had a disabled bathroom and one bedroom was fitted with a wider door. However, wheelchair access around the ward was difficult as the locked heavy interior doors did not have automated entry door pads.

Meeting the needs of all people who use the service

- The ward had an assisted bathroom and one bedroom had a wider doorway to allow a wheelchair access. There was a ramp to the education unit. The ward was easily accessible as it was on the ground floor.
- Leaflets were not available in a range of languages but a local translation service was used if a patient needed information in another language.
- There was a choice of food. The ward manager told us that they cooked halal and vegetarian food for some patients. We heard that staff regularly accompanied a patient to a local butcher to buy halal meat and helped them to prepare and cook their food. The unit was part of Wokingham Hospital which had a Patient Led Assessments of the Care Environment (PLACE) score of 97.3% for food overall. These assessments focused on the environment in which care was provided, as well as supporting non-clinical services such as cleanliness, food and, hydration.

Are services responsive to people's needs?

Good

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

- The ward manager told us that spiritual support was not offered on the ward, however the chaplain at Prospect Park hospital offered support and advice to patients.

Listening to and learning from concerns and complaints

- Staff told us that patients knew how to make a complaint. There was an iPad at reception where patients could type in feedback and there were complaint forms in the games room and in the welcome pack. However, three patients we spoke to said they did not know how to make a complaint.
- Some staff told us there was learning from complaints and that there was one ongoing complaint at the time of our inspection.

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 we spoke to were aware of the trust's vision and values and these were linked to staff appraisals and individual objectives.
- We heard that the team objectives were linked to the service becoming a Tier 4 unit. This meant that staff worked to make sure there was minimum disruption to patients while the service developed into a seven day a week service and worked with patients needing higher levels of support.
- Staff we spoke to knew the names of the senior trust management. The ward manager said that senior management supported the service very well and provided help when requested. For example the trust approved recruitment of additional staff to meet the needs of the new unit

Good governance

- The ward was organised and was meeting the needs of its three inpatients.
- The change of ward function to a Tier 4 service was on the Trust risk register. However the mixed sex accommodation and bathroom facilities were not on the risk register.The ward manager gathered delayed discharges information to monitor performance.
- The ward manager told us they had authority to do their job and had access to administrative support. We heard that the manager felt very supported by the trust.
- There was a regular patient safety and quality meeting to look at issues which need to be logged on the trust risk register.
- Two members of staff told us they were not informed about risks before a patient was admitted. This meant that staff had to read patient files to find out about patient risk information for themselves. However, staff told us that risk was discussed in daily handovers.
- On 16 December we carried out an unannounced visit to the unit. We did this to check that steps had been taken to improve safety regarding mixed sex accommodation and management of ligature risks on the ward. During our visit we interviewed the service manager, a senior nurse and a health care assistant. All staff told us about the new policies they used to ensure patients are kept safe. Staff told us that the policies will be discussed in ongoing ward meetings with staff and patients. We observed new written policies outlining changes in the management of mixed sex accommodation and concluded that staff knew how to identify and manage existing ligature risks.

Leadership, morale and staff engagement

- Staff we spoke to understood the whistleblowing policy. Some staff told management about inappropriate behaviour of some members of the team. We heard that management took appropriate action in response to the allegations.
- Staff reported mixed views about morale and told us that the team did not know what was expected of them to work as a Tier 4 service and that management was not strong.
- We heard that there was some tension on the ward between staff regarding the old way and the new way of doing things. However, some staff told us that professional differences were managed well in meetings.

Commitment to quality improvement and innovation

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

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 17 HSCA (RA) Regulations 2014 Good governance There were numerous ligature risks on the ward which had not been documented for mitigation in the ward risk assessment. This is a breach of regulation 17(b).

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 9 HSCA (RA) Regulations 2014 Person-centred care Care plans did not describe how staff and patients would manage risks which were identified in patients' risk assessments. This is a breach of regulation 9 3(b).